A SNAPSHOT OF MENTAL HEALTH

CACHE COUNTY, UT

PREPARED FOR
TCI Community
Stakeholder & Advisory Board

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USU TRANSFORMING COMMUNITIES INITIATIVE
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Executive Summary

Due to its growing prevalence, mental health has become a focus in the State of Utah. According to the National Survey on Drug Use and Health (SAMHSA, 2014), Utah has the highest rates of any mental illness (AMI) in the United States. As part of the Utah State University Transforming Communities Initiative, Drs. Jess Lucero, Jennifer Roark, Vonda Jump, and Terry Peak worked with stakeholders to study knowledge, perceptions, and stigma about Mental Health in Utah and in their community. The purpose of this study was to understand how the community perceives mental health and their knowledge of resources available to the community.

Utah State University Junior social work students throughout Utah, gathered data through community canvassing in the Cache Valley community, online survey distribution with various community and religious organizations, and throughout social media survey recruitment. After data was gathered, STATA software was used to analyze the data received. The following is an overview of the findings for Cache County.

Overview of Findings

- In the Cache Valley sample, the majority of respondents was female (62.9%), White (89.3%), heterosexual (94%), married (57.5%), and a member of the Church of Jesus Christ of Latter Day Saints (LDS) (67.1%).
- In total, roughly 1 in 5 Cache County residents are experiencing severe to extremely severe anxiety, depression, and/or stress, using the DASS-21 Scale.
- Of the participants who were experiencing severe or extreme levels of mental health distress, only 20.9% were currently receiving mental health services.
- Participants who were lower income were more likely to be experiencing severe or extremely severe mental health distress.
- LGBTQ* individuals experienced higher levels of depression, anxiety, and stress.
- Non-LDS participants compared to LDS participants had higher levels of agreement that LGBTQ* individuals experience the following: discriminated against, admired, bullied, and singled out.
- The top three responses on how LGBTQ* individuals are treated in their community, were bullied (38.3%), Never noticed (38.1%), and gossiped about (33.1%).
- Women (72.7%) compared to men (58.1%) were more likely to strongly disagree or disagree that women are less likely to be diagnosed with a mental illness compared to men.
- On average, participants disagreed that our community holds events raising awareness for mental health issues (M=2.82).
- Mental illness was the 5th most highly rated community concern.
- Participants reporting that they had a mental health diagnosis were overall more aware of agencies offering mental health services and their resources when compared to those who reported they did not have a current mental health diagnosis.
BACKGROUND

Mental health disorders are a leading cause of worldwide health-related disability (Whiteford, Harris, & Diminic, 2013). Due to its growing prevalence, mental health has become a focus in the State of Utah, which has the highest rates of any mental illness (AMI) in the United States according to the most recent data from the National Survey on Drug Use and Health (SAMHSA, 2014). AMI is defined as the presence of any mental, behavioral, or emotional disorder in the past year that met the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria. In Utah, 22.4% of the population have experienced any mental illness compared to 18.2% across the country. Additionally, almost 5% of adults aged 18 or older in Utah have had serious thoughts of suicide in the past year, and more than half of adults with any mental illness did not receive treatment the prior year (SAMHSA, 2015). The National Alliance on Mental Illness defines mental illness as a condition that can alter or influence one’s thinking, feeling, mood, and overall well-being. Research demonstrates that the general public has difficulty in defining mental illness and recognizing the warning signs and symptoms (Jorn, 2000). Difficulty in defining mental illness may also be intertwined with publicly-held stereotypes of mental illness or connected to the stigmatization of persons with mental illness (Rusch, Angermeyer, & Corrigan, 2005).

Compounding issues of the public’s knowledge of and attitudes towards mental illness are issues of access and utilization of services. Research demonstrates that many people, especially those in minority groups, may find hardships in accessing mental health resources due to lack of time and financial resources; cultural barriers, language barriers, transportation barriers, and limited available services (Ruiz, 2002; Young & Rabiner, 2015; Kessler et al., 2008; Garfield et al., 2011; Moskos, 2007; Kaufman, 2012). Also, many individuals in need of mental health services may not know where to gain assistance for their needs (Ruiz, 2002) and if they do know where to find providers, the providers may be limited (Young & Rabiner, 2015). Ultimately, only a small portion (between 33 and 46 percent) of persons seek mental health services (Henke, Chou, Chanin, Zides, & Hudson-Scholle, 2008).

The lack of mental health knowledge, amount of stigma, and barriers for seeking help each pose significant problems for communities across the United States and in Utah where mental illness rates are higher and service utilization rates are low. Although there are large-scale surveys on mental illness prevalence (e.g., the NSDUH), there is little in the way of community-based data that examines the nuances and contexts that accompany these rates of mental illness in Utah. Therefore, the purpose of this study was to examine Utah’s perceptions of mental illness and the rates of mild mental illness among the general public. Specifically, this study examined perceptions of stigma, barriers, sources of help-seeking, issues related to LGBTQ* mental health, and the general public’s rates of anxiety, depression, and stress. By gaining the general public’s perceptions (knowledge, attitudes, and experiences) regarding mental health, community-based mental health agencies can tailor community responses to mental illness. While this sort of work is important at various scales (i.e., national, state, and local), it may be most influential at the local level. These data are critical in order to inform future educational outreach efforts and community responses aimed at increasing public awareness of mental health issues.

To this end, a community-based research (CBR) project was developed. Community-based research is a collaborative research effort in which academic and community partners share in all aspects of the research process (Israel, Schelz, Parker, & Becker, 1998). In social work, CBR promotes social action and data-driven prevention/intervention strategies. CBR projects can facilitate long-lasting university-community partnerships and provide opportunities for students to be actively engaged in meeting the needs of their communities through research (Cooke & Thorme, 2011). This CBR project involved a partnership between numerous mental health agencies and Utah State University’s Social Work Program that focused on students’ collection, analysis, and application of data that assesses public knowledge, attitudes and experiences among Utah residents.
Research Questions
Below we describe our proposed research aimed at both the general public and the Utah Human Service Agencies.

1) What knowledge does the general public have concerning mental health (e.g., definitions, perceptions of effectiveness of community responses)?

2) What attitudes do the general public hold concerning mental health (e.g., level of denial, stigma, and perceptions of effectiveness of community responses)?

3) What is the general state of mental health for Utahns (e.g., depression, stress, anxiety)?
METHODS

Although this report details the results from the Cache County surveys, this project was a smaller portion of a larger project surveying areas throughout Utah. The methods describe the entire state-wide project. For the Cache County findings, we used neighborhood canvassing, social media, and community organization outreach.

Design

This project includes a quantitative, cross-sectional survey design wherein members of Utah’s general public were asked to provide their survey responses (hard copy or online) to a series of questions aimed at assessing their attitudes and knowledge regarding mental health

Student Training

In collaboration with numerous mental health agencies and under the direction of Assistant Professors Jessica Lucero, Vonda Jump, and Jennifer Roark, approximately 75 undergraduate social work students were trained in quantitative survey methods and data analysis. Students were CITI certified by the first week of class in the spring 2017 semester. For every component of the research project, students were instructed in how to competently engage in research. There was one dedicated class period for each stage of the sampling plan, wherein students were trained in how to respond to potential challenges that may arise as well as how to competently and respectfully interact with potential survey participants at their doorstep, over the phone, via email and through social media channels.

Sampling

The general public sample was recruited for survey participation in 3 separate ways: (1) through direct neighborhood canvassing efforts in Logan, Price, Moab, Brigham City, Tooele and Blanding; (2) through social media survey recruitment efforts in Salt Lake City, Ogden, and Provo; (3) through online survey distribution efforts with various community and religious organizations in the aforementioned cities. The ultimate goal of this three-pronged sampling plan was to obtain a sample of individuals who were diverse in race, socioeconomic status, and religion. The USU Social Work Program consists of students in Logan, Moab, Price, Tooele, Brigham City, and Blanding, Utah. In these cities, a stratified sampling technique was utilized wherein we identified neighborhoods (operationalized as block groups according to The U.S. Census Bureau) based on income and racial/ethnic diversity. Student researchers canvassed in-person to administer surveys in each city from a neighborhood in each strata (i.e., high, middle, low-income; higher proportion White, moderate proportion White; and low proportion White). Cut-off points were determined by calculating geographic area tercile points for the Census indicators in question. See Table 1.1 for a breakdown of our data collection goals by city and sample strata. We anticipated sampling method 1 would produce approximately 600 completed surveys.

In order to collect data from other cities in the state (i.e., Salt Lake City, Ogden, and Provo), we used social media survey promotion methods aimed specifically at regions of the state in which we did not have students. For this mode of data collection, all students in the class were asked to promote the survey through a variety of social media channels, using standardized language and asking their social media ‘friends’ and ‘followers’ to complete the survey and ‘share’ the survey if they live in the specified regions noted above. We anticipated collecting an additional 1,200 surveys through this sampling strategy.
Finally, in order to ensure we collected responses from a racially, socioeconomically, and religiously diverse sample, we approached various community and religious organizations in the aforementioned cities to inquire if they would send an online link to the survey to their listservs. We anticipated collecting an additional 200 surveys using this strategy. In each of the three sampling plans, trained student researchers used structured protocols for interaction and distributed letters of information prior to conducting the survey. Additionally, survey participants were offered an opportunity to be entered into a drawing for three $25 gift cards as a token of thanks for their participation.

### Data Analysis

Following entry of the hard copy survey data, we used STATA software to conduct basic descriptive and bivariate statistics that summarize the knowledge, attitudes, and experiences related to mental health among the general public. In order to test how our various sampling strategies produced demographically disparate samples, we coded surveys according to our 3 sampling strategies. This allowed us to estimate chi-squares, and ANOVA statistics that demonstrate the similarities/differences between sub-samples. Students were involved in every step of the analyses, but especially in the interpretation and dissemination of the results.

### Data Dissemination

In addition to providing a real-world context in which students learn to engage in macro-level research, this project has resulted in useful data that will help improve educational outreach efforts and community responses to mental health issues in communities across our state. At the end of the spring 2017 semester, students participated in various community outreach events across the state, informed by what they learned in class and what they learned from the research. Students were able to connect to over 600 community residents through outreach efforts in schools, at health fairs, through newspaper outreach, and at community meetings.
FINDINGS

Participants’ Demographics
The majority of the Cache County sample was female (62.9%), White (89.3%), heterosexual (94%), married (57.5%), and a member of the Church of Jesus Christ of Latter Day Saints (LDS) (67.1%). See table 1.1 for additional sample demographic characteristics.

Table 1.1 Sample Characteristics (Cache County N=567)

<table>
<thead>
<tr>
<th></th>
<th>% (Mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>62.9</td>
</tr>
<tr>
<td>Male</td>
<td>36.5</td>
</tr>
<tr>
<td>Other</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>57.5</td>
</tr>
<tr>
<td>Single</td>
<td>27.7</td>
</tr>
<tr>
<td>Not married but living with significant other</td>
<td>5.7</td>
</tr>
<tr>
<td>Divorced</td>
<td>4.8</td>
</tr>
<tr>
<td>Widowed</td>
<td>2.3</td>
</tr>
<tr>
<td>Other</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>89.3</td>
</tr>
<tr>
<td>Latino</td>
<td>5.5</td>
</tr>
<tr>
<td>Asian American/Pacific Islander</td>
<td>1.8</td>
</tr>
<tr>
<td>Native American</td>
<td>1.4</td>
</tr>
<tr>
<td>Black</td>
<td>0.2</td>
</tr>
<tr>
<td>Other</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>94.0</td>
</tr>
<tr>
<td>Gay or Lesbian</td>
<td>2.1</td>
</tr>
<tr>
<td>Bisexual</td>
<td>3.2</td>
</tr>
<tr>
<td>Other</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Political Party</strong></td>
<td></td>
</tr>
<tr>
<td>Republican</td>
<td>41.6</td>
</tr>
<tr>
<td>Democrat</td>
<td>20.1</td>
</tr>
<tr>
<td>Independent</td>
<td>19.3</td>
</tr>
<tr>
<td>Libertarian</td>
<td>5.0</td>
</tr>
<tr>
<td>Other</td>
<td>14.0</td>
</tr>
<tr>
<td><strong>Religious Affiliation</strong></td>
<td></td>
</tr>
<tr>
<td>LDS</td>
<td>67.1</td>
</tr>
</tbody>
</table>
Mental Health Status

To assess mental health status in our sample, we used the Depression, Anxiety, and Stress Scale-21 (DASS-21) item scale to assess for levels of depression, anxiety, and stress. In our Cache County sample, 8.4 percent were experiencing symptoms of severe or extreme levels of depression, 10.7 percent with symptoms of severe or extreme anxiety, and 6.1 percent with symptoms of severe or extreme stress. See Figure 2.1 for a breakdown of mental health status for the full sample.

**Figure 1. Percentage of Participants Who Met DASS-21 Cut-Off points for Stress, Anxiety, and Depression**

In total, approximately 1 in 5 Cache County residents are experiencing severe to extremely severe anxiety, depression, and/or stress. This figure is on par with national estimates. Of those who were experiencing severe or extreme levels of mental health distress, only 20.9 percent were currently receiving mental health services as shown in Figure 2.2.
One of the greatest barriers to accessing mental health services was related to costs. Figure 2.3 shows that those with lower income were more likely to be experiencing severe or extremely severe mental health distress. This is operationalized as falling into the severe or extremely severe category of depression, anxiety, or stress.

There were no statistically significant differences between men and women regarding severe or extreme mental health distress, but there were significant differences noted for those identifying as LGBTQ* as compared to those who did not. LGBTQ* individuals experienced higher levels of depression, anxiety, and stress. This is shown in Figures 2.4, 2.5, 2.6.
Figure 2.4 Depression by Sexual Orientation

![Depression by Sexual Orientation Diagram](image1.png)

Figure 2.5 Anxiety by Sexual Orientation

![Anxiety by Sexual Orientation Diagram](image2.png)

Figure 2.6 Stress by Sexual Orientation

![Stress by Sexual Orientation Diagram](image3.png)
Stigma
Participants were asked to rate their level of agreement after reading a series of statements regarding how most people in their community would think, respond, or behave to various mental health issues. These items represent participants’ perceptions of their community and the degree to which they believe their community stigmatizes mental health. In total, there were 12 items, and the items were summed into a scale score. The score ranged from 12-60, with higher scale scores indicating perceptions of greater community mental health stigma. For the full sample, the average stigma score was 35.40 (SD=7.02). Refer to table 3.1 for a breakdown of each item. Mean scores are interpreted on a scale of 1-5, with 1=strongly disagree to 5=strongly agree.

Table 3.1 Mean Scores for Perceptions of Community Mental Health Stigma

<table>
<thead>
<tr>
<th>Stigma Item</th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most people in this community would accept a person who has been in a mental hospital as a close friend.</td>
<td>3.20</td>
<td>0.97</td>
</tr>
<tr>
<td>Most people in this community believe that someone who has been hospitalized for mental illness is dangerous.</td>
<td>2.92</td>
<td>0.98</td>
</tr>
<tr>
<td>Most people in this community believe that a person who has been hospitalized for mental illness is just as trustworthy as the average citizen.</td>
<td>2.67</td>
<td>0.89</td>
</tr>
<tr>
<td>Most people in this community accept a person who has fully recovered from mental illness as a teacher of young children in a public school.</td>
<td>2.70</td>
<td>1.01</td>
</tr>
<tr>
<td>Most employers will not hire a person who has been hospitalized for mental illness</td>
<td>2.67</td>
<td>0.91</td>
</tr>
<tr>
<td>Most people in this community think less of a person after he/she has been hospitalized for a mental illness.</td>
<td>3.11</td>
<td>1.04</td>
</tr>
<tr>
<td>Most people in this community would be willing to marry someone who has been a patient in a mental hospital.</td>
<td>2.84</td>
<td>0.90</td>
</tr>
<tr>
<td>Most employers will hire a person who has been hospitalized for mental illness if he or she is qualified for the job.</td>
<td>3.55</td>
<td>0.83</td>
</tr>
<tr>
<td>Most people in this community believe that entering a psychiatric hospital is a sign of personal failure.</td>
<td>2.88</td>
<td>1.14</td>
</tr>
<tr>
<td>Most people in this community will not hire a person who has been hospitalized for serious mental illness to take care of their children, even if he or she had been well for some time.</td>
<td>3.42</td>
<td>0.97</td>
</tr>
<tr>
<td>Most people in this community in my community would treat a person who has been hospitalized for mental illness just as they would treat anyone.</td>
<td>3.10</td>
<td>0.99</td>
</tr>
<tr>
<td>Most young people in this community would be reluctant to date someone who has been hospitalized for a serious mental illness.</td>
<td>3.35</td>
<td>0.93</td>
</tr>
</tbody>
</table>

We examined stigma scores by various demographic characteristics and found several statistically significant comparisons. Individuals who were currently in severe to extremely severe mental health distress (M=36.8), had significantly higher stigma scores compared to those who were not (M=34.7). Furthermore, a One-Way ANOVA showed significant differences in stigma scores by religious affiliation. Specifically, we found that those who identified as Atheists reported significantly higher perceptions of stigma (M=38.7) compared to those who identified as LDS (M=34.6).
Perceptions and Knowledge of Mental Health

Participants were asked to rate their level of agreement with a series of statements concerning mental health. A Likert scale from 1 to 5 was used where 1 is strongly disagree, 2 is disagree, 3 is neutral, 4 is agree, and 5 is strongly agree. Descriptive statistics showed a fair amount of variation in level of agreement between statements. See Figure 4.1. For the full sample, on average, participants tended to disagree that women are less likely to be diagnosed with a mental illness compared to men (M=2.27). In other words, most people felt that women are more likely to have a mental illness compared to men. Participants also felt, on average, that men are less likely to access mental health services compared to women (M=3.61). However, most participants agreed that our society should adopt a more tolerant attitude toward mental illness (M=4.36).

Figure 4.1 Perceptions of Mental Health

Notes: Figure 4.1 Mean of participants in the full sample and their responses in regards to perceptions of mental health using a descriptive statistics test for Cache Valley.

To better understand the differences between demographics, a chi-square test was used to identify statistically significant differences. There was no statistical significance with income and perceptions of mental health. There were also no statistical differences with marital status and perceptions of mental health.

We were interested in the difference in perceptions of mental health between genders. Using a chi-square test, we found that women (72.7%) compared to men (58.1%) were more likely to strongly disagree or disagree that women are less likely to be diagnosed with a mental illness compared to men. See Figure 4.2.
**Figure 4.2 Gender Comparisons of Gendered Beliefs Regarding Mental Health**

Notes: **Figure 4.2** Percentage of participants between level of agreement in regards to the following statement: Women are less likely to be diagnosed with a mental illness compared to men. Chi-Square test was used and significance was shown (p<.05).

We were interested in the difference in perceptions of mental health between individuals with a current mental health diagnosis and those without. There were statistically significant differences in 5 items in regards to perceptions of mental health. See **Figure 4.3**.

**Figure 4.1 Perceptions of Mental Health**

Notes: **Figure 4.1** Mean of participants in the full sample and their responses in regards to perceptions of mental health using a descriptive statistics test for Cache Valley.

To better understand the differences between demographics, a chi-square test was used to identify statistically significant differences. There was no statistical significance with income and perceptions of mental health. There were also no statistical differences with marital status and perceptions of mental health.
We were interested in the difference in perceptions of mental health between genders. Using a chi-square test, we found that women (72.7%) compared to men (58.1%) were more likely to strongly disagree or disagree that women are less likely to be diagnosed with a mental illness compared to men. See Figure 4.2.

**Figure 4.2 Gender Comparisons of Gendered Beliefs Regarding Mental Health**

![Figure 4.2](image)

**Notes:** Figure 4.2 Percentage of participants between level of agreement in regards to the following statement: Women are less likely to be diagnosed with a mental illness compared to men. Chi-Square test was used and significance was shown (p<.05).

We were interested in the difference in perceptions of mental health between individuals with a current mental health diagnosis and those without. There were statistically significant differences in 5 items in regards to perceptions of mental health. See Figure 4.3.

**Figure 4.3 Perceptions of Mental Health between Participants with a Mental Health Diagnosis**

![Figure 4.3](image)

**Notes:** Figure 4.3 Mean comparison between participants who have a current mental health diagnosis and those who do not and their perceptions of mental health. *Signifies statistical significance using an independent samples t-test (p<.05).*
Community
Participants were asked to rate their level of agreement to a series of statements on a 5 point likert scale (higher scores indicating higher levels of agreement) in regards to their community and mental health. Below we present mean scores for each statement for the Cache County sample. On average, participants disagreed that our community holds events raising awareness for mental health issues (M=2.82). Across the board, there was relatively little agreement with each of the statements, suggesting this is an area of intervention to consider in the future. See Figure 5.1.

Figure 5.1 Community and Mental Health

![Bar chart showing mean levels of agreement for statements regarding community and mental health.]

Notes: Figure 5.1 Mean of levels of agreement (1=strongly disagree to 5=strongly agree) for statements regarding community and mental health.

We were interested to see how various demographic factors related perceptions about community and mental health. We found no statistical differences between level of education and level of agreement with community and mental health statements. However independent samples t-tests showed some significant differences by mental health status. Individuals who reported having a current mental health diagnosis had significantly lower levels of agreement that mental health issues are not a problem in their community and that their community makes mental health a priority when compared to individuals without a current mental health diagnosis. See figure 5.2 for details.

Figure 5.2 Beliefs about Community and Mental Health by Mental Health Diagnosis

![Bar chart showing mean level of agreement for statements regarding community and mental health by mental health diagnosis.]

Notes: Figure 5.2 Mean Comparison between participants with a current mental health diagnosis and those without and their level of agreement in regards to the larger community and mental health. *Signifies statistical significance using an independent samples t-test (p<.05)
Community Concerns

Participants were asked about their levels of concern for several community issues. There were 12 community issues listed as well as an other-specify option. Participants were asked to indicate their level of worry (1=Not Worried, 2=Somewhat Worried, 3=Neutral, 4=Worried, 5=Very Worried). For the full Cache County sample, on average, the concern most highly rated was school violence/bullying. Mental illness was the 5th most highly rated concern, and Burglary/Theft was the least concerning issue to the sample. See Table 6.1 for details and rankings of community concerns.

Table 6.1 Mean Level of Concern regarding Community Issues

<table>
<thead>
<tr>
<th>Community Issues</th>
<th>Mean Level of Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Violence/Bullying</td>
<td>3.76</td>
</tr>
<tr>
<td>Suicide</td>
<td>3.7</td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>3.64</td>
</tr>
<tr>
<td>Air Quality</td>
<td>3.59</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>3.4</td>
</tr>
<tr>
<td>Other</td>
<td>3.37</td>
</tr>
<tr>
<td>Pornography</td>
<td>3.36</td>
</tr>
<tr>
<td>Child Abuse</td>
<td>3.25</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>3.24</td>
</tr>
<tr>
<td>Traffic</td>
<td>2.94</td>
</tr>
<tr>
<td>Drugs and Drug Dealing</td>
<td>2.88</td>
</tr>
<tr>
<td>Human Trafficking</td>
<td>2.31</td>
</tr>
<tr>
<td>Burglary/Theft</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Agency Awareness

Participants were asked about their levels of awareness for several mental health or related agencies in the community. Seventeen community agencies were listed and participants were asked to indicate their level of awareness of the agency (i.e., Unaware, Aware of the agency but NOT aware of the mental health services they offer, or Aware of the agency and the services they offer). Figure 7.1 shows the levels of awareness of the full Cache County sample for each agency. The figure depicts a trend that held true for 10 of the 17 agencies listed (i.e., Community Health Centers, Health Department- Substance Abuse, Community Mental Health Clinic, Intermountain’s Behavioral Health Network, Local Hospital BHU, National Alliance for the Mentally Ill, National Suicide Prevention Lifeline, Private Practice, University Resources, Veteran’s Crisis Line) showing that while people may be aware of an agency, many are not aware of what mental health services are offered.

To further examine levels of awareness, we employed a chi square test to examine the responses of participants who reported that they have a current mental health diagnosis. We found that participants reporting that they had a mental health diagnosis were overall more aware of agencies offering mental health services and the services they offered when compared to those who reported they did not have a current mental health diagnosis. For example, when looking at levels of awareness of Community Health Centers among participants, we found that 30.1% of those who have a current mental health diagnosis are aware of the agencies and what services they offer, compared to 19.1% of those who reported not having a current mental health diagnosis. This trend held true for all agencies suggesting that those who have been exposed to the mental health system are more likely to be aware and knowledgeable of resources.
Figure 7.1 Levels of Awareness for Community Agencies

Notes: Figure 7.1 Depicts percentages of the sample by each category of awareness for all 17 agencies for the full sample

Barriers to Accessing Mental Health Services

Participants were asked what they felt were barriers to accessing mental health services in the community. For the full sample, the most often cited barriers were cost, lack of mental health coverage, shame, and the fear of being discriminated against. Conversely, weather, geographic distance, and transportation were some of the least cited barriers. These results indicate that external barriers related to travel seem to be less important than internal barriers like shame or fear of discrimination. Of note, cost and lack of mental health coverage (external barriers), are the most pervasive barriers in our sample with 4 out of 5 participants in the full sample citing this issue as a barrier to seeking mental health services in their Cache County community.

In order to get a better sense of how barriers may differ based on key demographic factors, we employed a series of bivariate statistical tests. Figure 8.1. shows the discrepancies between men and women participants in mental health barriers. There were statistically significant differences between men and women in the proportion who reported childcare, family responsibilities, lack of mental health coverage, cost, weather, and transportation as barriers. For every barrier except religious beliefs, a higher proportion of women cited each barrier than did men.
Related to barriers, our survey assessed how much a typical session with a mental health service provider would cost an individual, and how much they would be willing to pay for those services. Given that the most common barrier cited in the full sample was cost, these data provide further insight. In general, the more that a session costs, the more people are not willing to pay for mental health services. This is shown in Figure 8.2.

**Figure 8.2 Breakdown of Cost Willingness/Necessity for Mental Health Services**

As the LDS religion was the most prevalent religious affiliation in the sample, we looked at what barriers were distinctly different based on if the respondent was LDS or not. The only statistically significant differences were barriers regarding sexual orientation and religious beliefs. These results are shown in Figure 8.3.
We also looked at barriers that were unique to the LGBT population. The only statistically significant difference in reported barriers by sexual orientation was sexual orientation. Amongst the LGBT population, 48.6 percent listed sexual orientation as a barrier to seeking mental health services, whereas in the non-LGBT population, only 26.6 percent listed it as a barrier.
**Timeliness of Services**

Participants were asked to indicate their perceptions of the likelihood of receiving timely services from seven agencies (i.e., General Health Practitioners, Community Mental Health Center, Emergency Room, Family Place, LDS Family Services, Private Practice, USU Mental Health Services). Generally, for the full sample, about 1/3 or more indicated they would ‘likely’ receive timely services from every agency listed.

To investigate further, we ran a chi-square test to examine the differences in responses of participants who reported that they have a current mental health diagnosis compared to those who did not. We observed a statistically significant difference in perceptions of participants reporting to have a current mental health diagnosis compared to those who do not have a current mental health diagnosis. We observed that generally, more of those who reported to have no current mental health diagnosis were more optimistic about receiving timely services by indicating that they were ‘likely’ to receive timely services in comparison to those who indicated having a current mental health diagnosis who reported differing perceptions about receiving timely services. For example, figure 9.1 illustrates one such instance in the case of Community Mental Health Centers where those with no mental health diagnosis were more likely to report that they would be able to obtain timely services whereas those reporting having a current mental health diagnosis reported the opposite. This suggest that individuals who have been in the mental health system and have direct experience with this issue, tend to believe that they will not receive timely services in their community.

*Figure 9.1 Perceptions of Timeliness of Services: Community Mental Health Centers*
System of Belief
We wanted to assess the level of importance of people's "system of belief" in regards to mental health. We defined "system of belief" as any religious, spiritual, or non-religious/spiritual system of values, beliefs, and practices that represent [participants'] relationship to God, a higher power, or the lack thereof. Figure 10.1 shows the level of agreement with each statement in reference to one's system of belief between LDS and non-LDS participants. Those who identified as LDS had a higher level of agreement with all of the statements.

Figure 10.1 Perceptions of Mental Health within One’s System of Belief

Effectiveness of Services
Participants were asked to rate the effectiveness of 13 resources in the community (i.e., Community Mental Health Clinic, Close Friends, Extended Family, Immediate Family, General Health Practitioner, LDS Family Services, Mental Health Court, Neighbors/Community, Police, Private Practice, Spiritual/Religious Community, Family Place, University Mental Health Services) based on their perceptions of effectiveness (i.e., Very Ineffective, Ineffective, Neutral, Effective, Very Effective).

For the full sample, on average, we found the mean score of effectiveness for all agencies was at a minimum a 3.0 or above on a 5-point scale (i.e., Very Ineffective, Ineffective, Neutral, Effective, Very Effective). To further investigate reported perceived effectiveness, we compared the mean reported levels of perceived effectiveness of participants who reported having a current mental health diagnosis against those who reported they did not have a current mental health diagnosis. We found that in every category, with the exception of private practice, those with no reported current mental health diagnosis had higher mean scores, indicating that they perceived the agency to be more effective than those reporting they had a current mental health diagnosis. Figure 11.1 depicts our findings.
LGBTQ*

The study aimed to gain more information about the community’s perceptions and knowledge of LGBTQ* individuals. Participants were asked if they ever felt marginalized because of their sexual orientation, and 5.9% of participants indicated ‘yes’. Participants were also asked how aware they were about LGBTQ* issues in their community with 16.9% responding ‘very aware’, 46.2% ‘somewhat aware’, 11.9% ‘neutral’, 11.2% ‘somewhat unaware’ and 11.5% ‘unaware’. They were also asked how LGBTQ* people are currently treated in their community. For the full sample, the highest responses were bullied, never noticed, gossiped about, and singled out. See Figure 12.1.

Figure 12.1 LGBTQ* and Community Treatment

Notes: Figure 12.1 Percentage of participants and how they felt that LGBTQ* individuals are treated in the community. This item was a check all that apply, so percentages do not add up to 100%.
We used a chi-square test to investigate further the differences between LGBTQ* participants and non-LGBTQ* participants. There were statistically significant differences between how LGBTQ* and non-LGBTQ* individuals felt LGBTQ* individuals were treated in the wider community. LGBTQ* participants felt that LGBTQ* individuals are more likely to be bullied, discriminated against, singled out, admired, and popular. See Figure 12.2.

*Figure 12.2 Beliefs about Community Treatment of LGBTQ* Individuals by Sexual Orientation*

![Figure 12.2](image)

*Notes: Figure 12.2* Percentage of LGBTQ* and Non-LGBTQ* Participants in the full sample who felt that LGBTQ* individuals are more likely to be treated in the certain ways by the larger community. Items were statistically significant using a Chi-Square test (p<.05).

We were interested in the differences between LDS and non-LDS participants in this area, and employed another chi-square test to determine the differences in perceptions of LGBTQ* treatment by religious affiliation. There were statistically significant differences between discriminated against, admired, bullied, and singled out. Non-LDS participants were more likely to agree that LGBTQ* individuals were treated unfairly in the larger community comparing the scale items. See Figure 12.3

*Figure 12.3 Beliefs about Community Treatment of LGBTQ* Individuals by Religious Affiliation*

![Figure 12.3](image)

*Notes: Figure 12.3* Percentage of Participants and the differences between LDS and Non-LDS participants and their perceptions of LGBTQ* treatment in the larger community using a chi-square test (p<.05).
Participants were also asked for their level of agreement in regards to how much they agreed that LGBTQ* people are at greater risk of various experiences. Figure 12.4 shows the mean levels of agreement (range of 1 to 5 with higher numbers indicating higher levels of agreement) of participants in the full sample in reference to experiences of the LGBTQ* community. The highest mean scores in the full sample included religious isolation, bullying, and suicide. In other words, Cache County residents believe that LGBTQ* individuals in their community are at greater risk of experiencing religious isolation, bullying and suicide compared to those who are not LGBTQ*.

**Figure 12.4 Perceptions of LGBTQ* Experiences in the Community**

Chi-square tests were conducted to determine if there were significant differences between LGBTQ* participants and non-LGBTQ* participants in perceptions of LGBTQ* risks. Results showed that LGBTQ* participants were on average more likely to agree that LGBT individuals are at risk of experiencing social isolation from family/friends, homelessness, bullying, violence, suicide, religious isolation, and domestic violence. Non-LGBTQ* participants were on average more likely to agree compared to LGBTQ* participants that LGBTQ* individuals experience nothing different than anyone else. See Figure 12.5

**Figure 12.5 Perceptions of LGBTQ* Experiences in the Community by Sexual Orientation**

Notes: Figure 12.4 Mean level of participant agreement on a 5-point Likert scale of 1=strongly disagree to 5=strongly agree.

Notes: Figure 12.5 Mean level of participant agreement on a 5-point Likert scale of 1=strongly disagree to 5=strongly agree.

* Signifies statistical level of significance using an independent samples t-test (p<.05).
We used an independent samples t-test to compare LDS and non-LDS participants and their level of agreement in LGBTQ* experiences. There was a statistically significance difference between groups across all items. Non-LDS participants were on average more likely to agree that LGBTQ* individuals are at risk of experiencing each of the harmful scenarios compared to those who were LDS. See Figure 12.6.

Figure 12.6. Perceptions of LGBTQ* Experiences in the Community by Religious Affiliation

Notes: Figure 12.6 Mean level of participant agreement on a 5-point likert scale of 1=strongly disagree to 5=strongly agree. There is a statistical level of significance with all items using an independent samples t-test (p<.05).
Conclusion and Recommendations

Based on the results, various recommendations were made by the TCI Stakeholders Board during a meeting. One of the main statements made by various stakeholders included the importance of letting community members know resource lists available to them. Through the Bear River Health Department in the Tri-County area, there is a list of mental health providers throughout Cache Valley. This list includes detailed information on different resources such as insurance plans accepted, LGBT affirmative treatment, specialty areas, etc. There is also a list through Intermountain Hospital. Stakeholders mentioned how the city or county could play a role in information residents of the resource lists.

It is important to raise for community awareness and events that address mental health. Stakeholders informed others that ACE so coalition is working on doing community events.

Something heard throughout the meeting was how we can use the data from this study to start a wider conversation. Various ideas were thrown out in the meeting. A representative of Logan City suggested presenting to Logan City Council and the County Commissioners the results in September. There was also suggestions by various Stakeholders to present at a town hall meeting about this issue. Stakeholders also mentioned how it would be important to inform the Cache County Suicide Prevention coalition, a sub group coalition of the Interagency council, the data of this study.

Overall, the information and data received from this survey is very beneficial in helping inform policymakers, local city government, and community members on mental health and the resources available, as well as where there are gaps in the community.

Utilizing Research

If interested in the data from this study or for additional data analysis of relationship between particular issues contact Dr. Jessica Lucero at Jessica.lucero@usu.edu
References


TRANSFORMING COMMUNITIES INITIATIVE

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The TCI is a community-based research initiative that brings together faculty, students, and community leaders. We partner with human service agencies to address the pressing social needs within our local and statewide communities and social service system through research, teaching, and action.