Creating Culturally Competent and Responsive Mental Health Services: A Case Study Among the Amish Population of Geauga County, Ohio

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Abstract

Providing effective mental health services requires knowledge about and cultural competence across a wide array of beliefs and practices. This study provides an example of a successful project to improve public mental health service delivery in an Amish community. County boards of mental health in a rural area of Northeast Ohio contacted researchers in 1998 to provide assistance in reaching the Amish community because of a concern that mental health services were not being utilized by the Amish population. Following meetings with community leaders, changes were made to improve the relationships of service providers and public funding agencies with the local Amish community, disseminate information about mental health concerns and services, and improve accessibility to mental health services. In 2013, a follow-up analysis of records found a 320% increase in public mental health service utilization by the Amish community within the first five years after these changes were made.

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Introduction

Cultural competence plays an essential role in providing effective mental and behavioral health services in diverse communities.[1–3,*] Service providers and agencies can improve service use among the diverse communities they serve by expanding knowledge about the variation in attitudes towards mental illness, preferences regarding mental health services, and treatment strategies and efficacy.[4–6] Previous literature has identified the roles that organizational, structural, and clinical barriers play in providing culturally competent care for minority patients and acknowledged the importance of tailoring health care to address disparities among different populations.[1,2] This paper provides an example of a successful project to enhance mental health service delivery among the Amish in the fourth largest Amish settlement, which is centered in Geauga County, Ohio.

Local mental health boards and mental health service providers initiated the first stage of the project after an examination of their patient records led them to conclude county services were being heavily underutilized by their Amish residents. Although the Amish made up about 11% of Geauga County's population in 1998 (9572 out of 88,788), only 17 Amish patients were utilizing mental health services in the county. Therefore, the design of the initial project was to learn from the Amish if this perception was correct, and what culturally appropriate changes one could implement to increase Amish utilization of services. After receiving feedback and instituting changes in service delivery, the second stage of the project arose with an opportunity to assess mental health care utilization by the Amish between 2000 and 2013.

Background on the Amish

The Old Order Amish (henceforth referred to as the Amish) are an Anabaptist religious group in North America with Western European origins. As of 2015, approximately 300,000 Amish lived in 31 states and 2 Canadian provinces across 501 different settlements,[7] with about two thirds of all Amish residing in Ohio, Pennsylvania, and Indiana. In particular, a total of 17,020 Amish individuals resided in the Geauga Settlement in 2015.[8,9]

Epidemiology and use of services for mental health issues Relatively little research has been conducted on the epidemiology of mental health or the use of mental health services by the Amish.[10,11] At the time the project described here was initiated, there was almost no research available on these topics, though subsequent publications by Cates, a clinical psychologist working with Amish clients in northeast Indiana, have addressed the specifics of providing mental health services to the Amish community.[10,12] In general, the literature suggests that the Amish experience the same conditions as the non-Amish, although some syndromes appear to have somewhat different manifestations.[10,11]

Even less is known about the utilization of mental health services by the Amish than the epidemiology of mental illness among this religious group.[10,13,14] The function of bishops is critical since they play an important role in determining what types of mental health services are acceptable.[15,16] While many Amish appear to be increasingly receptive to viewing mental illnesses which can be treated with psychoactive medications as physical ailments, there is still limited, although increasing, use of psychological services, primarily because many Amish continue to believe that counseling is a

* For the purposes of this paper, the authors operationalize "cultural competence" using Betancourt et al.'s definition: "understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations."[1(p. 297)]

role best performed by bishops and ministers within the Amish church.[10,12,13,15] Because of the primacy of religion in all aspects of Amish life, there is also concern that outside counselors may be agnostic; thus, Christians are preferred when outside counselors are utilized.[12] Furthermore, previous research from one of the authors (JK) has established how culturally tailored health care in other domains can improve health care utilization by the Amish.[17]

Aspects of Amish culture influencing care There are two primary interacting aspects of Amish life that have a major impact on the general use of health care services and, more specifically, the use of mental health services. The first is the moral authority of the bishop. The basic unit of organization among the Old Order Amish is the congregation, or church district, which consists of an average of 30 households with about 150 people.[18,19] Each congregation is led by a bishop, whose role and authority in all aspects of Amish life, including health care utilization, cannot be overstated. Because Amish bishops are chosen by lot, their authority is seen as granted by God, and thus above question or reproach. Bishops are responsible for the well-being of their church members both on earth and for eternity. In addition to spiritually leading the church district, the bishop is also the mediator between church members and the outside world. As a result, bishops can either facilitate or prohibit access to and use of services. All outside organizations and services, health and otherwise, are judged on whether or not they conflict with Amish religious views, as interpreted by each bishop for his church district. If an individual decides to go against the bishop and access a service that is not approved, that individual is thwarting not simply the bishop, but the community and God. This is a powerful disincentive.

Second, Amish behavior is guided by *Gelassenheit*, a principle which roughly translates as submitting to God's will and acting with humility and simplicity at all times.[18] One implication of *Gelassenheit* is that the community should always take precedence over the individual. The rationale for behaviors and beliefs typically associated with the Amish is the Amish belief that one can only adhere to *Gelassenheit* and achieve true grace by living in isolation from the temptations of the English (non-Amish) world. For example, belief in Gelassenheit is the reason, with some recent exceptions, that the Amish reject commercial health insurance and most of the federal safety net programs. This stems from a concern that use of these outside resources will erode reliance on the Amish community for support in times of need. In addition, the orientation of Western therapy towards the individual is anathema to Amish conceptions of well-being that roots individual good in the collective good.

Given these aspects of Amish society, the project took on the starting point that effective service delivery, including appropriate counselors, must have a solid grounding in Amish culture.[10] In a high-context and closed community such as Amish settlements,[†] information about the appropriateness of treatments, both positive and negative, spreads rapidly through a community.[10] As a result, a single misstep can influence the use of mental health services by others in the future. For the same reason, it is often necessary to include others, particularly family members and the bishop, in a treatment plan.[10] For the Amish, knowing a practitioner as a person is more important than their credentials.[14]

Project Rationale and Design

In 1998, the executive directors of the Geauga County Board of Mental Health and Recovery Services and the Trumbull County Mental Health & Recovery Board concluded, as noted earlier,

[†] Noted Amish scholar Hostetler borrows Hall's notion to describe the Amish as a "high-context culture."[18] In high-context cultures, deep connections and unspoken knowledge exist between actors.[18] This practice emphasizes importance of place within networks and allows new contacts to place one another socially.

that the use of mental health services among Amish populations in their counties was underrepresented. They resolved to determine if this was truly an unmet need, and if so, why and how to institute changes to increase Amish utilization of services. To address these issues, funding was obtained through a grant from the Office of Consumer Services of the Ohio Department of Mental Health. The boards of two other nearby counties (Mental Health and Recovery Board of Portage County and the Ashtabula County Alcohol, Drug Addiction, and Mental Health Services Board) that had much smaller Amish populations were also included in the project in order to create a comprehensive program covering all Amish in the Geauga Settlement. Based on previous work among the Amish in the Geauga Settlement, two of the authors (Korbin and Greksa) from the Department of Anthropology at Case Western Reserve University were contacted and asked to assist in the development of an evaluation program.

Using personal networks established in a previous project on Amish birthing practices,[17] Korbin and Greksa consulted informally with Amish bishops and community members about both whether this was an issue for the Amish community, and how to approach such a project. The Amish, as a high-context culture, place a great deal of importance on personal relationships, which influenced the nature of the project's approach. First, it became clear that Amish bishops and community members had little or no firsthand experience with mental health care providers and that an important step would be bringing these two groups together. Second, the research team received advice to focus the project on group engagement rather than individual meetings for a greater chance of success due to the Amish emphasis on community.

Based on these informal discussions, the researchers decided that the key component of the evaluation would be to arrange meetings of mental health professionals, including board directors and the directors of the primary mental health facilities, with bishops and other members of the Amish community. These meetings were intended to (1) obtain information about Amish beliefs and understanding of mental illness and of their awareness of the services available within each county; (2) provide the Amish community with information about mental illness and particularly about the availability of mental health care services within their county; (3) obtain their suggestions as to ways in which the provision of mental health care services to the Amish community might be improved; and, most importantly, (4) establish personal relationships between mental health professionals and members of the Amish community.

The first step in arranging meetings with Amish bishops was to send letters from the director of each county's board to the Amish bishops within their county ($n = 66$) requesting their participation in meetings to learn more about mental health. This approach was based on the research team's initial consultations that the Amish population heavily relies on printed communications in the form of church letters and weekly Amish newspapers that convey news from far-flung communities. In addition, a written letter was suitable as it would give the bishops a chance to consider the team's request and discuss this among themselves. As a follow-up to the mailed letter, the anthropology consultants visited all 66 bishops in the Geauga Settlement to ask about their interests and willingness to attend a meeting with mental health care professionals.

Altogether, the team invited 39 bishops who had expressed some interest to the consultants, or about 62% of all bishops in the Geauga Settlement, to one of six different meetings. A total of 22 men (17 from Geauga County, 5 from Trumbull County) attended a meeting, representing 35% of all bishops in the Settlement. At each meeting with bishops, the team offered to also hold a community meeting for any interested individuals in their congregations. Two bishops expressed interest in such a meeting; thus, one community meeting took place in Geauga County (18 women and 5 men attending) and a second in Trumbull County (10 men and 2 women attending).

At the suggestion of the research team's informal networks, all meetings began with introductions and a brief educational presentation by the mental health professionals, which included a brief description of the available mental health services and primary mental health syndromes. All attendees, both bishops and community members, were provided with a packet

containing information on the different major mental illnesses, as well as information on the mental health services available in each county. A similar packet was mailed to the bishops who did not attend a meeting. Each meeting also included a period of open discussion, questions, and comments. The anthropology consultants opened each of the meetings with introductions and a brief explanation of the purpose of the project, obtained informed consent, and recorded written fieldnotes (electronic recording of the sessions was not possible due to religious prohibitions).

The research team also arranged meetings with local mental health care practitioners and Amish clients who had utilized local services. A meeting was held with 12 practitioners in Geauga County, and telephone interviews were conducted with 2 practitioners in Trumbull County. A total of 17 Amish clients were identified as having utilized the services of Ravenwood Mental Health Center in Geauga County. Two of these clients agreed to an interview by one of the consultants (JK).

The project described here was designed to answer a specific service utilization issue: why were Amish residing in Geauga County, Ohio, not utilizing local tax-funded mental health care resources? Given the nature of Amish society, it was clear that standard survey procedures would not be effective. Instead, the research team decided that standard anthropological qualitative techniques were better suited for the project at hand, particularly open-ended individual and group interviews. In addition, these methods provided an opportunity for the development of personal relationships between the Amish community and mental health care providers. Personal relationships are regarded as critical by the Amish community to promote a sense of trust that mental health care providers will respect Amish values.

The follow-up study's design (described later) also addressed a specific mental health service delivery issue: an evaluation of the effectiveness of programmatic changes instituted as a result of the initial project. As further described subsequently, data was abstracted from the records of the Geauga County Board of Mental Health and Recovery Services. Standard descriptive statistical techniques were applied to these data to assess the impact of program changes on the utilization of mental health care services.

Findings from Meetings with Amish Bishops and Community Members

During the initial visits to the bishops' homes, individual cases were described anecdotally in which some forms of mental health services, often medications, were being utilized, but that individuals were often traveling outside of their home counties to obtain these services. It was difficult to obtain explanations for why they were not utilizing local services. One story that surfaced several times was that sometime in the past, a young person who had been seeing a local counselor decided to not accept adult baptism and join the church. This story, which assumed the counselor's advice was critical in this decision, quickly spread throughout the settlement, as often happens in a high-context culture,[10] resulting in a widespread loss of trust in local services. While it is not clear if this story was true, it was believed to be true and had been widely discussed in the community.

Attendees were active participants in these meetings, with very specific questions about a number of mental health topics, including obsessive–compulsive disorder, anorexia and bulimia, postpartum depression, clinical depression, bipolar disorder, schizophrenia, suicide, alcoholism and drug abuse, and self-harming behaviors. Most participants felt that there was some stigma associated with mental illnesses, although several argued that individuals who seek help and who try to get better are less stigmatized than those who do not seek help and, as a result, are unable to function as members of the community. One reason expressed for the stigma was the idea that mental illness is sometimes felt to be the result of a failure to lead a proper Christian life. Several attendees felt that such an attitude can create a barrier for those who wish to seek mental health care services and that the role of the bishop is key in overcoming this barrier. In particular, it was

felt that if the bishop is not supportive of seeking mental health services and instead takes the view that mental illness is a shortcoming of the individual, it is much more difficult for church members to seek professional care. At the same time, there was little hesitation in meetings for attendees to discuss a family member with a mental illness, suggesting that the stigma is not so great that family members with mental disorders remain hidden.

The team found that the Amish attending the meetings typically did not know what local services were available or had an outdated idea about the availability and quality of services, despite their interest in mental health. For example, some were not aware that there were mental health facilities within their home counties, where to get emergency care, if physicians were on staff who could prescribe medications, and what type of expertise a psychiatrist has in treating mental illness that makes this preferable to using a family physician. One bishop mentioned, and several others concurred, that Amish women suffering from severe postpartum depression sometimes gave their children to family members or friends of the family until the symptoms diminished, an indication of an unmet need for more formal assistance.

In addition, almost none of the Amish attendees at either the bishop or community meetings were aware that county agencies used a sliding scale based on a resident's family size and income to fund mental health services at a significant reduction in cost for themselves and their family members. They also were unaware that their property taxes funded this program. This is important because most Amish have strong religious concerns about receiving assistance from outside the Amish community, particularly from the government. As a result, most Amish opt out of many, if not all, provisions within the Social Security Act, often including Medicaid and Medicare. Several of the bishops felt that they had an important responsibility to clarify that they could not receive any assistance for mental health services from an agency linked to the Social Security Administration. However, once they learned that their real estate taxes funded the sliding scale utilized by the county, most felt that this was an acceptable form of assistance for the members of their congregations.

Consistent with the literature,[10,12,13,15] most of the Amish respondents distinguished between mental disorders which can be treated with medications and those which require counseling. There was a general willingness to accept that any illness treatable by psychoactive medications was one which had a physical basis and thus need not reflect a lack of faith, making utilizing health services acceptable. There was less consensus on the appropriateness of the use of professional counseling, either alone or in conjunction with the use of psychoactive medications. A strong belief frequently expressed was that those who require counseling should first, and in some cases only, obtain it within the community from family members, church members, and especially bishops and ministers. On the other hand, there was recognition by some bishops and community members that outside help is sometimes needed and could be effective by giving families the privacy they needed to resolve differences.

Some Amish expressed the idea that some mental illnesses, particularly depression, could result from life stresses, such as death of a family member, a move to an isolated home, the inability to have children, or other major life events, and thus required counseling rather than medication. Nevertheless, everyone expressed concern, and generally very strong concern, about the potential for non-Amish professional counselors who did not understand Amish culture to act in ways that did not promote the best interests of the Amish community, in the belief that they were acting in the best interests of the individual. In particular, there was concern that counselors would provide advice that would encourage young Amish to leave the church. Because *rumspringa* is such a critical period in Amish culture, it was among the primary concerns that Amish bishops and community members expressed regarding mental health services which, they felt, had an orientation towards individual good at the expense of the community in direct contrast to Amish beliefs that individual good is inextricably linked to community good. Not surprisingly, bishops and other community members wanted assurance from the mental health care representatives that

counselors would provide advice that was consistent with Amish culture and their Christian beliefs. The mental health representatives consistently and strongly stated that their counselors would always honor Amish cultural and religious beliefs. At several meetings, the director of the mental health agency explicitly stated that he would not continue to employ anyone who did not respect the beliefs of others. This was very well received.

Overall, the findings of this initial study regarding attitudes towards psychoactive medications and counseling are similar to those described by Cates.[10] For example, he describes a general sense of wariness towards counselors with individual variation across a continuum, with individual counselors gaining the trust of the community after developing relationships to ensure they are respectful of the Amish culture.[10]

Actions Taken by Local Boards in Response to Initial Study

A focus of the research team's discussions with members of the Amish community was on steps that public funding agencies and local mental health service providers could take to enhance the delivery of services to the Amish population. The actions described below reflect those contributions.

Policy challenges

County boundaries presented a challenge in treating Amish people in the Geauga Settlement, which stretches across four counties, as a unified whole. Ohio HB 648, which created community mental health boards in 1967, and subsequent legislation (SB 156 in 1988, HB 317 in 1989, HB 274 in 1996) mandate that each board is only responsible for planning, funding, and evaluating services for persons who reside within its jurisdiction. State funding controlled and allocated to Boards by the Ohio Department of Mental Health has certain restriction on use and expenditures. In addressing those legal mandates on state funding, it was determined that while state funds could not be used to pay for services provided at an out-of-county agency, local Mental Health Boards could utilize local property tax funds to pay for treatment services for their residents seeking out-of-county care. However, they could not be used to fund residents of other counties receiving services in local agencies (e.g., Geauga County property taxes could not fund services for Trumbull, Portage, nor Ashtabula County residents, and vice versa).

Nevertheless, before contracts were in place with surrounding counties, Ravenwood Mental Health Center and the Geauga Board committed to funding a local site that would be open to Amish patients from throughout the northeast Ohio Geauga Settlement. They agreed to staff the location with psychiatrists, counselors, and a dedicated full-time Amish case manager who would represent the "face of mental health" to the entire Amish settlement. Ashtabula, Trumbull, and Portage County Boards agreed to pay a stipend for Amish residents that crossed county lines for Ravenwood services.

While the use of mental health, and now substance abuse treatment, services continue to grow within the Amish population, changes in funding patterns at the state and federal level have trickled down to local Boards, forcing many to re-examine their use of local property tax funds. Today, only Trumbull and Geauga County continue to fund Amish specific services in the original Middlefield, Ohio, location. Since almost 90% of all Amish live in these counties, however, most Amish continue to be able to take advantage of this consortium.

Dissemination of information

Few Amish participants in the meetings were aware of the available local mental health services. Therefore, a key part of the plan was to ensure that people who needed mental health services

would have some mechanism of learning what services were available locally and would know how to access them. The team followed an idea of one of the bishops who suggested that contact information could be posted in phone booths that were used by everyone in the Amish community. Although the use of cell phones has increased substantially in the past 10 years, they were rare at the time of the project. Phones however were available in phone booths located outside of Amish shops and other businesses. The initial rationale for these phones was that they were necessary for the business owners to be competitive, but they were available to others in the community and were widely used to set up medical appointments, hire drivers, and to make other arrangements. The team thus prepared laminated flyers for posting in phone booths. Since everyone used these phones, everyone would see the cards and be aware that they were there if needed. The cards provided the name and phone number for a Clinical Support Coordinator dedicated to the Amish population (described below) and a 24-hour emergency hotline. This number was monitored by the Geauga County mental health center but could be utilized by Amish living in any of the four counties comprising the Geauga Settlement.

Opening a facility in the community

Amish individuals in the Geauga Settlement were often not aware of the services offered by the Ravenwood Mental Health Center in Geauga County, the county with the majority of the Amish population. In addition, even those Amish who were aware of the available services noted that, because of its location at the western edge of the county, it was often just as easy to go to providers outside of the county as it was to go to Ravenwood. The research team concluded that a key component of any plan to increase the utilization of local health services must include improving access for this horse-and-buggy population. To this end, the Geauga County Board of Mental Health and Recovery Services and the Ravenwood Mental Health Center committed to opening a mental health outpatient facility in Middlefield, Ohio, which is centrally located in the Geauga Settlement, and, as a result, is where many Amish come regularly to shop, bank, visit physicians, and conduct business. The clinic was established in a building that housed general practitioners. Amish clients have many reasons for coming to this location and are not identifiable as necessarily coming for mental health, which reduces concerns about potential stigma associated with receiving treatment for a mental illness. Given the importance that the Amish place on personal relationships, the decision was made to have one psychiatrist dedicated to this Middlefield location, in order to enhance the ability of patients to establish personal relationships with their care provider. The protocol at the main facility was for patients to see whichever psychiatrist was on duty at the time of their appointment. The new facility was opened in April 2000. Members of the Amish community were invited to open houses for both the opening and the one-year anniversary of the center.

Dedicated clinical support coordinator

An MSW-level clinical support coordinator was assigned to work solely in the Amish community. The coordinator has the responsibility to be involved in all aspects of mental health services in the Amish community, from serving as an initial contact point to being central to community outreach efforts. For example, the coordinator meets with patients in their homes and, when necessary, provides them with transportation to the Middlefield clinic. Visiting homes has been essential to the success of this position. Cates notes that it was often necessary for him to visit homes, rather than having patients visit his office.[10] As noted earlier, in a high-context culture such as that of the Amish, both good and bad news spread quickly. It was therefore necessary to select someone with the appropriate "down-to-earth" characteristics who was familiar with Amish culture and respected Amish cultural and religious beliefs. The individual chosen for this position fit all of the requirements and quickly became known favorably throughout the Amish settlement. His ability to interact appropriately with Amish patients was

critical to the success of the program. Cates describes the importance of providing consistent care with one individual in gaining Amish community support for mental health services, to act as a bridge between providers and the community.[10]

Follow Up: Amish Mental Health Care Usage Since 2000

Impact of program modifications on Amish mental health care utilization

In 2013, the opportunity arose to revisit the question of utilization of mental health services in the Amish community, notably in the community that had undertaken specific measures to attempt to increase Amish use of these services. A member of the research team (SMF) collected data at the Geauga County Board of Mental Health and Recovery Services to assess the extent to which the programmatic changes described above influenced the use of local mental health care services by the Amish in the Geauga Settlement, as well as to assess specific services utilized. Due to ethics board restrictions, only records of clients with services billed to the Geauga Board, and not from other counties involved in the original project, could be included in the databases. Using a combination of information from the Amish community support worker and billing records from the mental health service provider, the records of a total of 285 Amish clients between 2000 and 2013 were identified.

In order to learn more about the Amish clientele served during this period, a database of a sampling of Amish clients was created under the supervision of the board (SMF & JM). Out of the 285 Amish clients sampled between 2000 and 2013, 228 were matched to a record of at least one expense billed to the Board of Mental Health between FY2000 and FY2013 and were included in the database. In order to capture a sample that was representative of multiple levels of service utilization, the total amount of dollars billed per patient was divided into five quintiles and a random sample of 10 clients from each quintile was obtained, for a total of 49 Amish clients (one client had been misidentified as Amish and was excluded).

All individuals were currently Amish (either church members or too young to join church but living in a practicing Amish family). The sample was 63.3% female and 36.7% male. As all Amish end their education at the eighth grade, save for some who attend apprenticeship programs, educational attainment was presumed to be equal among all clients over age 14. The average age at first contact with public mental health services was 33.2 years old (range: 5 to 84). Average household income at first contact was $24,983. Household income was unavailable for 4 clients. Furthermore, four clients reported lifetime or current alcohol abuse, while 3 reported lifetime or current substance abuse. One reported a history of physical abuse, and 2 reported a history of mental abuse. Four reported a history of sexual abuse and an additional 2 had perpetrated sexual abuse.

Table 1 describes the number of Amish clients treated by the Geauga County primary mental health center each year during this time period, as well as the expenditures by the Geauga County Board of Mental Health and Recovery Services to reimburse the mental health center for these services. There was a substantial increase in usage of mental health services in Geauga County following the program modifications instituted in response to the research team's interactions with Amish members of the Geauga Settlement. In particular, usage rates increased by 320% between 2000 and 2005, and then leveled off at just under 100 patients seen annually. Total expenditures by the Board increased by 81% over this time period while average expenditures per patient decreased by 58%.

Figure 1 shows the sources of funding for these patients. Some overlap occurs due to multiple sources of funding. Most received funding from county subsidies. In addition, though still rare,

Table 1
Mental health service expenditures for Amish patients in Geauga County, OH, rounded to the nearest dollar

Year	Cases (*n*)	Median ($)	Total ($)	Mean expenditure per patient ($)
2000	23	544	67,961	2955
2001	38	938	91,016	2395
2002	55	1043	110,108	2002
2003	60	1123	128,615	2145
2004	78	726	122,641	1572
2005	97	725	122,801	1265
2006	112	729	153,350	1369
2007	96	598	153,301	1597
2008	99	751	135,247	1366
2009	97	647	130,548	1345
2010	94	550	129,179	1374
2011	95	639	132,140	1391
2012	93	772	152,941	1645
2013	92	641	101,226	1100

more individuals have accepted Medicaid as a payment source, largely based on the chronicity of their mental illness.

Figure 2 denotes service utilization for the 5 most-used services from FY2000 to FY2013. The most commonly used services were diagnostic assessments, followed by the following: psychiatric care, case management, individual counseling, and crisis management. Median and range were used as descriptive statistics, as all variables were highly right-skewed. The highest median number of visits per client was for case management. In addition, 5 clients

Figure 1
Funding sources, FY2000–FY2013

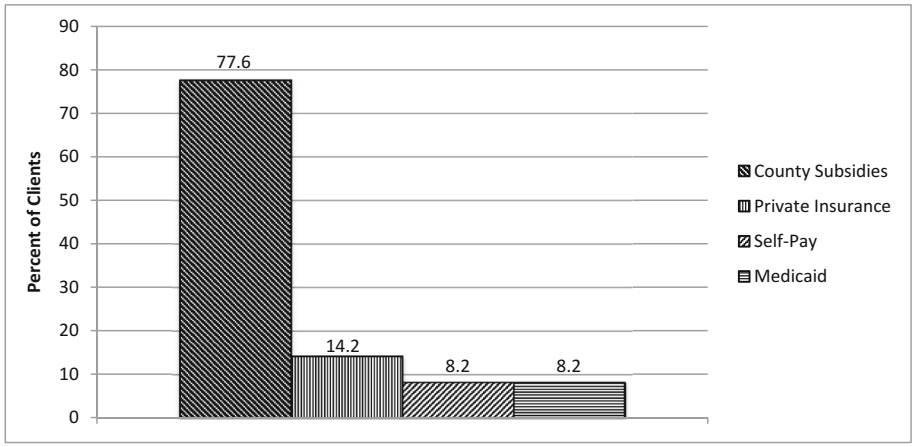
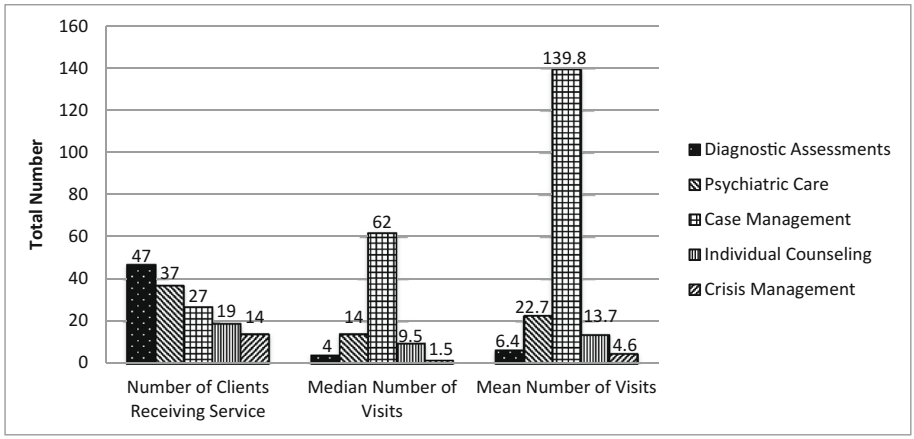


Figure 2
Service utilization by type of service, FY2000–FY2013



received inpatient care that was documented in their charts, with a median stay of 34.5 days in care. Two clients received group counseling and two clients received family counseling. In addition, the research team uncovered a total of 5365 documented contacts with Ravenwood Mental Health Center. The median number of contacts per client was 32 (ranging from 0 for a client who completed intake but did not receive services to 1570 for a client served over 13 years with a high number of documented case management contacts). As is documented here, case management, most frequently with the dedicated caseworker, had the highest number of visits, while diagnostic assessments and psychiatric care were the services used by the highest number of clients.

Figure 3
Percent of clients by diagnosis, FY2000–FY2013 ($n = 49$)

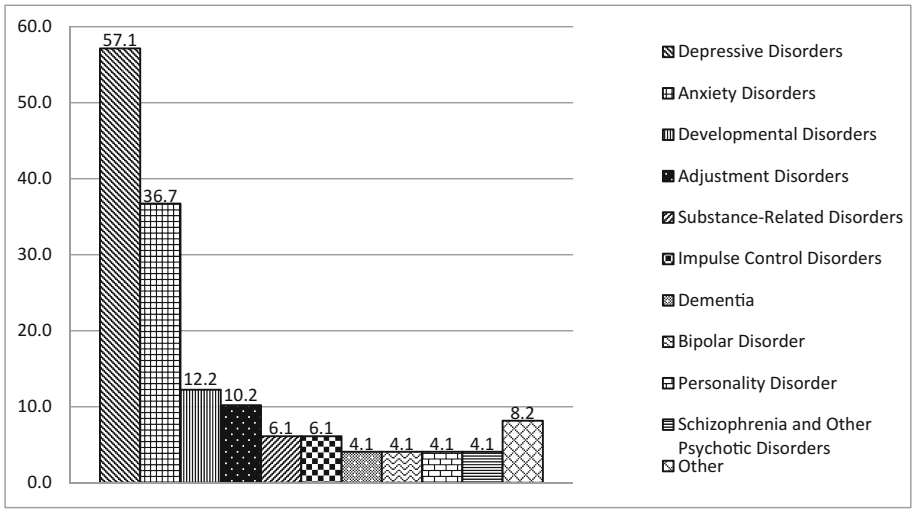


Figure 3 shows the percent of clients by diagnosis. The majority of patients were treated for depressive disorders (57.1%), followed by anxiety disorders (36.7%) and developmental disorders (12.2%). There is some overlap due to co-occurring disorders.

Discussion

This study, while limited in its ability to describe Amish mental health needs across the community, documented a 320% increase in mental health care utilization within the Geauga Settlement between 2000 and 2013. The authors cannot prove that this increased usage was only the result of the program changes instituted after the first phase of the project. However, given that the program changes which were instituted were to an important extent vetted by Amish informants, it seems likely that some, and probably much, of the increase in usage was the direct result of programmatic changes. Whatever the cause of the increase in usage rates, the magnitude of the increase strongly suggests that the initial assessment by county and agency personnel that their services were being underutilized by the Amish was correct. Modifications in mental health care delivery to this population was clearly needed.

In addition to documenting change in usage rates over time, this study also provides an assessment of current public mental health service utilization patterns as well as documentation of the increase in mental health service use following changes designed to enhance mental health care utilization. Over time, the proportion of Amish clients, with high intensity and high cost service needs decreased, resulted in a higher client load at lower per-client costs. The authors hypothesize that this may indicate an increase in utilization by clients with mild or moderate illness. Rather than reflecting an increase in mental health problems among the Amish, it is likely that this pattern reflects an increasing number of Amish patients choosing to receive local services rather than either forgoing services or obtaining services in another county. The high number of case management visits shows the importance of a dedicated case manager for this community, as they are the primary contact for mental health services for many clients. Psychiatric care remains more acceptable than the use of counseling, though the case manager may be providing informal counseling assistance, based on some conversations with community members. More extensive qualitative research is needed to fully understand the reasons for the use of certain services over others. Furthermore, a general assessment of mental illness prevalence within the Amish community would be beneficial to determine whether all needs have been met.

Implications for Behavioral Health

The above case study demonstrates a clear strategy for and benefits of implementing culturally responsive care in public behavioral and mental health service delivery. Service providers and their public funding agencies must listen to community members and community leaders especially regarding the needs of diverse communities. Focus groups and community meetings can play a key role in identifying important factors for effective service delivery. Furthermore, service providers and public funding agencies, when able, should implement suggested changes to meet the needs of diverse communities. This study demonstrates the benefits of community-focused research and collaborations between researchers, providers, and community members to assess needs and implement changes, especially when targeting hard-to-reach populations. Finally, providers and agencies should follow up to ensure that the changes have been effective in improving service use and promoting health equity.

Compliance with Ethical Standards

Conflict of Interest The authors have no conflicts of interest to disclose.

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