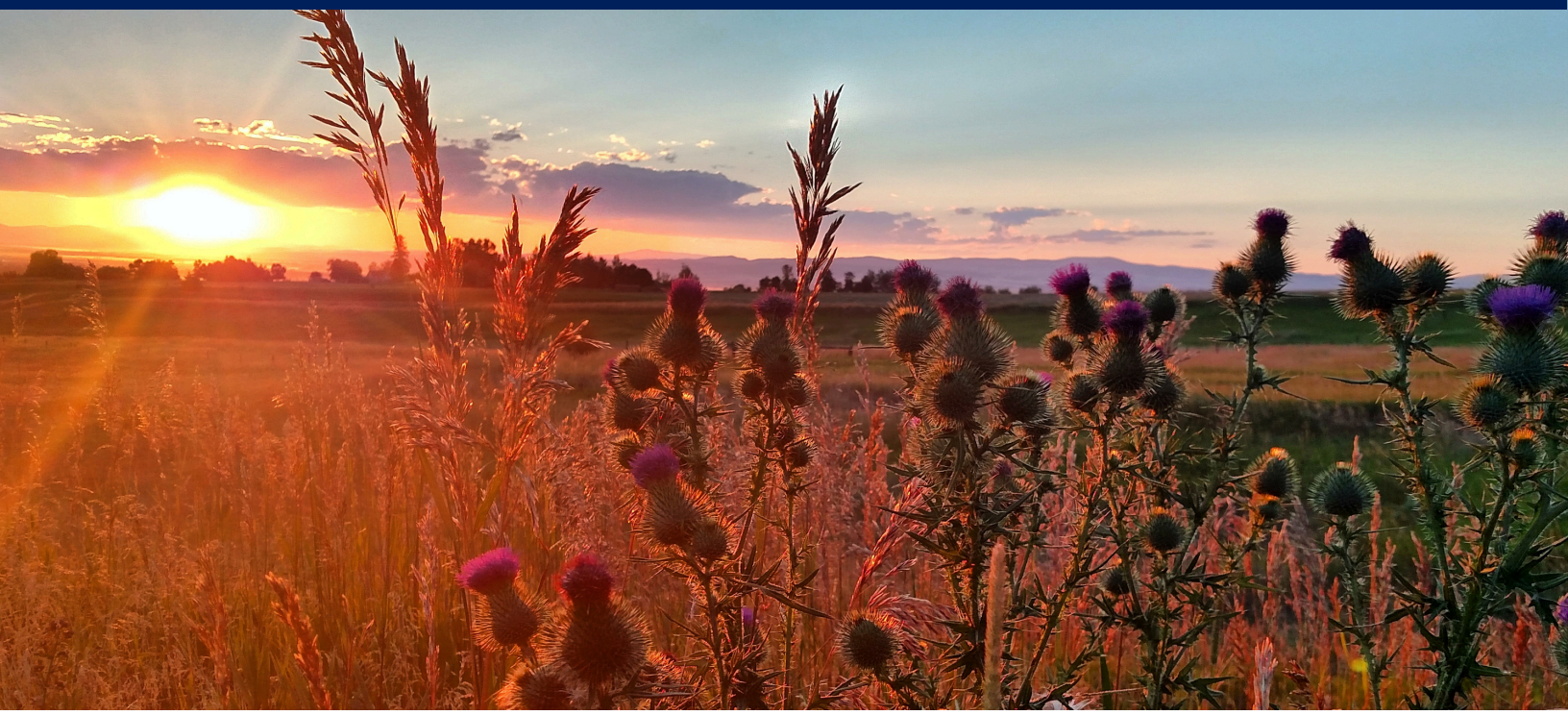
MONTANA AREA HEALTH EDUCATION CENTER'S

2024 REGIONAL BEHAVIORAL HEALTH NEEDS & TRAINING ASSESSMENT



MONTANA STATE UNIVERSITY | Office of Rural Health | Area Health Education Center

AHEC MONTANA AREA HEALTH EDUCATION CENTER

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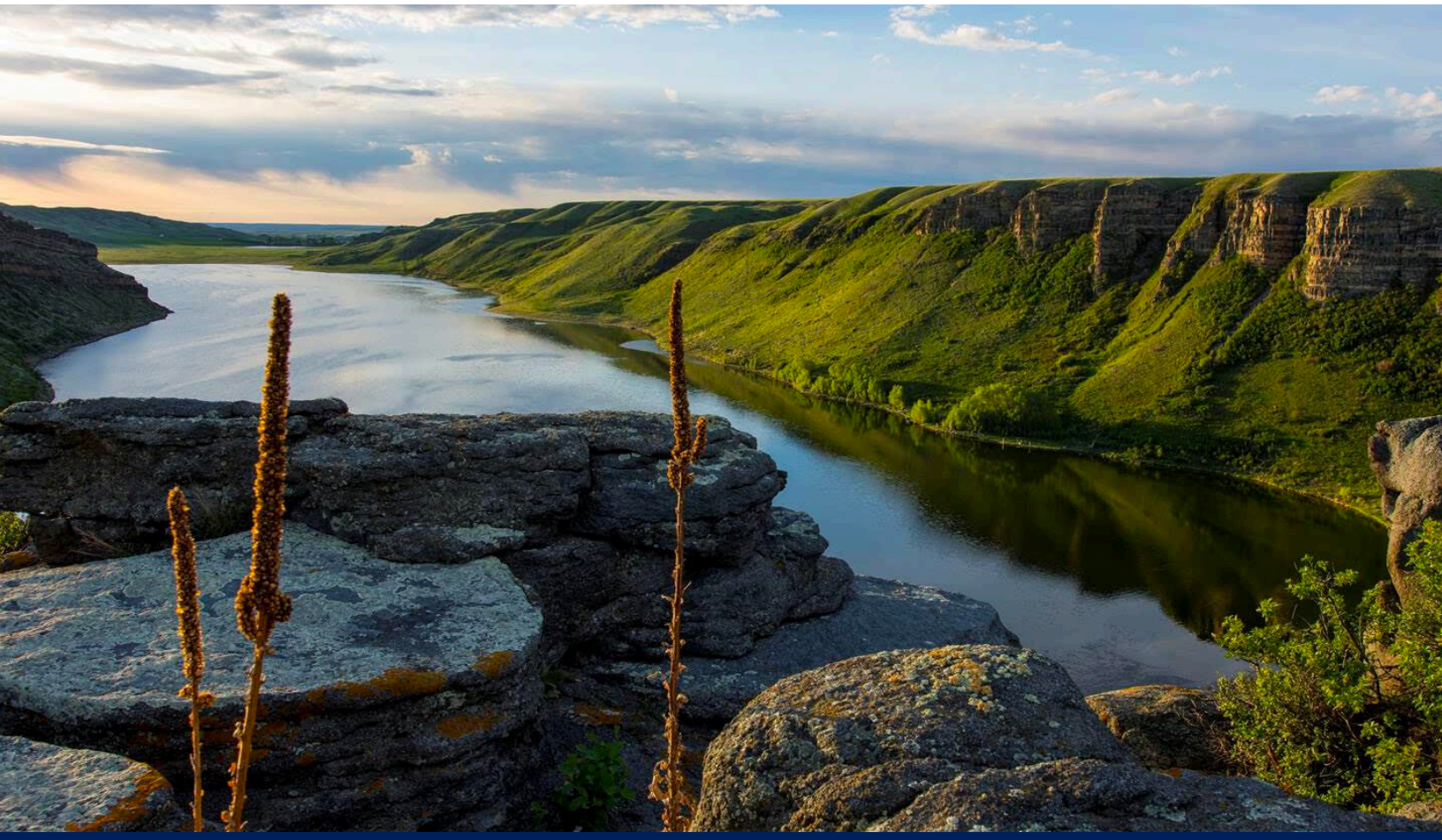


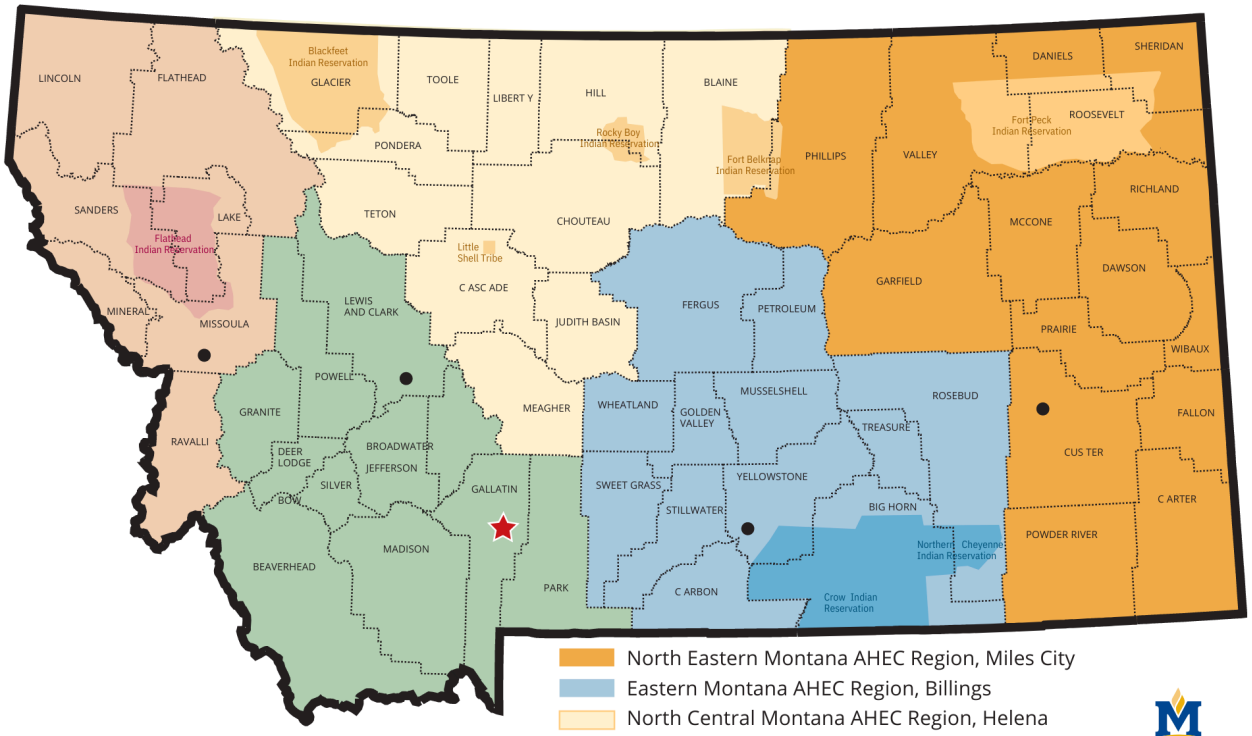
Introduction

The Montana Office of Rural Health and Area Health Education Center (MORH/AHEC) is steadfast in its mission to enhance access to quality healthcare by fostering a robust supply and equitable distribution of healthcare professionals through strategic community and academic collaborations. The Montana AHEC Behavioral Health Needs & Training Assessment Survey for Spring 2024 embodies this commitment by seeking to uncover the critical behavioral health access and training needs across our Montana AHEC Regions. This assessment was made possible due to funding through the HRSA Rural Health Network Development Grant, a funding pillar of our Montana Behavioral Health Network. Community and participant feedback are invaluable and will directly influence the development of AHEC behavioral health initiatives, ensuring our efforts are tailored to meet the unique challenges and capitalize on the opportunities within each region. As we continue to build out behavioral health programming and workforce support, we invite you to join us in this ongoing effort to improve healthcare access and outcomes in Montana.

Kailyn Mock, Director
MORH/AHEC

Montana AHEC Regions

For more information: (406) 994-7709



AHEC (Area Health Education Center) Mission:
To enhance access to quality health care, particularly primary and preventive care, by improving the supply and distribution of health care professionals through community/academic educational partnerships

6/6/22

MONTANA STATE UNIVERSITY

Survey and Focus Group Methodology

Instrument

From February to June 2024, surveys were distributed to key stakeholders residing in the five MT AHEC regions. Stakeholders were made aware of the survey via email and social media and were able to access it on the regions' various platforms, including websites and social media. The survey was designed to provide the Montana Area Health Education Center with information about the communities of interest regarding:

- The state of mental health in Montana
- Availability and utilization of mental health services
- Access to related services
- Potential barriers to accessing services

Focus groups were conducted in each of the regions with select stakeholders and key informants who were knowledgeable about the mental health services and needs in their community. Focus groups consisted of Health Equity coalition, taskforce, and collaborative members, graduate students at a university within one of the regions, and AHEC advisory board members. The questions for the focus groups were designed to provide Montana AHEC with stakeholders' opinions on challenges, barriers, and potential solutions to improve behavioral health in Montana.

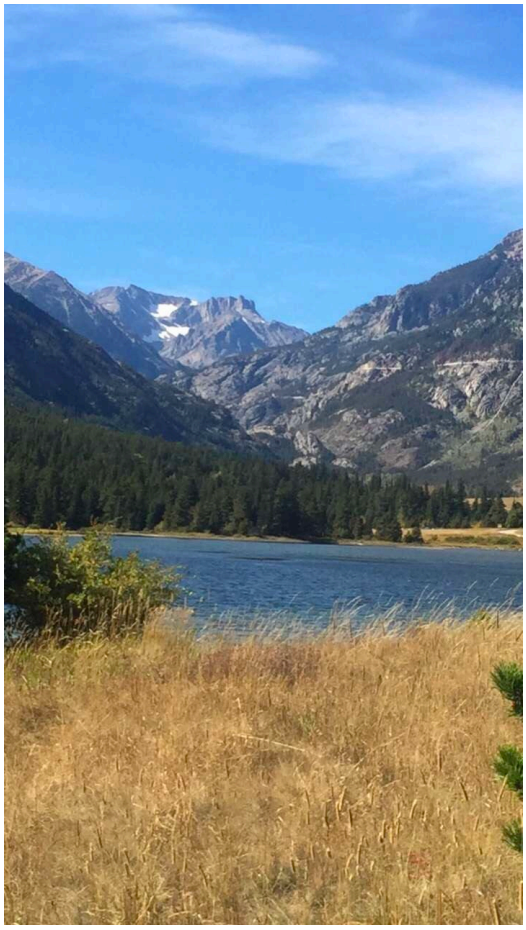
Sampling

The MT AHEC Program Office, located in Bozeman, MT, collaborated with the five AHEC offices in each region (Eastern: Billings, MT; North Central: Helena, MT; Northeastern: Miles City, MT; South Central: Helena, MT; Western: Missoula, MT) to determine stakeholder selections. Stakeholders were contacted via email and social media about the survey, and via email about participating in the focus groups. At least two focus groups or key informant interviews were conducted in each of the five regions to identify strengths and areas for improvement regarding mental health services in Montana.

Questions for the **survey** and the **focus groups** are available in **Appendix A and B.**

Information Gaps - Data

The MT AHEC Program Office, located in Bozeman, MT, collaborated with the regional MT AHEC offices (Eastern: Billings, MT; North Central: Helena, MT; Northeastern: Miles City, MT; South Central: Helena, MT; Western: Missoula, MT) to determine stakeholders. Stakeholders were contacted via email about the survey and focus groups opportunities.

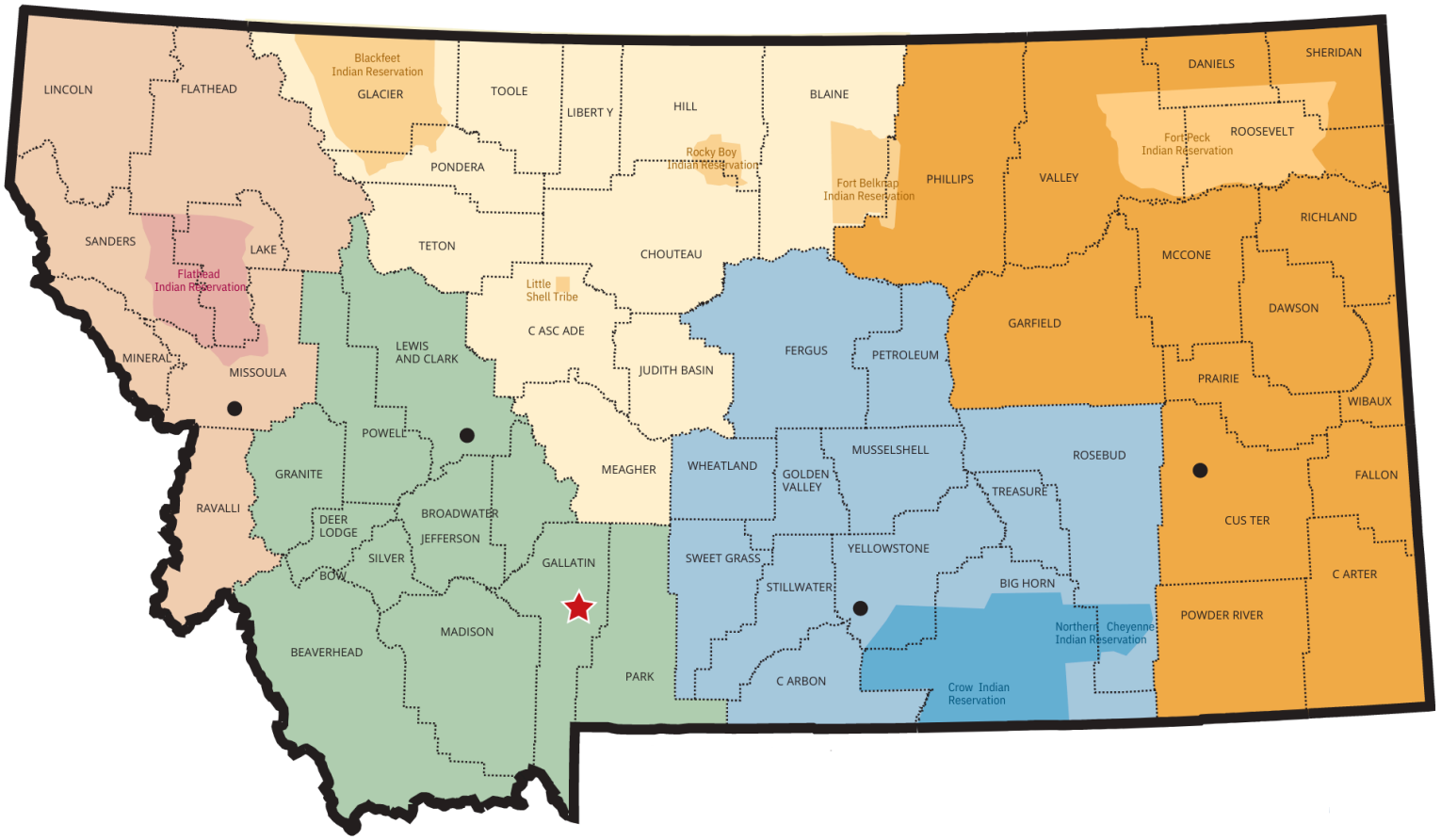


It is a difficult task to define the behavioral health of various communities in Montana due to the large geographic size, economic, and environmental diversity, and low population density. Obtaining reliable, localized mental health status indicators while maintaining anonymity and confidentiality continues to be a challenge in Montana. Additionally, there are gaps in the workforce data for rural and frontier areas creating difficulties in accurately measuring the severity of the shortage of professionals, as well as the true number of Montana residents who would benefit from behavioral health services. Gaps in data from the survey findings may be due to lack of stakeholder response, as the AHEC offices were not able to reach all desired stakeholders. Social media and email were used to reach stakeholders, so it is possible that younger generations were more represented than older generations who may not utilize technology as often.

Limitations in Survey and Key Informant Interview Methodology

A common approach to survey research is the online survey. However, this approach does have its limitations. The concerns of online surveys include non-response due to lack of personal connection or internet accessibility, both of which may affect the representativeness of the sample. Thus, it is recommended to use a variety of data collection methodologies

Focus groups can gain the responses of those who may not respond to or cannot access a survey. However, qualitative data can be challenging to analyze. For better analysis, focus group data are differentiated into common themes that were discussed across multiple groups. The themes were determined based on MORH/AHEC employee participation in data collection and interpretation of the data from all focus groups. To better understand the themes, please review the summaries of each focus group in Appendix B. Due to the small size of the various communities, participants may still have been hesitant to express their views freely. Personal identifiers are not included in the focus group transcripts or summaries; however, we cannot ensure complete anonymity among focus group participants.



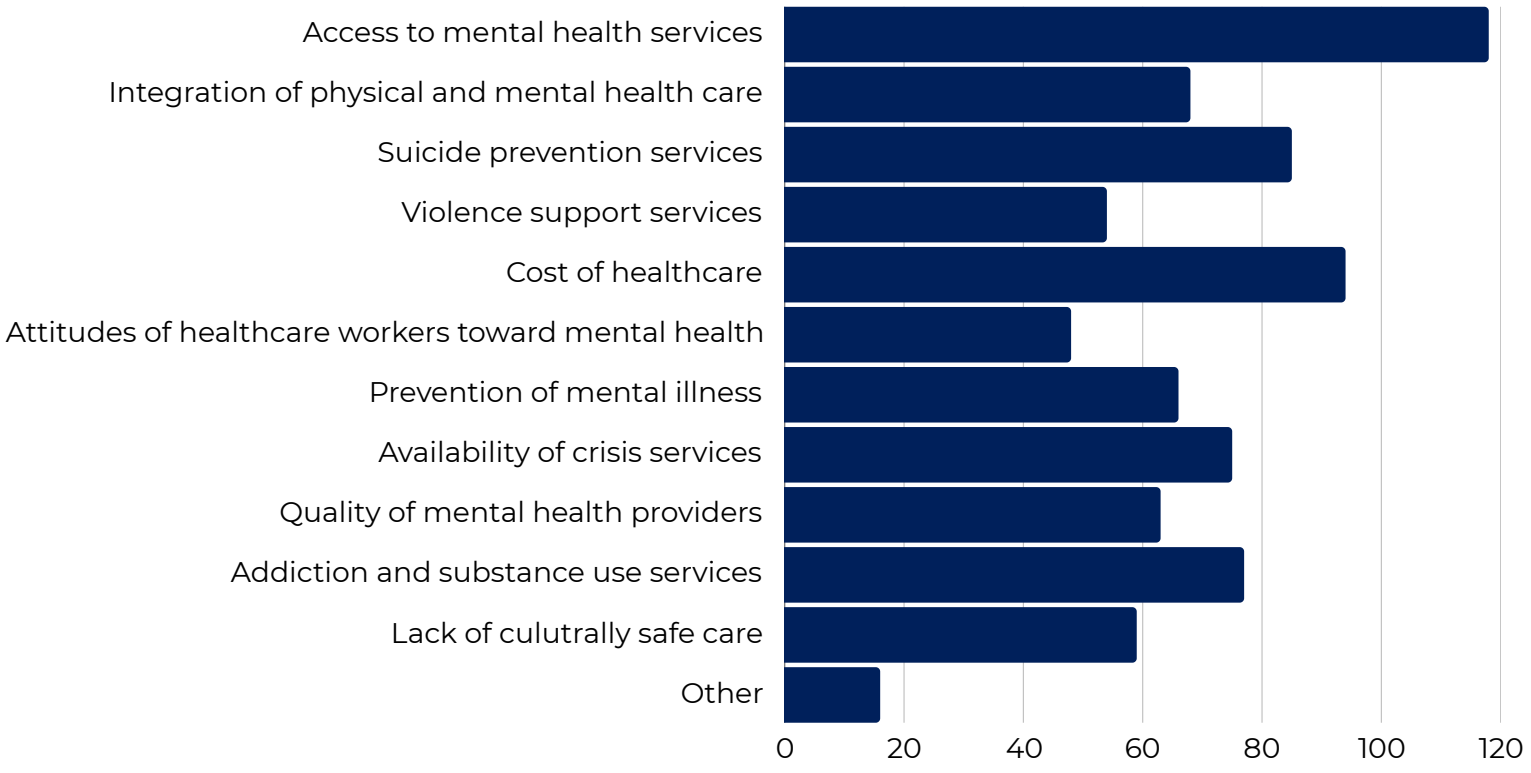
SURVEY RESULTS

ALL AHECS

ASSESSING MENTAL HEALTH CARE IN MONTANA

Topics of Concern (Question 1)

Respondents were asked to identify the topics that most concerned them when thinking about mental health in Montana. Most (n=140; 81.87%) of respondents answered this question. The majority of respondents (n=118; 84.29%) indicated that access to mental health services was their main concern. Nearly half (n=68; 4857%) of the respondents chose the integration of physical and mental health care as a main concern, and over half (n=85; 60.71%) felt that suicide prevention was important. Fifty-four (n=54; 38.57%) respondents selected violence support services as a top concern, while ninety-four (n=94; 67.14%) respondents chose the cost of healthcare. Forty-eight (n=48; 34.29%) respondents indicated that they were concerned about the attitudes of healthcare workers toward mental health, and sixty-six (n=66; 47.14%) respondents selected prevention of mental illness as a concern. Over half (n=75; 53.57%) of respondents selected the availability of crisis services as a concern, and ninety (n=90; 64.29%) respondents were concerned about the number of mental health providers. Sixty-three (n=63; 45.0%) respondents were concerned about the quality of mental health providers,, seventy-seven (n=77; 55.0%) selected addiction and substance use services as a concern, and fifty-nine (n=59; 42.14%) respondents chose lack of culturally safe care as a concern. Sixteen (n=16; 11.43%) selected “Other).



17 out of 20 respondents selected that the most common concern was access to mental health services.

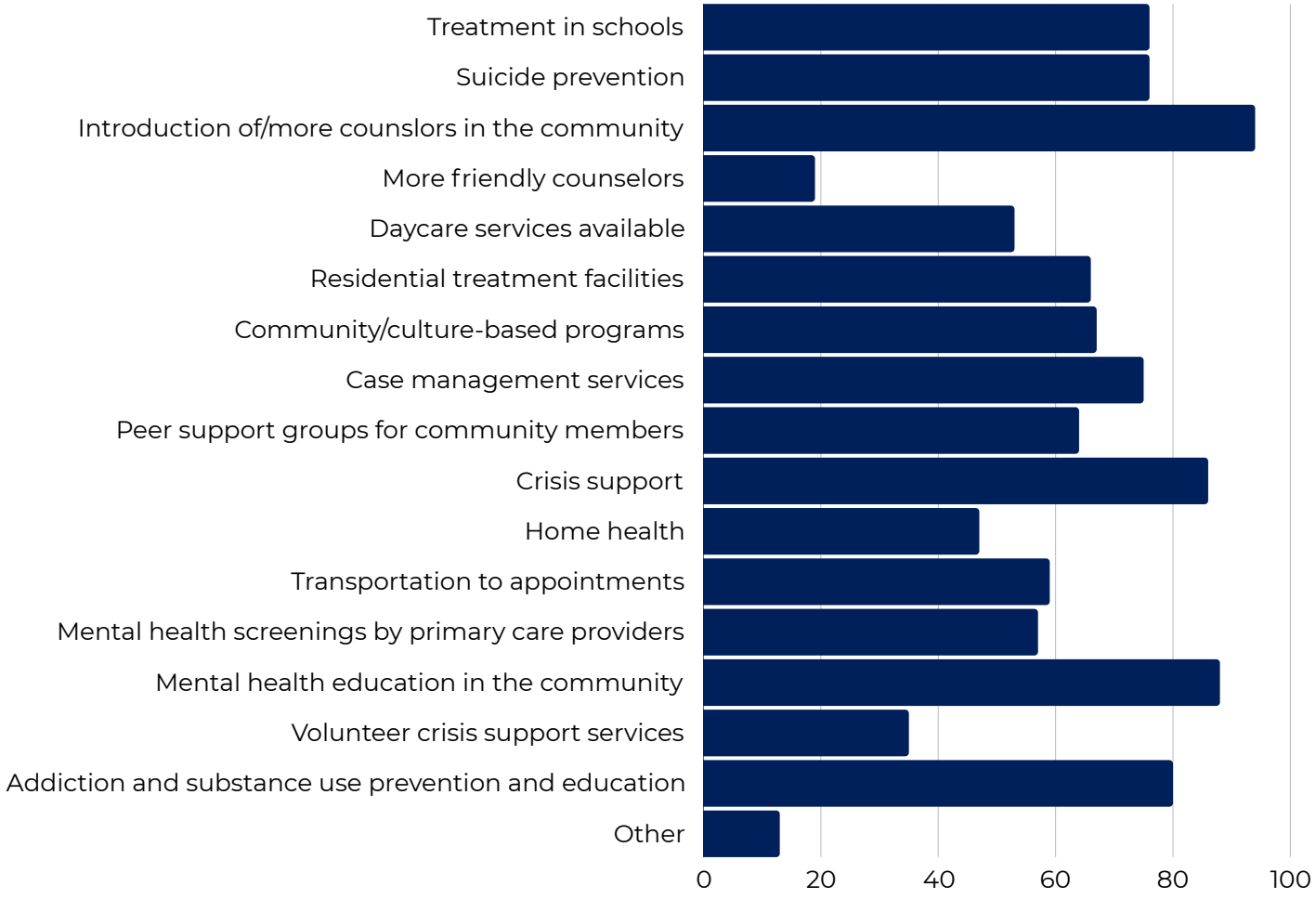
Other Concerns (Question 1)

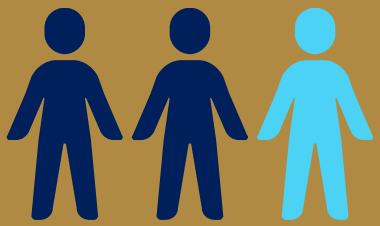
Those who selected “Other” on question 1 were asked to elaborate upon this answer in a provided. Their answers were:

- Access to safety net mental health services, number of safety net providers
- Limited number of beds available for inpatient treatment of mental health disorders
- Stabilization centers
- With influx of immigrants in the area I am located, we are needing more bilingual services, better interpretation resources for those with LEP
- Social isolation
- No mental health providers in [town]
- Support for psych NPs in rural MT in private practices needing to repay student loans
- Access to advanced mental health care technology
- Long term mental care! For severe illnesses
- Spanish language resources
- nursing home care that focuses on supporting those with mental health issues that prevent them from thriving under conventional care
- Lack of providers with expertise and openness to serving transgender and non-binary clients
- Behavioral Health Care for children/adolescents
- Youth Support/Services
- Cuts to mental health services in the state of Montana
- Policing and criminalization related to mental health complications

Mental Health Services (Question 2)

Respondents were asked to identify the mental health services needed to better ser56ve Montanans. Most (n=141; 81.03%) answered this question. Seventy-six (n=76; 53.90%) selected treatment in schools, and seventy-six (n=76; 53.90%) also chose suicide prevention services. Two-thirds (n=94; 66.67%) of respondents chose either the introduction of or an increased number of mental health counselors, and nineteen (n=19; 13.47%) chose the need for more friendly counselors. Fifty-three (n=53; 37.59%) respondents indicated that daycare services were needed, and sixty-six (n=66; 46.81%) stated that residential treatment facilities were needed. Nearly half (n=67; 47.52%) of the respondents chose community or culture-based programs, and over half (n=75; 53.19%) of the respondents selected case management services. Sixty-four (n=64; 45.39%) respondents indicated that peer support groups for community members were needed, and over half (n=86; 60.99%) stated that crisis support was needed. One-third (n=47; 33.33%) of respondents chose home health services, and fifty-nine (n=59; 41.84%) chose transportation to appointments. Fifty-seven (n=57; 40.42%) respondents selected mental health screenings by primary care providers as a need, and eight-eight (n=88; 62.41%) chose mental health education in the community. Nearly one-quarter of respondents (n=35; 24.82%) indicated that volunteer crisis support services were needed, and over half (n=80; 56.74%) chose addiction and substance use prevention and education. Thirteen (n=13; 9.22%) respondents selected others.





The most common service respondents chose as a need was the introduction of/increase in the number of mental health counselors, with **2** out of **3** selecting it.

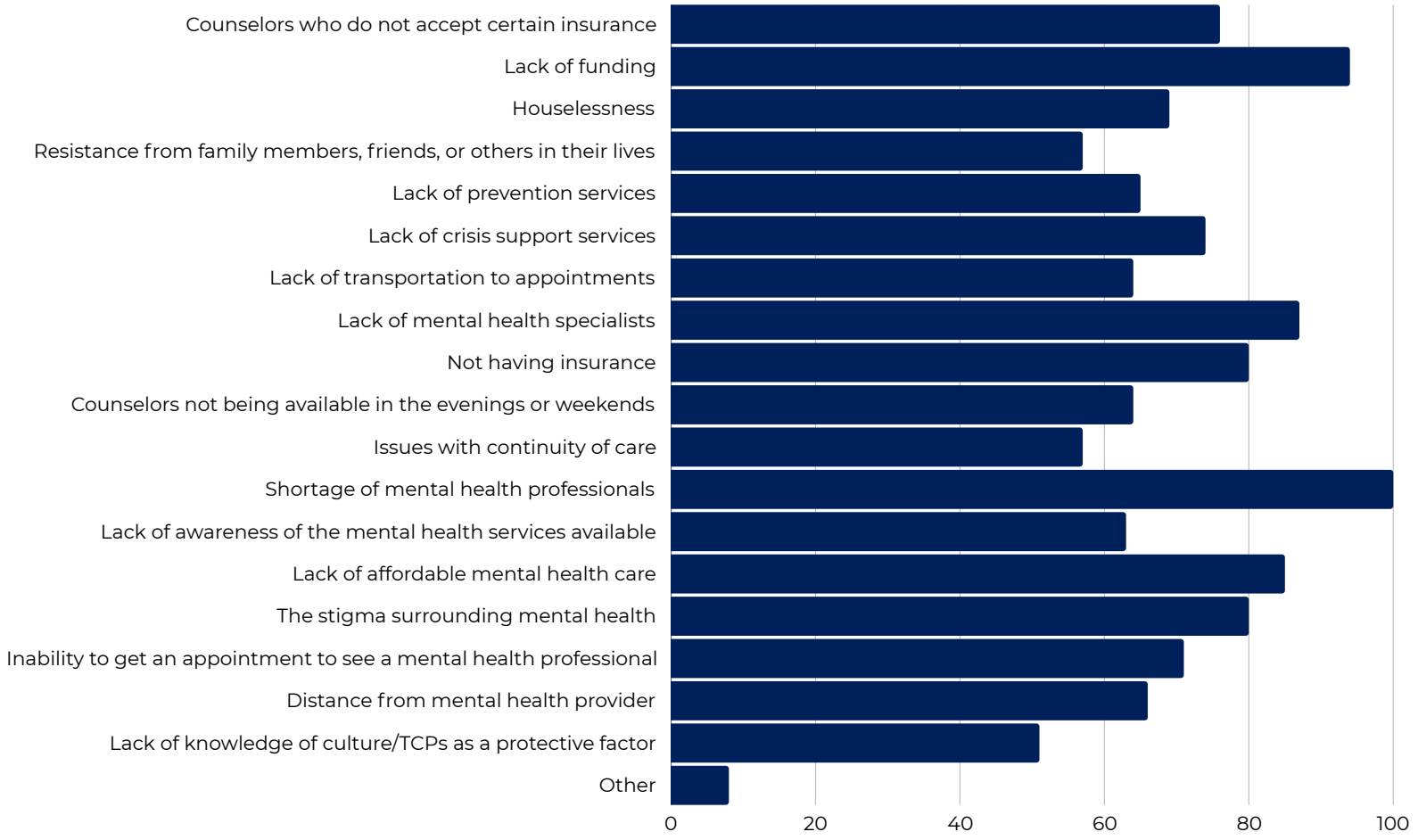
Other Needed Services (Question 2)

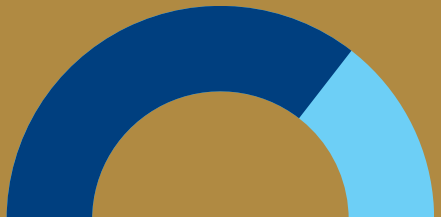
Those who selected “Other” on question 2 were asked to elaborate upon this answer in a provided. Their answers were:

- More safety net providers
- More inpatient beds for mental health patients, both young and old
- Education on various titles of mental health professionals/services they provide
- In-patient facility for children and adolescents who take children who are aggressive, not just suicidal. Those who are mentally ill
- More mobile care/crisis units
- Resources for kids especially
- Qualified individuals to perform high level assessments
- More prevention in schools- more school PK-12 school counselors
- Crisis Stabilization
- Family residential treatment for meth/opiates
- Comprehensive care for Transgender, Non Binary & Two Spirit folks
- Rec centers for adolescents
- Institution and support for alternatives to policing in responding to behavioral health issues

Barriers to Mental Health Care (Question 3)

Respondents were asked to identify the barriers they perceived to be preventing Montanans from accessing mental health care. Most (n=141; 81.03%) answered this question. Seventy-six (n=76; 53.90%) selected counselors who do not accept certain insurances, and two-thirds (n=94; 6.67%) lack of funding for mental health services. Nearly half (n=69; 48.94%) of the respondents chose houselessness, and fifty-seven (n=57; 40.42%) chose resistance from family members, friends, or others in their lives. Sixty-five (n=65; 46.10%) respondents indicated that lack of prevention services was a barrier, and over half (n=74; 52.48%) selected lack of crisis support services. Sixty-four (n=64; 45.39%) respondents chose lack of transportation to appointments, and eight-seven (n=87; 62.70%) chose lack of mental health specialists. Over half (n=80; 56.74%) of respondents selected not having insurance, and sixty-four (n=64; 45.39%) indicated that counselors not being available in the evenings or weekends was a barrier. Fifty-seven (n=57; 40.42%) respondents selected issues with continuity of care, and most (n=100; 70.92%) chose a shortage of mental health providers. Eighty (n=80; 56.74%) respondents chose the stigma surrounding mental health, and sixty-three (n=63; 44.68%) selected lack of awareness of the mental health services available. Eighty-five (n=85; 60.28%) respondents indicated that a lack of affordable mental health care was a barrier, and seventy-one (n=71; 50.35%) chose inability to get an appointment to see a mental health professional, and sixty-six (n=66; 46.81%) selected distance from a mental health provider as a barrier. Fifty-five (n=55; 36.17%) respondents indicated that lack of knowledge of culture and/or Traditional Ceremonial Practices (TCPs) as a protective factor was a barrier. Eight (n=8; 5.67%) respondents selected “other”.





70.92% of respondents identified the shortage of mental health professionals as the greatest barrier to accessing behavioral health services.

Other Barriers (Question 3)

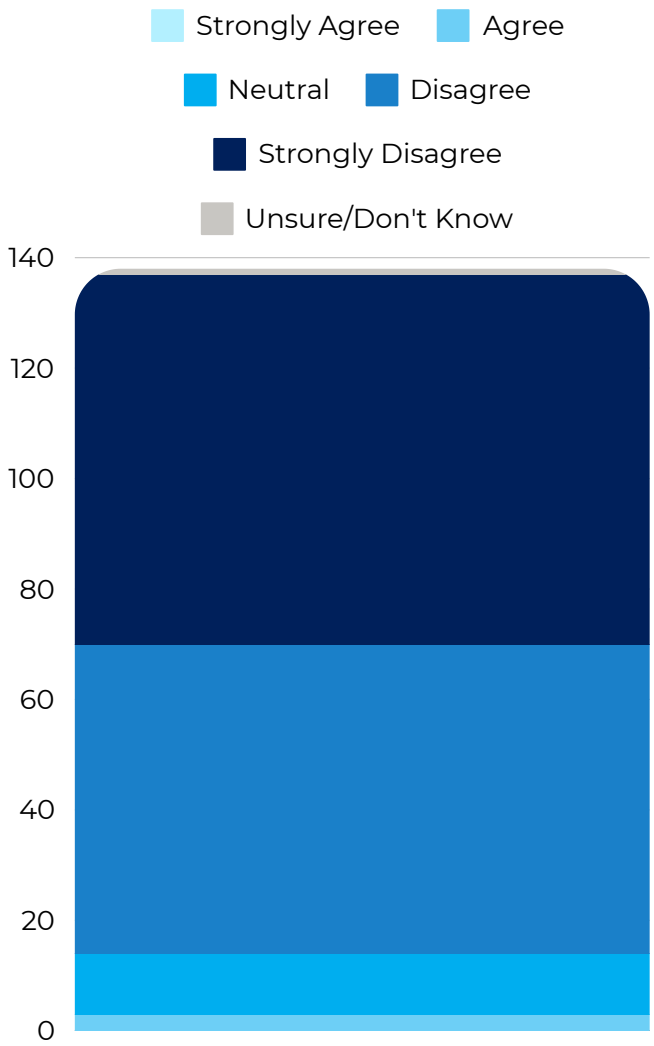
Those who selected “Other” on question 3 were asked to elaborate upon this answer in a provided. Their answers were:

- Substance use is a barrier
- Lack of Spanish-speaking providers
- Lack of highly qualified providers
- Shortage of school counselors
- Anti trans bias
- Recreational activities not available to adolescents in the community
- Homelessness, specifically evicting the Unhoused from areas they're living/mobile support can reach them
- No matching services for compatible patients and mental health clinicians. Also poor integration for employee benefits to access mental healthcare while at work. The cost of living increases causes people to work more to have no time or additional funds for mental health prevention.

AVAILABILITY AND UTILIZATION OF CARE

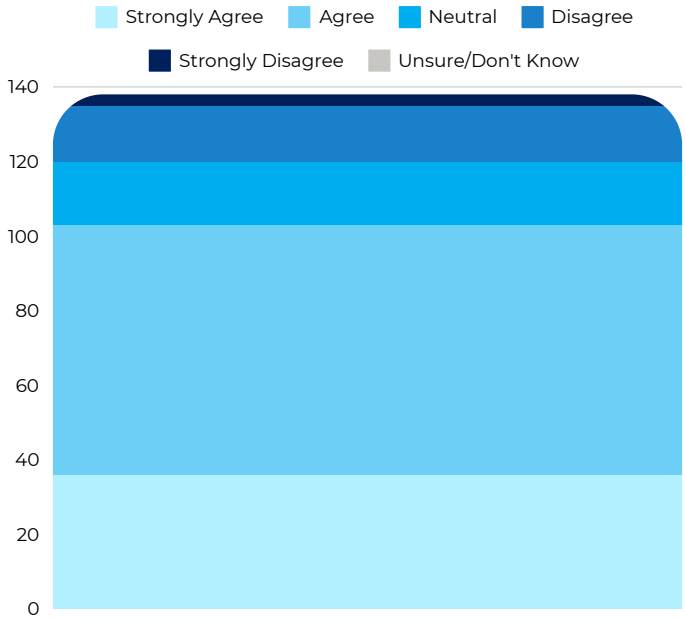
Meeting of Needs Across the State (Question 1)

Respondents were asked about their perspective on whether they felt that Montana's mental health needs were being met. Most (n=138; 79.3%) of survey participants answered this question. Three (n=3; 2.17%) respondents indicated that they agreed with the statement, "Montana's mental health needs are being met." Eleven (n=11; 7.97%) respondents felt neutral about the statement, fifty-six (n=56; 40.58%) respondents disagreed, and sixty-seven (n=67; 48.55%) strongly disagreed. One (n=1; 0.72%) respondent stated that they were unsure or did not know, and no respondents strongly agreed with the statement.



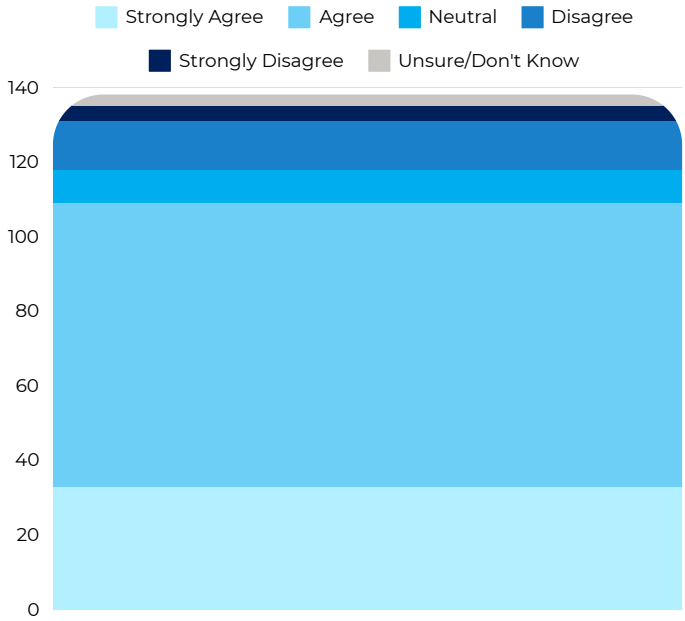
Comfort Seeking Services (Question 2)

Respondents were asked whether they agreed with the statement, “I feel comfortable seeking mental health services.” Most (n=138; 79.3%) of participants answered this question. Thirty-six (n=36; 26.09%) of respondents strongly agreed, sixty-seven (n=67; 48.55%) agreed, seventeen (n=17; 12.31%) felt neutral, fifteen (n=15; 10.87%) disagreed, and three (n=3; 2.17%) strongly disagreed. No respondents indicated that they were unsure or did not know.



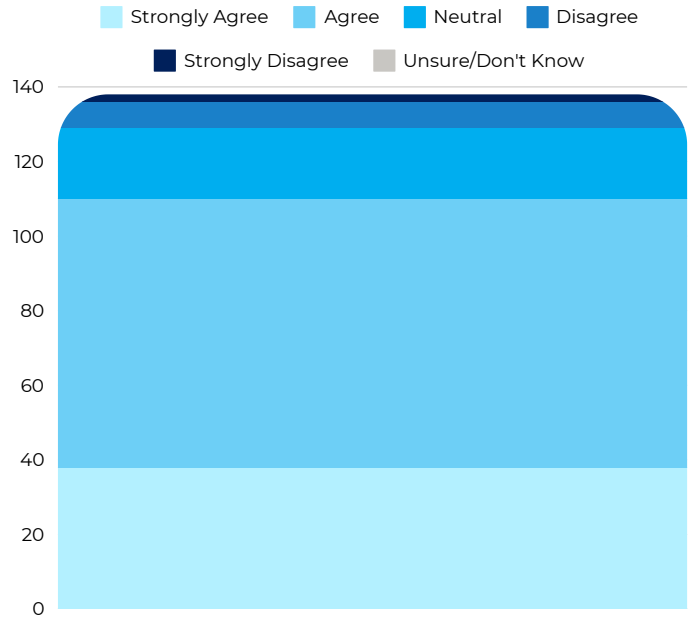
Knowledge of Where to Seek Help (Question 3)

Respondents were asked whether they agreed with the statement, “I know where to seek help for mental health concerns.” Most (n=138; 79.3%) of participants answered this question. Thirty-three (n=33; n=23.91%) respondents strongly agreed, seventy-six (n=76; 55.07%) agreed, nine (n=9; 6.52%) felt neutral, thirteen (n=13; 9.42%) disagreed, and four (n=4; 28.98%) strongly disagreed. Three (n=3; 2.17%) respondents were unsure or did not know.



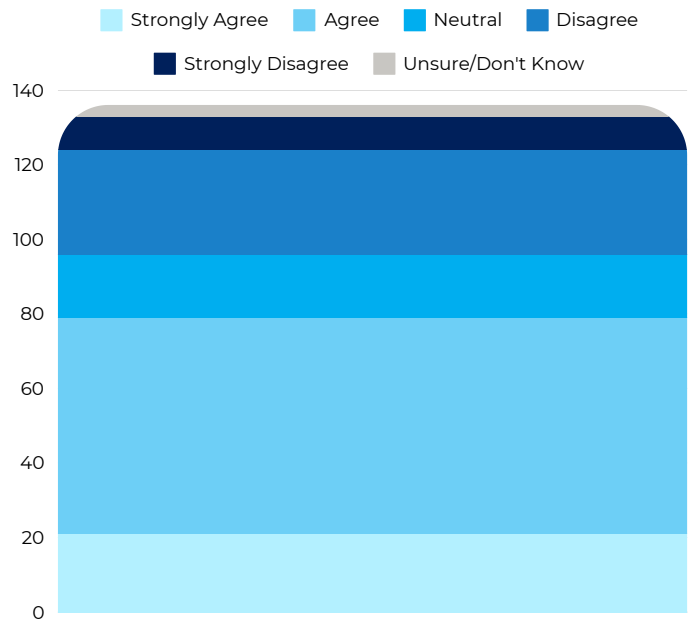
Substance Use and Addiction (Question 4)

Respondents were asked whether they agreed with the statement, “I am educated on substance use and addiction.” Most (n=138; 79.3%) of participants answered this question. Thirty-eight (n=38; 27.54%) respondents strongly agreed, seventy-two (n=72; 52.17%) agreed, nineteen (n=19; 13.77%) felt neutral, seven (n=7; 5.07%) disagreed, and two (n=2; 1.45%) strongly disagreed. No respondents were unsure or did not know.



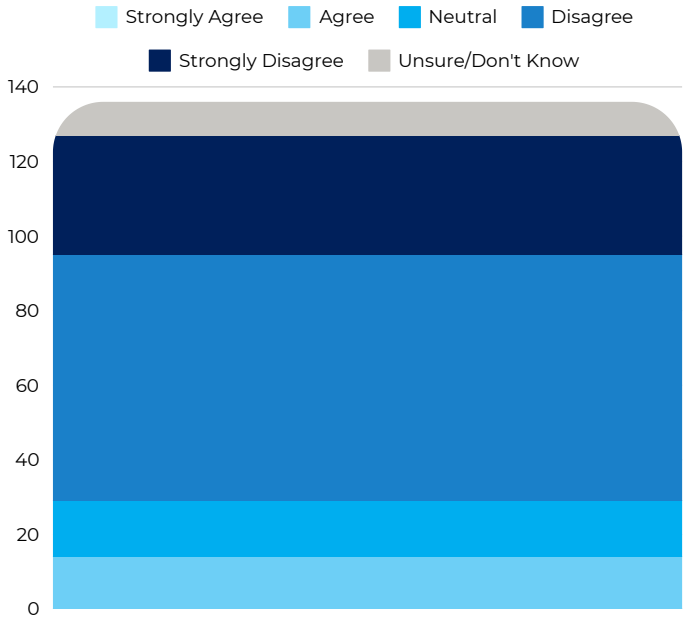
Knowledge of Where to Seek Help for Substance Abuse and Addiction (Question 5)

Respondents were asked whether they agreed with the statement, “I know where I can get help for substance use and addiction concerns.” Most (n=136; 78.16%) of participants answered this question. Twenty-one (n=21; 15.44%) of respondents strongly agreed, fifty-eight (n=58; 42.65%) agreed, seventeen (n=17; 12.5%) felt neutral, twenty-eight (n=28; 20.59%) disagreed, and nine (n=9; 6.62%) strongly disagreed. Three (n=3; 2.20%) respondents were unsure or did not know.



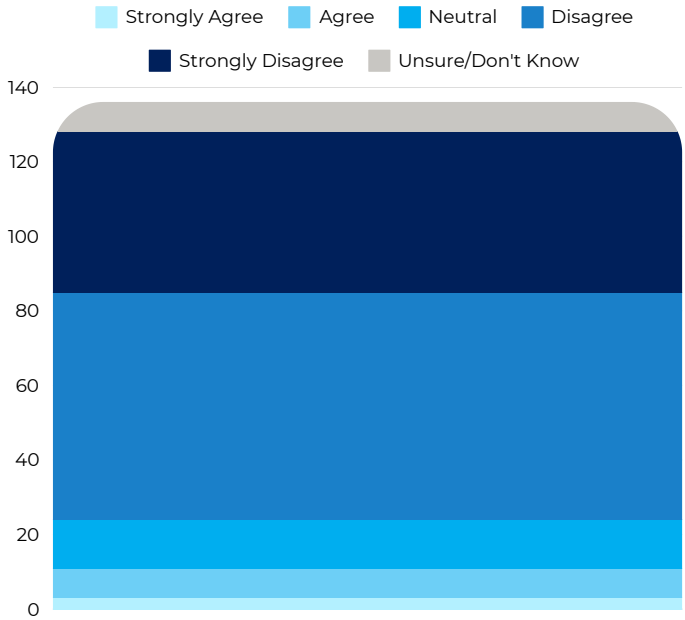
Resources for Veterans (Question 6)

Respondents were asked whether they agreed with the statement, “Veterans in my community have adequate resources for their mental health needs.” Most (n=136; 78.16%) of participants answered this question. Fourteen (n=14; 10.29%) respondents agreed, fifteen (n=15; 11.03%) felt neutral, sixty-six (n=66; 48.53%) disagreed, and thirty-two (n=32; 23.53%) strongly disagreed. Nine (n=9; 6.62%) felt unsure or did not know, and no respondents strongly agreed with the statement.



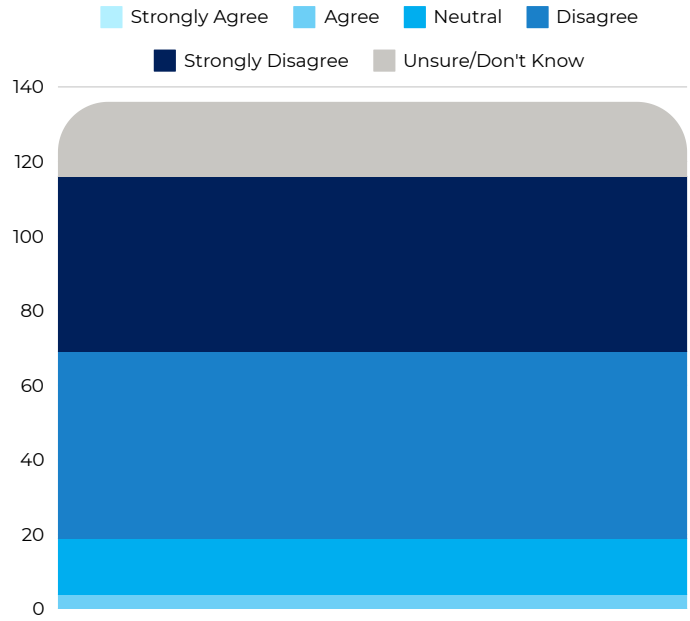
School Services (Question 7)

Respondents were asked whether they agreed with the statement, “Schools in my community have adequate mental health services for their students.” Most (n=136; 78.16%) of participants answered this question. Three (n=3; 2.20%) respondents strongly agreed, eight (n=8; 5.88%) agreed, thirteen (n=13; 9.56%) felt neutral, sixty-one (n=61; 44.85%) disagreed, and forty-three (n=43; 31.62%) strongly disagreed. Eight (n=8; 5.88%) respondents were unsure or did not know.



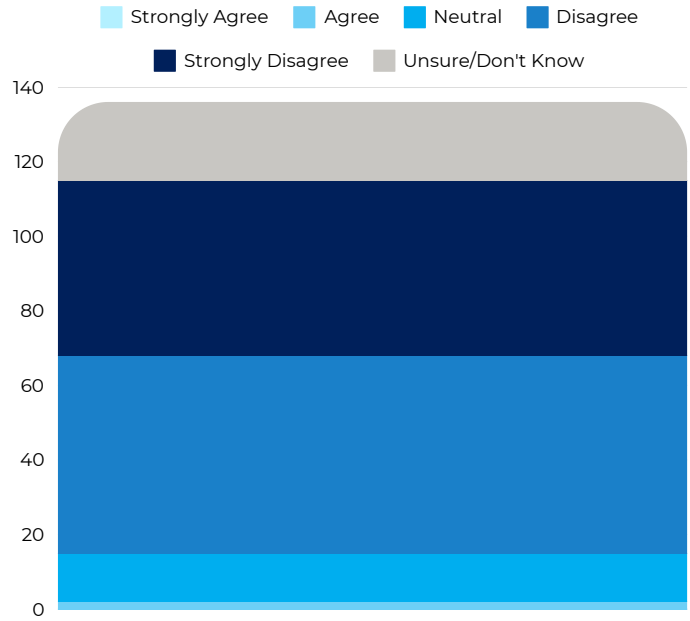
Services at Nursing Homes and Assisted Living Facilities (Question 8)

Respondents were asked whether they agreed with the statement, “Nursing homes and assisted living facilities in my community have adequate mental health care for their patients.” Most (n=136; 78.16%) of participants answered this question. Four (n=4; 2.94%) respondents agreed, fifteen (n=15; 11.03%) felt neutral, fifty (n=50; 36.76%) disagreed, and forty-seven (n=47; 34.56%) strongly disagreed. No respondents strongly agreed, and twenty (n=20; 14.71%) were unsure or did not know.



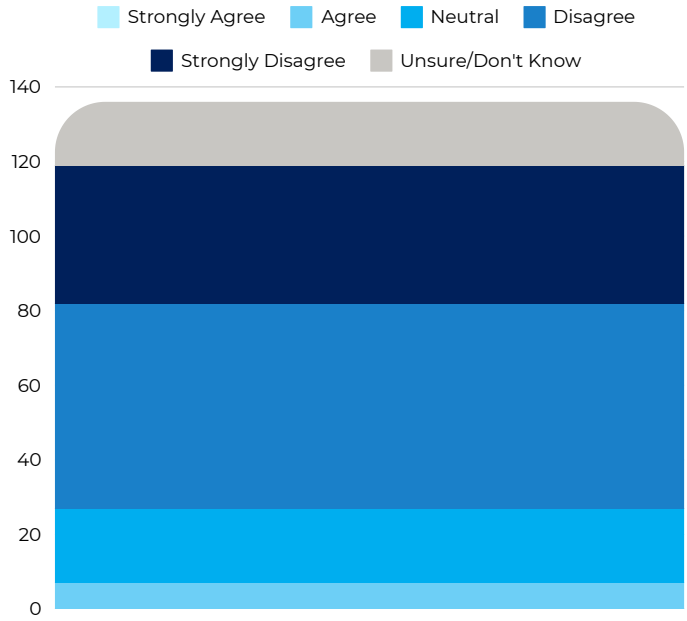
Resources for Children (Question 9)

Respondents were asked whether they agreed with the statement, “My community has adequate mental health resources for children aged 11 and younger.” Most (n=136; 78.16%) of participants answered this question. Two (n=2; 1.47%) respondents agreed, thirteen (n=13; 9.56%) felt neutral, fifty-three (n=53; 38.97%) disagreed, and forty-seven (n=47; 34.56%) strongly disagreed. No respondents strongly agreed, and twenty-one (n=21; 15.44%) felt unsure or did not know.



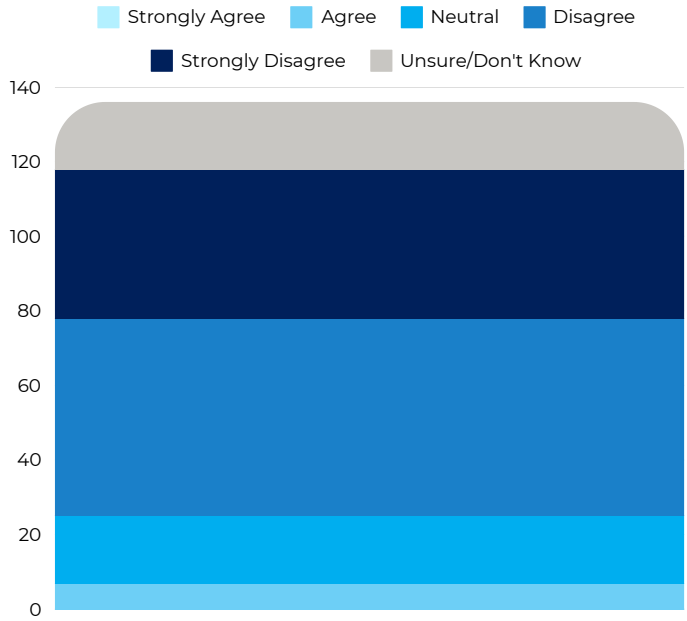
Resources for Seniors (Question 10)

Respondents were asked whether they agreed with the statement, “My community has adequate mental health resources for seniors ages 65 and above.” Most (n=136; 78.16%) of participants answered this question. Seven (n=7; 5.15%) respondents agreed, twenty (n=20; ; 14.71%) felt neutral, fifty-five (n=55; 40.44%) disagreed, and thirty-seven (n=37; 27.21%) strongly disagreed. No respondents strongly agreed, and seventeen (n=17; 12.5%) were unsure or did not know.



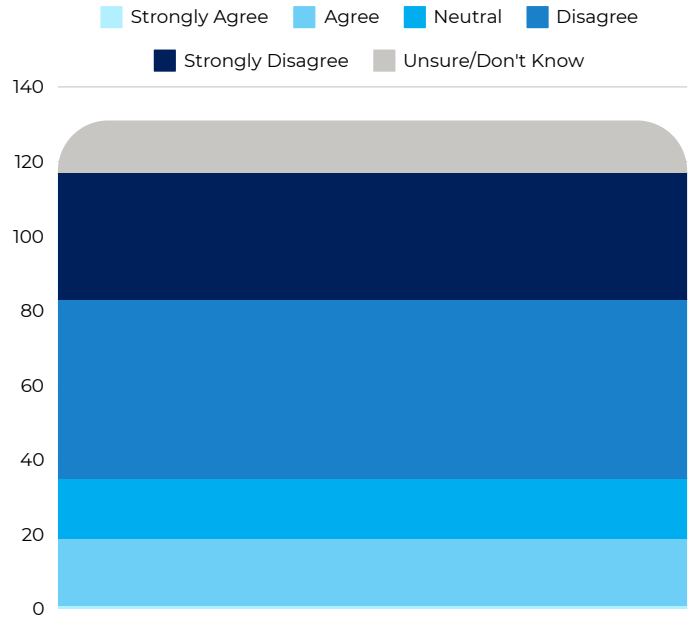
Resources for People with Disabilities & Accessibility Needs (Question 11)

Respondents were asked whether they agreed with the statement, “My community has adequate mental health resources for members with disability and accessibility needs.” Most (n=136; 78.16%) of participants answered this question. Seven (n=7; 5.15%) respondents agreed, eighteen (n=18; 13.23%) felt neutral, fifty-three (n=53; 38.97%) disagreed, and forty (n=40; 29.41%) strongly disagreed. No respondents strongly agreed, and eighteen (n=18; 13.23%) felt unsure or did not know.



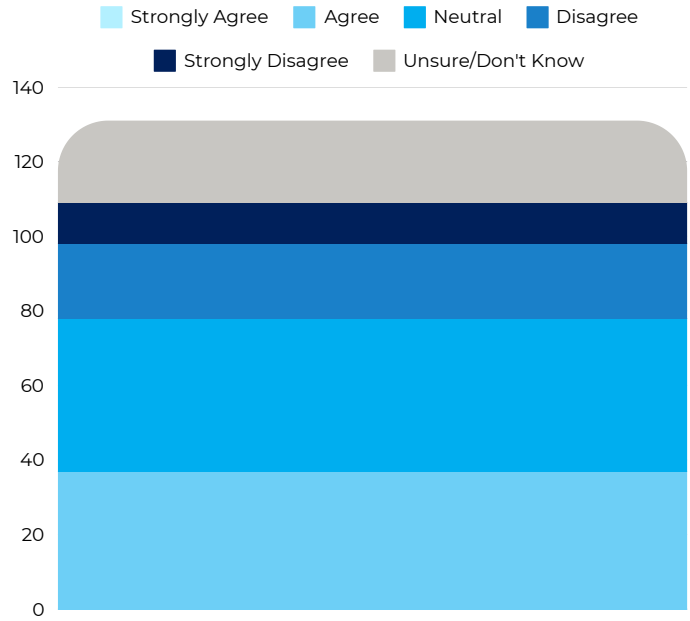
Affordability of Services (Question 12)

Respondents were asked whether they agreed with the statement, “There are affordable mental health services for low-income individuals in my community.” Most (n=131; 75.29%) of participants answered this question. One (n=1; 0.76%) respondent strongly agreed, eighteen (n=18; 13.74%) agreed, sixteen (n=16; 12.21%) felt neutral, forty-eight (n=48; 36.64%) disagreed, and thirty-four (n=34; 25.95%) strongly disagreed. Fourteen (n=14; 10.69%) were unsure or did not know.



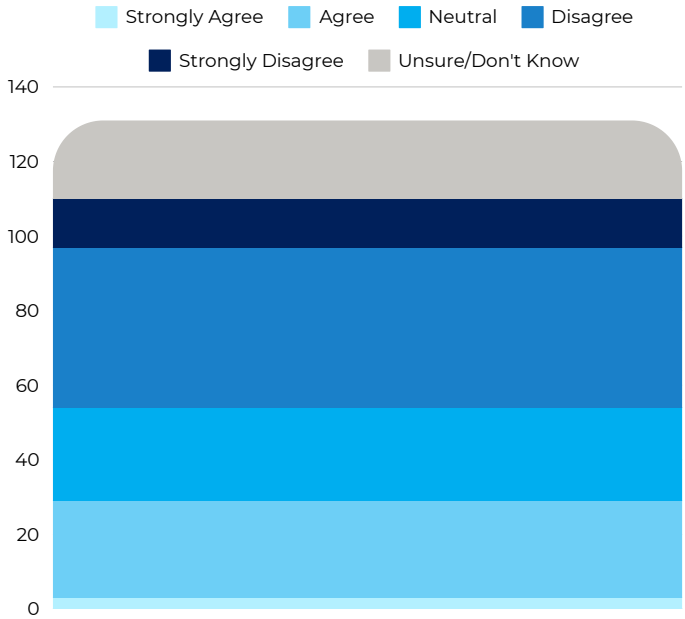
Support During Treatment (Question 13)

Respondents were asked whether they agreed with the statement, “During the treatment process, clients are adequately supported by their mental health provider.” Most (n=131; 75.29%) of participants answered this question. Thirty-seven (n=37; 28.24%) respondents agreed, forty-one (n=41; 31.30%) felt neutral, twenty (n=20; 15.27%) disagreed, and eleven (n=11; 8.40%) strongly disagreed. No respondents strongly agreed, and twenty-two (n=22; 16.79%) were unsure or did not know.



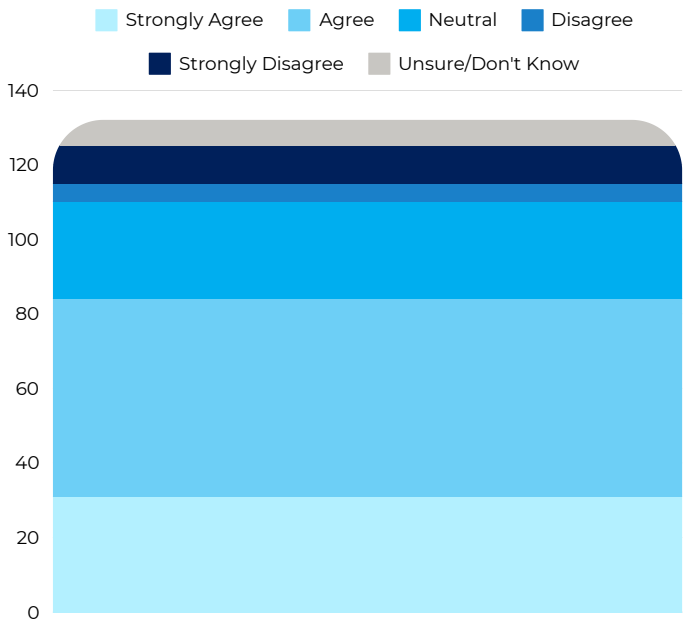
Access to Follow-Up Services (Question 14)

Respondents were asked whether they agreed with the statement, “Clients of local mental health providers have access to follow-up services should they need them.” Most (n=131; 75.29%) of participants answered this question. Three (n=3; 2.29%) respondents strongly agreed, twenty-six (n=26; 19.85%) agreed, twenty-five (n=25; 19.08%) felt neutral, forty-three (n=43; 32.82%) disagreed, and thirteen (n=13; 9.92%) strongly disagreed. Twenty-one (n=21; 16.03%) respondents felt unsure or did not know.



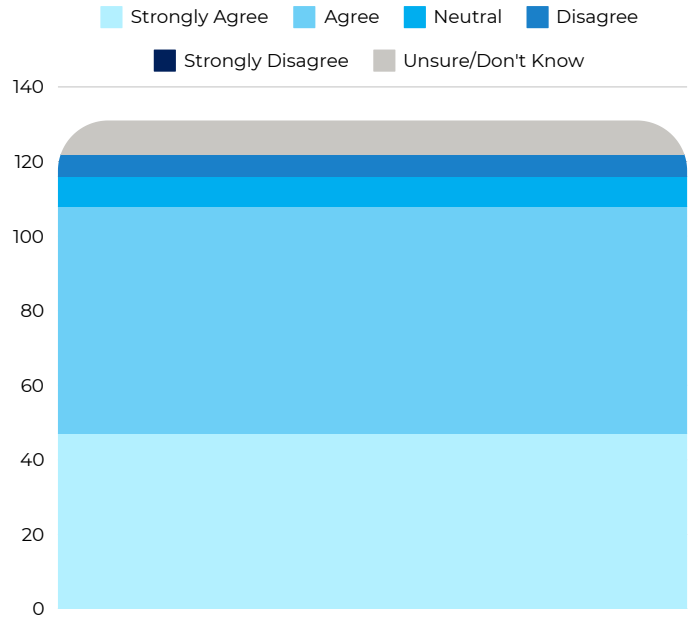
Trusted Mental Health Providers (Question 15)

Respondents were asked whether they agreed with the statement, “There is a mental health provider in my community that I trust.” Most (n=132; 75.86%) of participants answered this question. Thirty-one (n=31; 23.48%) respondents strongly agreed, fifty-three (n=53; 40.15%) agreed, twenty-six (n=26; 19.70%) felt neutral, five (n=5; 3.79%) disagreed, and ten (n=10; 7.58%) strongly disagreed. Seven (n=7; 5.30%) respondents felt unsure or did not know.



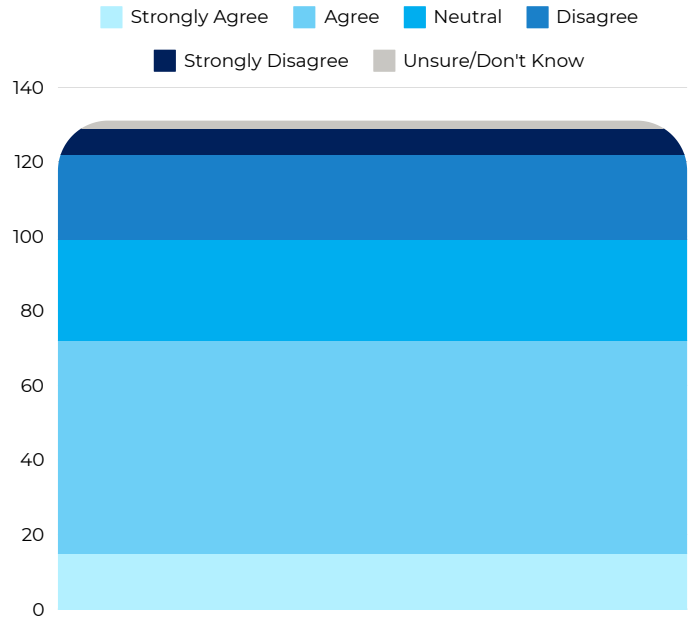
Knowledge of Inaccessibility (Question 16)

Respondents were asked whether they agreed with the statement, “I know one or more people in my community who have not been able to access the mental health care that they needed.” Most (n=131; 75.29%) of participants answered this question. Forty-seven (n=47; 35.88%) respondents strongly agreed, sixty-one (n=61; 46.56%) agreed, eight (n=8; 6.11%) felt neutral, six (n=6; 4.58%) disagreed, and no respondents strongly disagreed. Nine (n=9; 6.87%) respondents felt unsure or did not know.



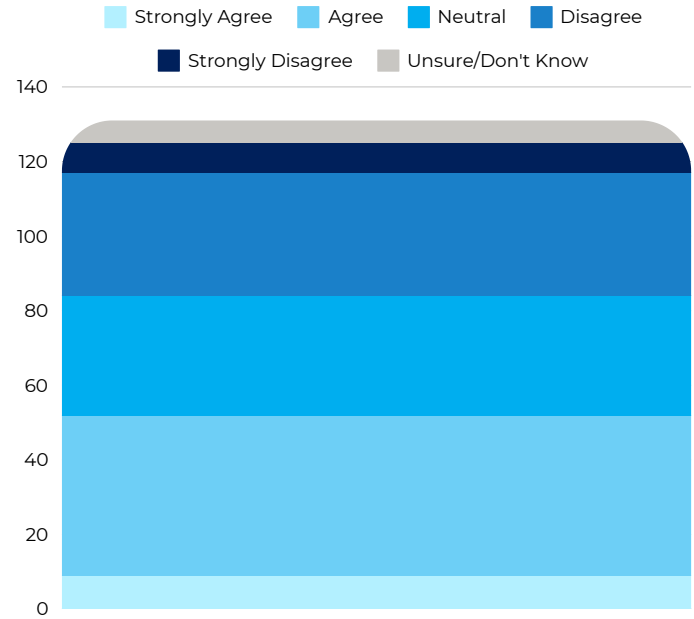
Recommendation of Services in the Community (Question 17)

Respondents were asked whether they agreed with the statement, “I am comfortable recommending local mental health services to others in my community.” Most (n=131; 75.29%) of participants answered this question. Fifteen (n=15; 11.45%) respondents strongly agreed, fifty-seven (n=57; 43.51%) agreed, twenty-seven (n=27; 20.61%) felt neutral, twenty-three (n=23; 17.56%) disagreed, and seven (n=7; 5.34%) strongly disagreed. Two (n=2; 1.53%) respondents felt unsure or did not know.



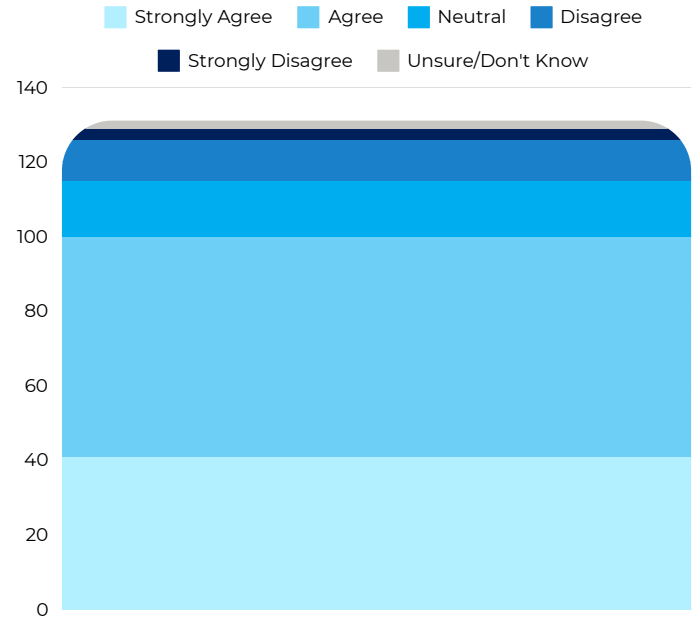
Recommendation of Services in Surrounding Communities (Question 18)

Respondents were asked whether they agreed with the statement, “I am comfortable recommending mental health services in a nearby community to members of my own community.” Most (n=131; 75.29%) of participants answered this question. Nine (n=9; 6.87%) respondents strongly agreed, forty-three (n=43; 32.82%) agreed, thirty-two (n=32; 24.43%) felt neutral, thirty-three (n=33; 25.19%) disagreed, and eight (n=8; 6.11%) strongly disagreed. Six (n=6; 4.58%) respondents felt unsure or did not know.



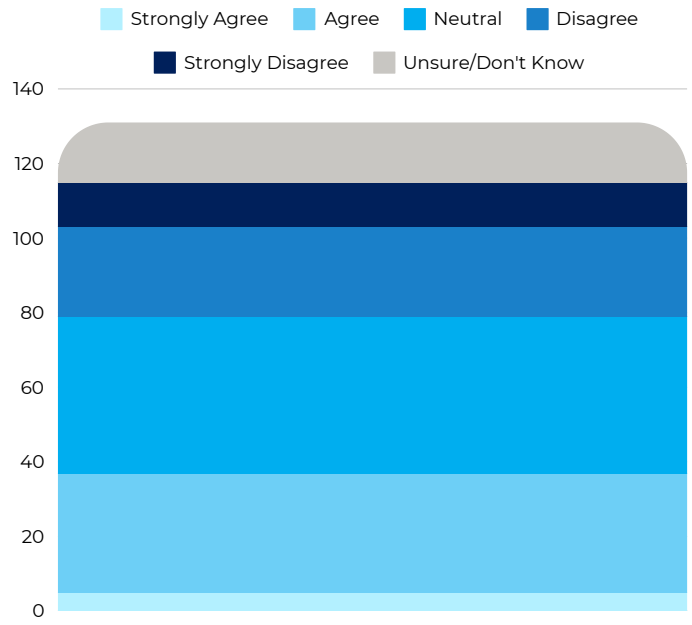
Expectations of Confidentiality (Question 19)

Respondents were asked whether they agreed with the statement, “If I seek mental health services through a healthcare facility, I expect and trust that the information I share will remain confidential.” Most (n=131; 75.29%) of participants answered this question. Forty-one (n=41; 31.30%) respondents strongly agreed, fifty-nine (n=59, 45.04%) agreed, fifteen (n=15; 111.45%) felt neutral, eleven (n=11; 8.40%) disagreed, and three (n=3; 2.29%) strongly disagreed. Two (n=2; 1.53%) respondents felt unsure or did not know.



Adequacy of Telehealth Services (Question 20)

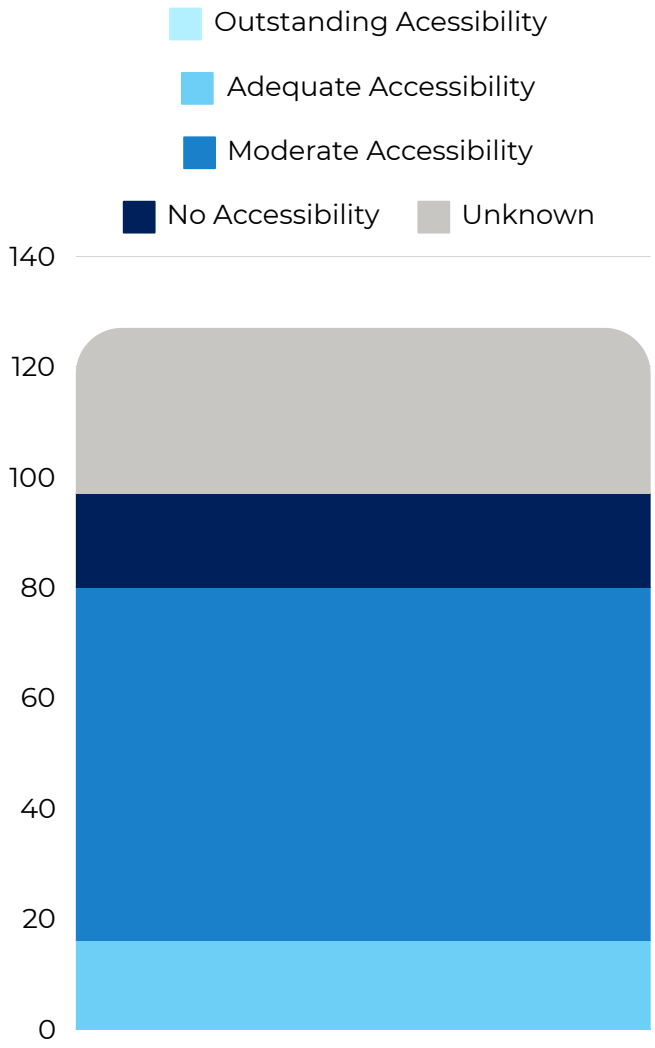
Respondents were asked whether they agreed with the statement, “There are adequate online or telehealth services for behavioral health in my community.” Most (n=131; 75.29%) of participants answered this question. Five (n=5; 3.82%) respondents strongly agreed, thirty-two (n=32; 24.43%) agreed, forty-two (n=42; 32.06%) felt neutral, twenty-four (n=24; 18.32%) disagreed, and twelve (n=12; 9.16%) strongly disagreed. Sixteen (n=16; 12/21%) felt unsure or did not know



ACCESSIBILITY

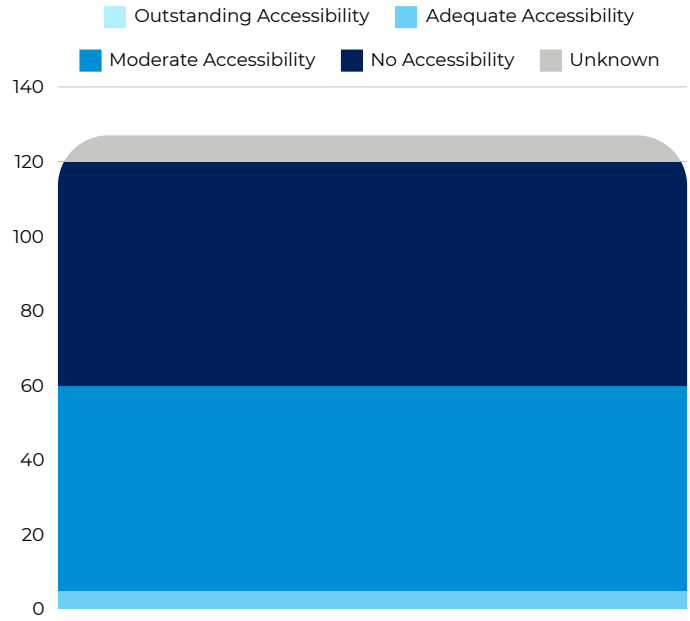
Peer Support Groups (Question 1)

Respondents were asked about their perception of the availability of various peer support groups in their community. Most (n=127; 72.98%) respondents answered this question. No respondents chose outstanding accessibility, sixteen (n=16; 12.60%) chose adequate accessibility, sixty-four (n=64; 50.39%) chose moderate accessibility, and seventeen (n=17; 13.39%) chose no accessibility. Thirty (n=30; 23.62%) did not know how accessible peer support groups were in their community.



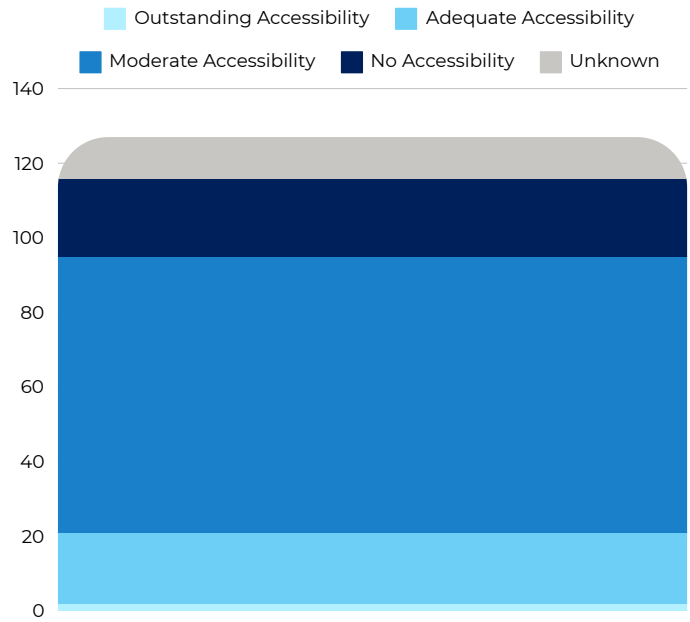
Safe Housing Options (Question 2)

Respondents were asked about their perception of the availability of affordable and safe housing options in their community. Most (n=127; 72.98%) respondents answered this question. No respondents chose outstanding accessibility, five (n=5; 3.94) chose adequate accessibility, fifty-five (n=55; 43.31%) chose moderate accessibility, and sixty (n=60; 47.24%) chose no accessibility. Seven (n=7; 5.51%) respondents did not know how accessible safe housing options were in their community.



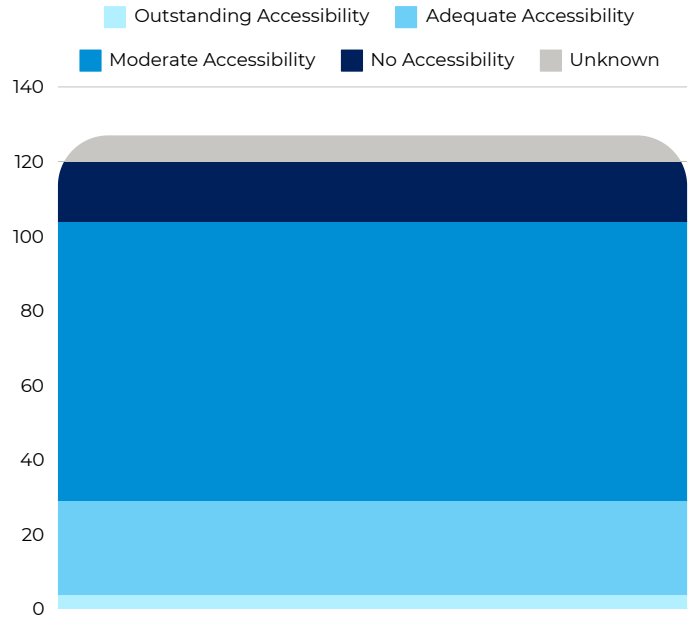
Employment Services (Question 3)

Respondents were asked about their perception of the availability of employment services (support and job placement) in their community. Most (n=127; 72.98%) respondents answered this question. Two (n=2; 1.57%) respondents chose outstanding accessibility, nineteen (n=19; 14.96%) chose adequate accessibility, seventy-four (n=74; 58.27%) chose moderate accessibility, and twenty-one (n=21; 16.53%) chose no accessibility. Eleven (n=11; 8.66%) respondents did not know how accessible employment services (support and job placement) were in their community.



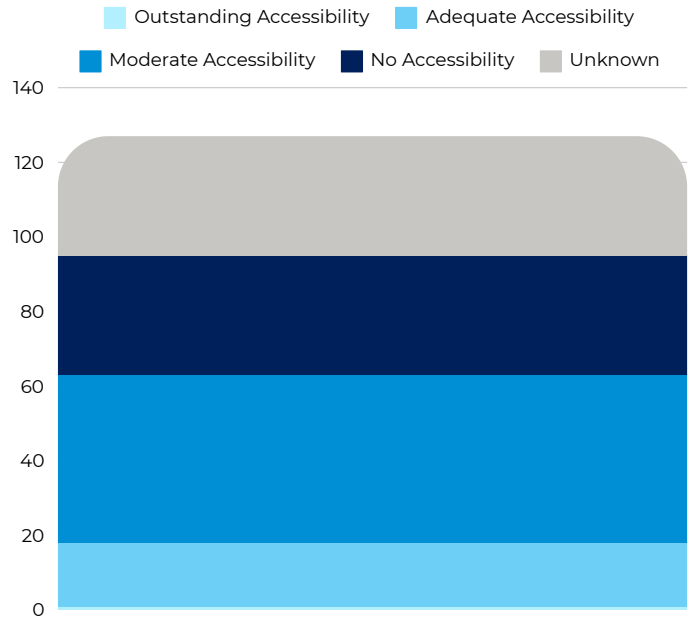
Local Transportation Services (Question 4)

Respondents were asked about their perception of the availability of local transportation services in their community. Most (n=127; 72.98%) respondents answered this question. Four (n=4; 3.15%) respondents chose outstanding accessibility, twenty-five (n=25; 19.68%) chose adequate accessibility, seventy-five (n=75; 59.05%) chose moderate accessibility, and sixteen (n=16; 12.60%) chose no accessibility. Seven (n=7; 5.51%) respondents did not know how accessible local transportation services were in their community.



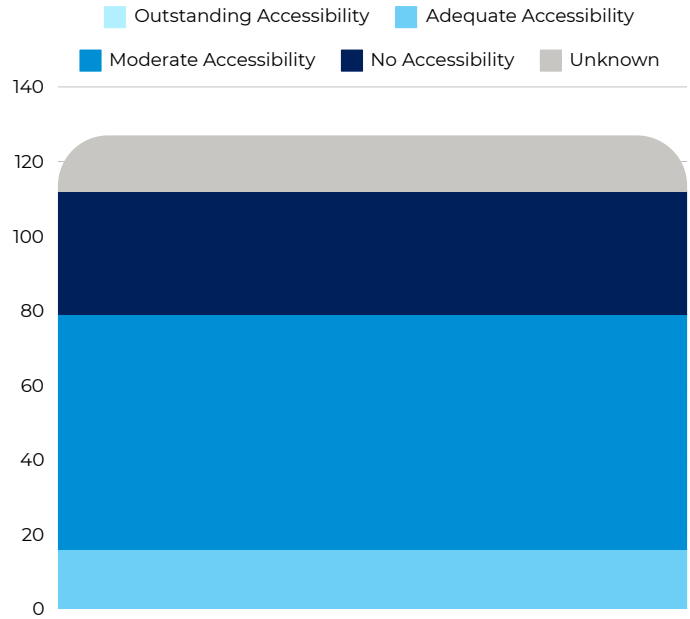
Mobile Crisis Services (Question 5)

Respondents were asked about their perception of the availability of various peer support groups in their community. Most (n=127; 72.98%) respondents answered this question. One (n=1; 0.79%) respondent chose outstanding accessibility, seventeen (n=17; 13.38%) chose adequate accessibility, forty-five (n=45; 35.43%) chose moderate accessibility, and thirty-two (n=32; 25.20%) chose no accessibility. Thirty-two (n=32;25.20%) respondents did not know how accessible mobile crisis services were in their community.



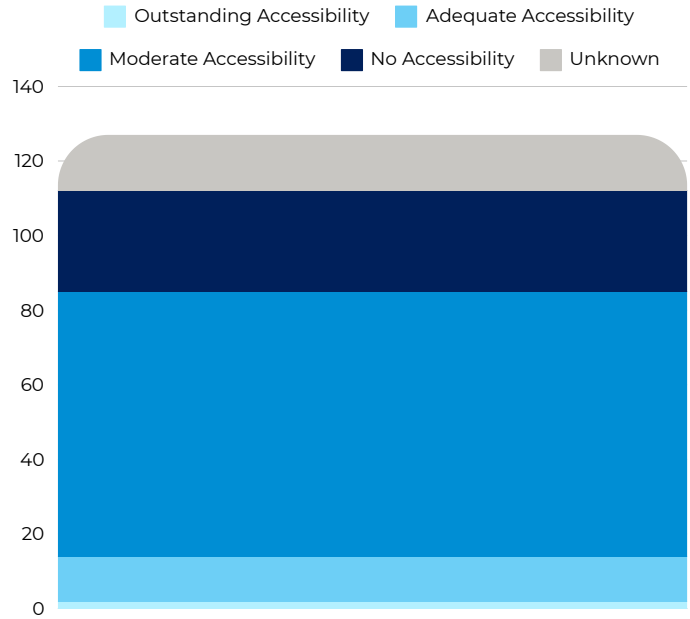
Addiction and Substance Use Services (Question 6)

Respondents were asked about their perception of the availability of addiction and substance use services (rehabilitation, detox, etc.) in their community. Most (n=127; 72.98%) respondents answered this question. No respondents chose outstanding accessibility, sixteen (n=16; 12.60%) chose adequate accessibility, sixty-three (n=63; 49.61%) chose moderate accessibility, and thirty-three (n=33; 25.98%) chose no accessibility. Fifteen (n=15; 11.81%) respondents did not know how accessible addiction and substance use services (rehabilitation, detox, etc.) were in their community.



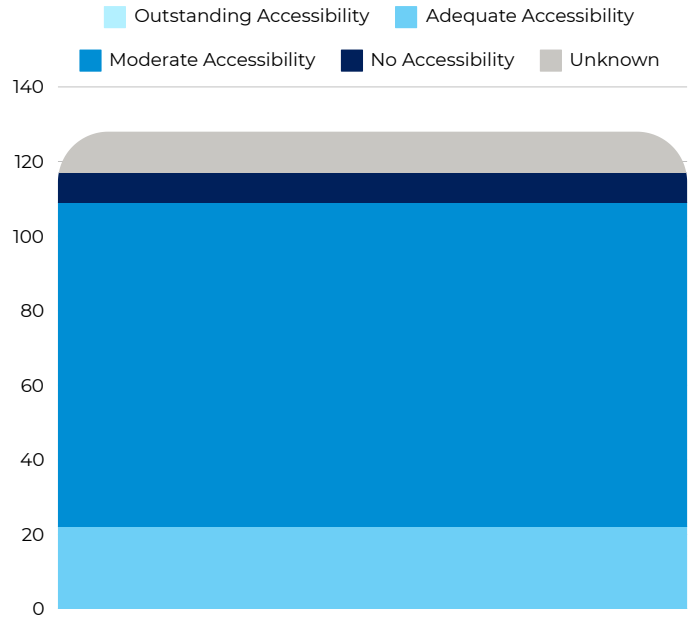
Psychiatry Services (Question 7)

Respondents were asked about their perception of the availability of psychiatry services in their community. Most (n=127; 72.98%) respondents answered this question. Two (n=2; 157%) respondents chose outstanding accessibility, twelve (n=12; 9.45%) chose adequate accessibility, seventy-one (n=71; 55.91%) chose moderate accessibility, and twenty-seven (n=27; 21.26%) chose no accessibility. Fifteen (n=15; 11.81%) did not know how accessible psychiatry services were in their community.



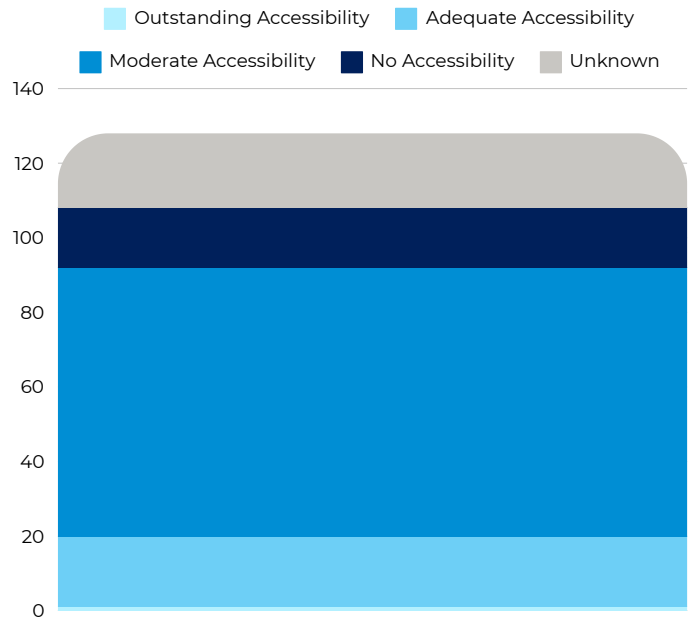
Outpatient Mental Health Services (Question 8)

Respondents were asked about their perception of the availability of mental health services (outpatient) in their community. Most (n=127; 72.98%) respondents answered this question. No respondents chose outstanding accessibility, twenty-two (n=22; 17.32%) chose adequate accessibility, eighty-seven (n=87; 68.50%) chose moderate accessibility, and eight (n=8; 6.30) chose no accessibility. Eleven (n=11; 8.66%) respondents did not know how accessible mental health services (outpatient) were in their community.



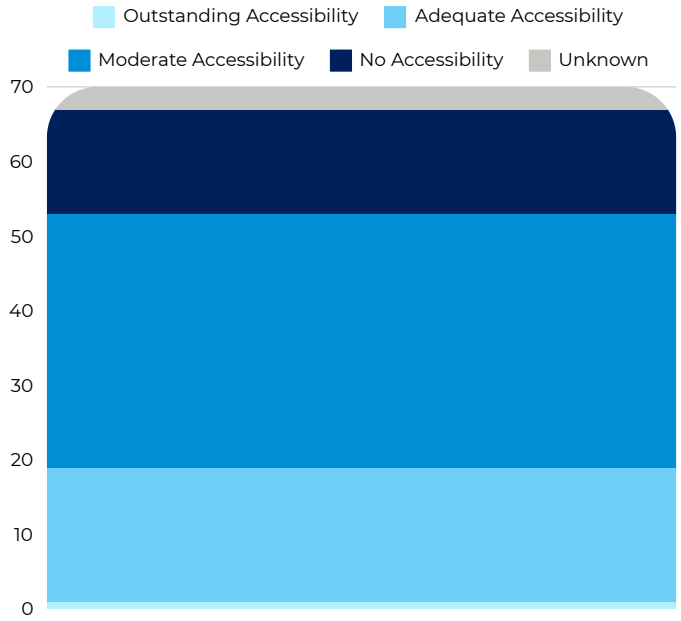
Prevention Services & Screenings (Question 9)

Respondents were asked about their perception of the availability of prevention services and screenings in their community. Most (n=127; 72.98%) respondents answered this question. One (n=1; 0.79%) respondent chose outstanding accessibility, nineteen (n=19; ; 14.96%) chose adequate accessibility, seventy-two (n=72; 56.69%) chose moderate accessibility, and sixteen (n=16; 12.60%) chose no accessibility. Twenty (n=20; 15.75%) respondents did not know how accessible prevention services and screenings were in their community.



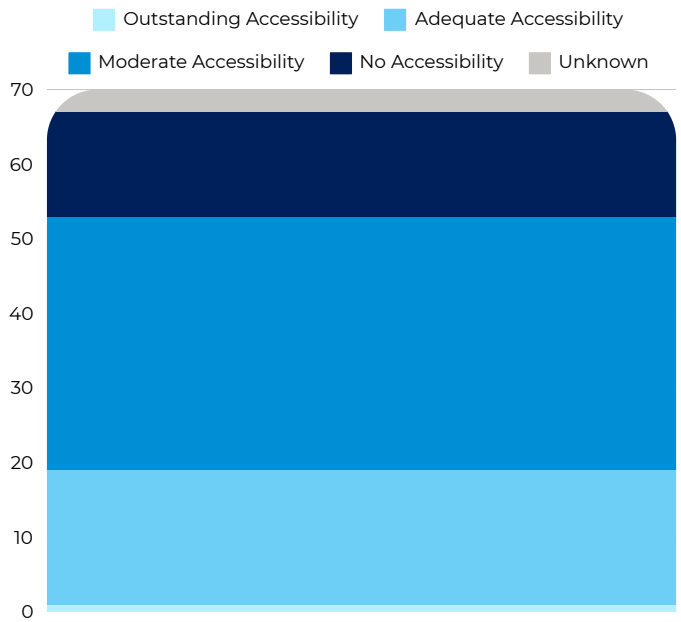
Affordability of Services (Question 12)

Respondents were asked about their perception of the availability of various peer support groups in their community. Most (n=127; 72.98%) respondents answered this question. No respondents chose outstanding accessibility, sixteen (n=16; 12.60%) chose adequate accessibility, sixty-four (n=64; 50.39%) chose moderate accessibility, and seventeen (n=17; 13.39%) chose no accessibility. Thirty (n=30; 23.62%) did not know how accessible peer support groups were in their community.



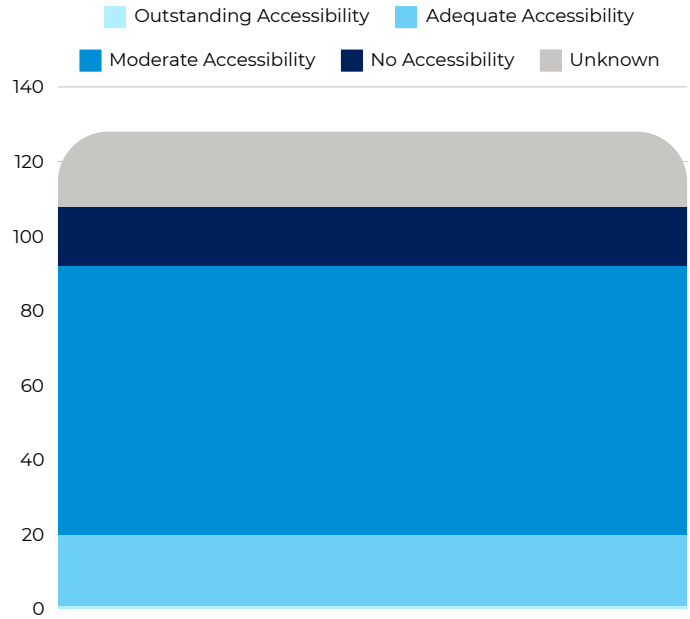
Support During Treatment (Question 13)

Respondents were asked about their perception of the availability of various peer support groups in their community. Most (n=127; 72.98%) respondents answered this question. No respondents chose outstanding accessibility, sixteen (n=16; 12.60%) chose adequate accessibility, sixty-four (n=64; 50.39%) chose moderate accessibility, and seventeen (13.39%) chose no accessibility. Thirty (n=30; 23.62%) did not know how accessible peer support groups were in their community.



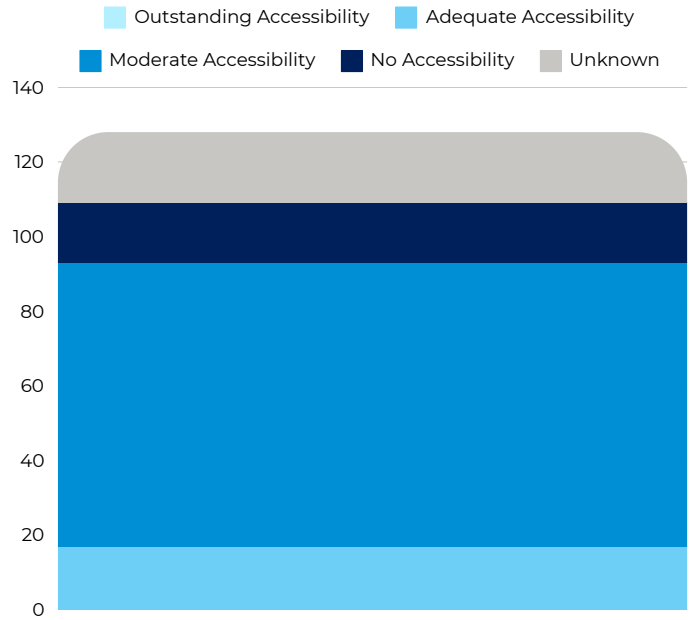
Prevention Services (Question 14)

Respondents were asked about their perception of the availability of various peer support groups in their community. Most (n=128; 73.56%) respondents answered this question. One (n=1; 0.78%) respondent chose outstanding accessibility, nineteen (n=19; 14.84%) chose adequate accessibility, seventy-two (n=72; 56.25%) chose moderate accessibility, and sixteen (n=16; 12.5%) chose no accessibility. Twenty (n=20; 15.62%) respondents did not know how accessible peer support groups were in their community.



Crisis Intervention Services (Question 15)

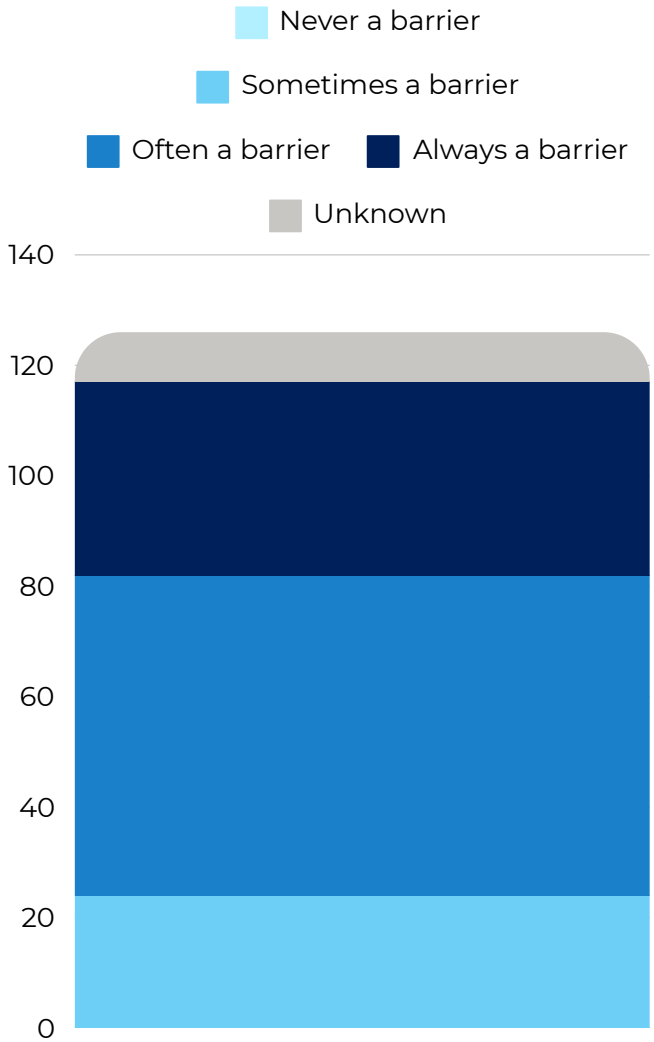
Respondents were asked about their perception of the availability of crisis intervention services in their community. Most (n=128; 73.56%) respondents answered this question. No respondents chose outstanding accessibility, seventeen (n=17; 13.28%) respondents chose adequate accessibility, seventy-six (n=76; 59.37%) chose moderate accessibility, and sixteen (n=16; 12.5%) chose no accessibility. Nineteen (n=19; 14.84%) respondents did not know how accessible crisis intervention services were in their community.



POTENTIAL BARRIERS TO SERVICES

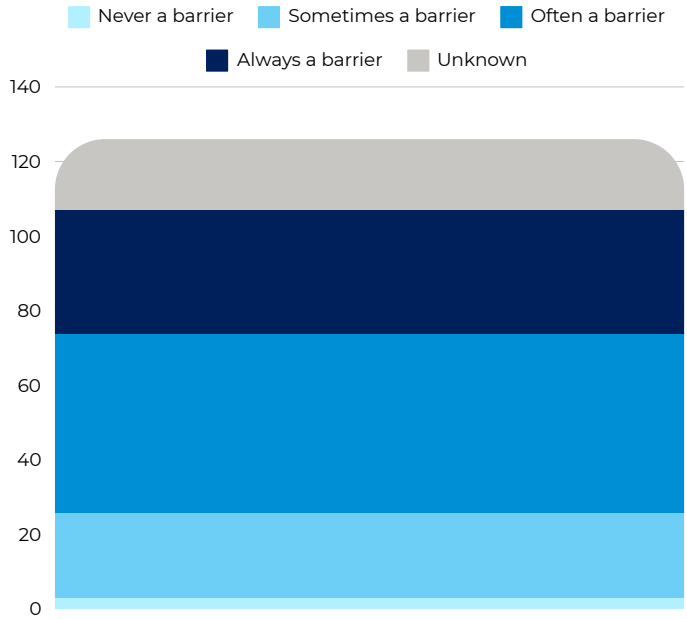
Long Wait Times (Question 1)

Respondents were asked about their perception of the frequency at which long wait times to get appointments created a barrier for patients. Most (n=126; 72.41%) respondents answered this question. No respondents chose never a barrier, twenty-four (n=24; 19.05%) chose sometimes a barrier, fifty-eight (n=58; 46.03%) chose often a barrier, and thirty-five (n=35; 27.78%) chose always a barrier. Nine (n=9; 7.14%) respondents did not know whether long wait times to get appointments were a barrier.



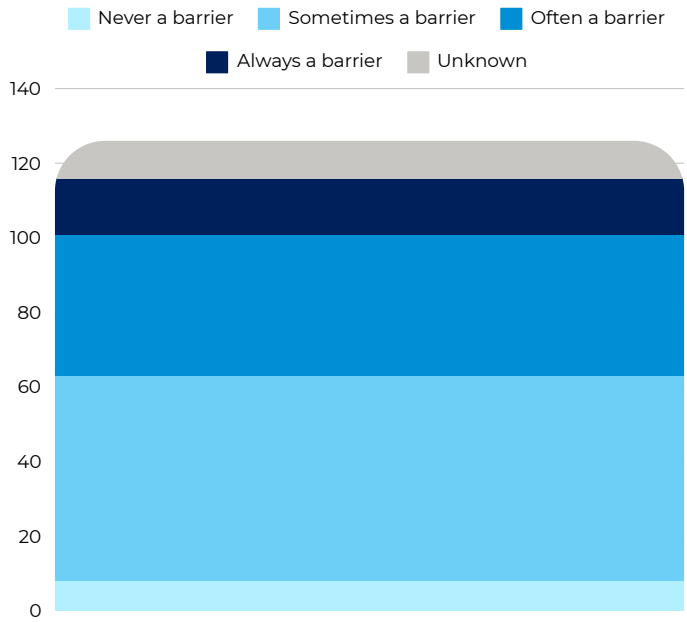
Outreach to Homeless Populations (Question 2)

Respondents were asked about their perception of the frequency at which lack of outreach to those who experiencing homelessness created a barrier for patients. Most (n=126; 72.41%) respondents answered this question. Three (n=3; 2.38%) respondents chose never a barrier, twenty-three (n=23; 18.25%) chose sometimes a barrier, forty-eight (n=48; 38.09%) chose often a barrier, and thirty-three (n=33; 26.19%) chose always a barrier. Nineteen (n=19; 15.08%) did not know whether lack of outreach to those who experiencing homelessnesss were a barrier.



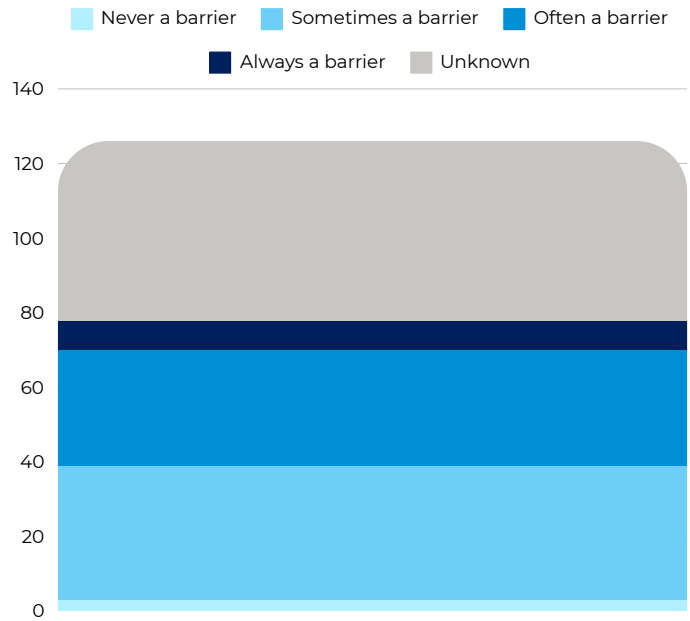
Language or Cultural Barriers (Question 3)

Respondents were asked about their perception of the frequency at which language or cultural barriers created a barrier for patients. Most (n=126; 72.41%) respondents answered this question. Eight (n=8; 6.35%) respondents chose never a barrier, fifty-five (n=55; 43.65%) chose sometimes a barrier, thirty-eight (n=38; 30.16%) chose often a barrier, and fifteen (n=15; 11.90%) chose always a barrier. Ten (n=10; 7.94%) did not know whether language or cultural barriers were a barrier.



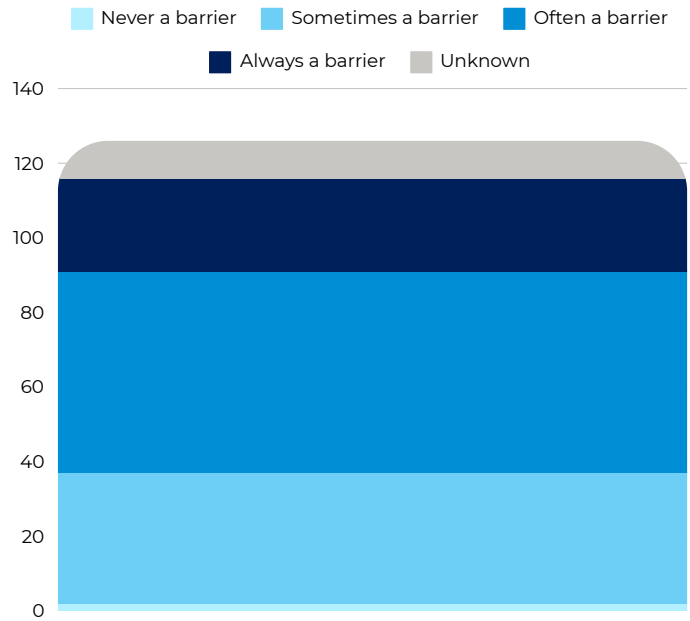
Medication Policies (Question 4)

Respondents were asked about their perception of the frequency at which restrictive medication policies created a barrier for patients. Most (n=126; 72.41%) respondents answered this question. Three (n=3; 2.38%) respondents chose never a barrier, thirty-six (n=36; 28.57%) chose sometimes a barrier, thirty-one (n=31; 24.60%) chose often a barrier, and eight (n=8; 6.35%) chose always a barrier. Forty-eight (n=48; 38.09%) respondents did not know whether restrictive medication policies were a barrier.



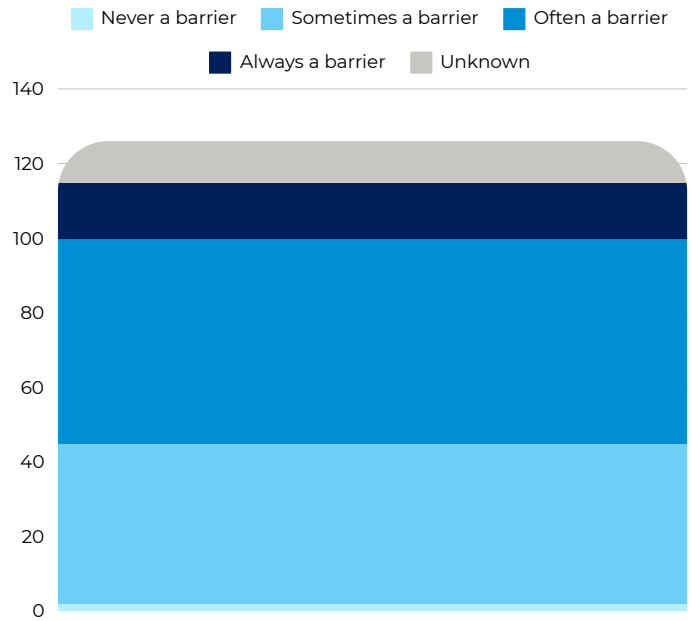
Hours of Availability (Question 5)

Respondents were asked about their perception of the frequency at which limited hours of availability created a barrier for patients. Most (n=126; 72.41%) respondents answered this question. Two (n=2; 1.59%) respondents chose never a barrier, thirty-five (n=35; 27.78%) chose sometimes a barrier, fifty-four (n=54; 42.86%) chose often a barrier, and twenty-five (n=25; 19.84%) chose always a barrier. Ten (n=10; 7.94%) respondents did not know whether limited hours of availability were a barrier.



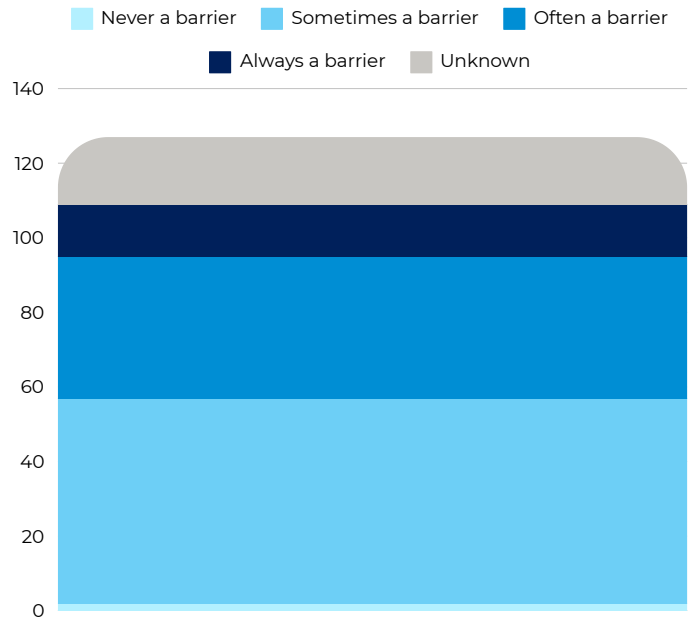
Transportation (Question 6)

Respondents were asked about their perception of the frequency at which lack of transportation to appointments created a barrier for patients. Most (n=126; 72.41%) answered this question. Two (n=2; 1.59%) respondents chose never a barrier, forty-three (n=43; 34.13%) chose sometimes a barrier, fifty-five (n=55; 43.65%) chose often a barrier, and fifteen (n=15; 11.90%) chose always a barrier. Eleven (n=11; 8.73%) respondents did not know whether lack of transportation to appointments was a barrier.



Training for Medical Staff (Question 7)

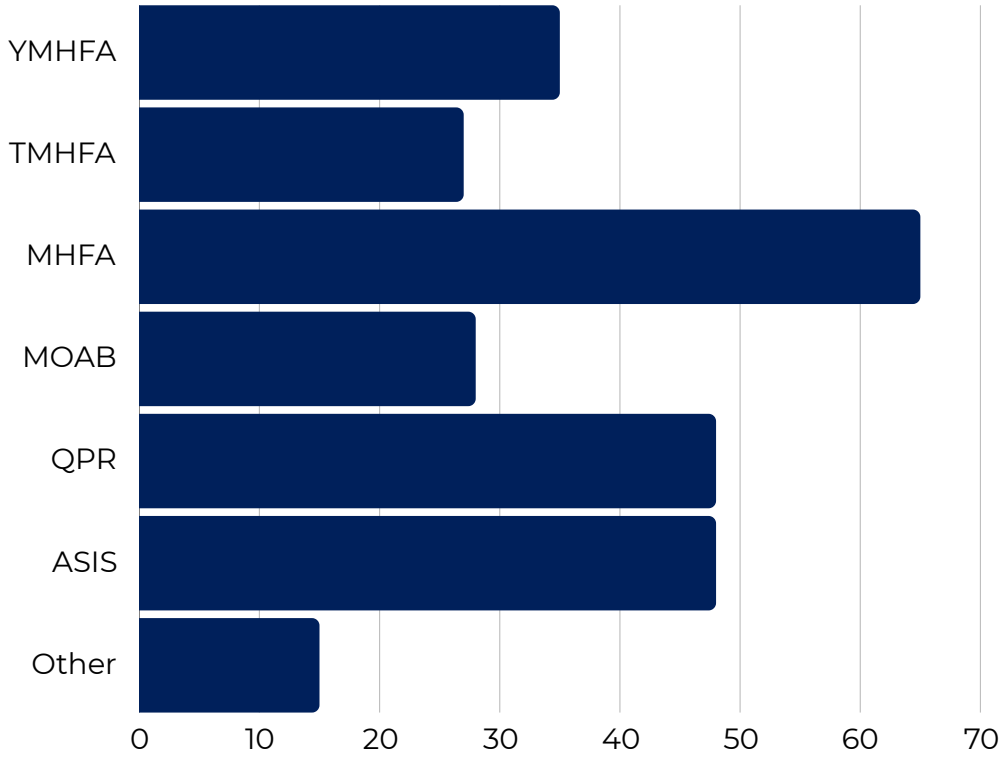
Respondents were asked about their perception of the frequency at which lack of adequate training for medical staff on behavioral health created a barrier for patients. Most (n=126; 72.41%) respondents answered this question. Two (n=2; 1.59%) respondents chose never a barrier, fifty-five (n=5; 43.65%) chose sometimes a barrier, thirty-eight (n=38; 30.16%) chose often a barrier, and fourteen (n=14; 11.11%) chose always a barrier. Eighteen (n=18, 14.29%) respondents did not know whether lack of adequate training for medical staff on behavioral health were a barrier.



BEHAVIORAL HEALTH TRAINING

Trainings Known by Community Members (Question 1)

Respondents were asked to provide the behavioral health trainings with which they were familiar. Most (n=111; 63.79%) respondents answered this question. Thirty-five (n=35; 31.53%) respondents selected Youth Mental Health First Aid, twenty-seven (n=27; 24.32%) chose Teen Mental Health First Aid, and over half (n=65; 58.56%) selected Mental Health First Aid. Twenty-eight (n=28; 25.22%) respondents indicated that they had heard of the Management of Aggressive Behaviors (MOAB) training, forty-eight (n=48; 43.24%) chose Question, Persuade, Refer (QPR) training, forty-eight (n=48; 43.24%) selected Applied Suicide Intervention Skills (ASIS), and fifteen (n=15; 13.51%) chose "other".



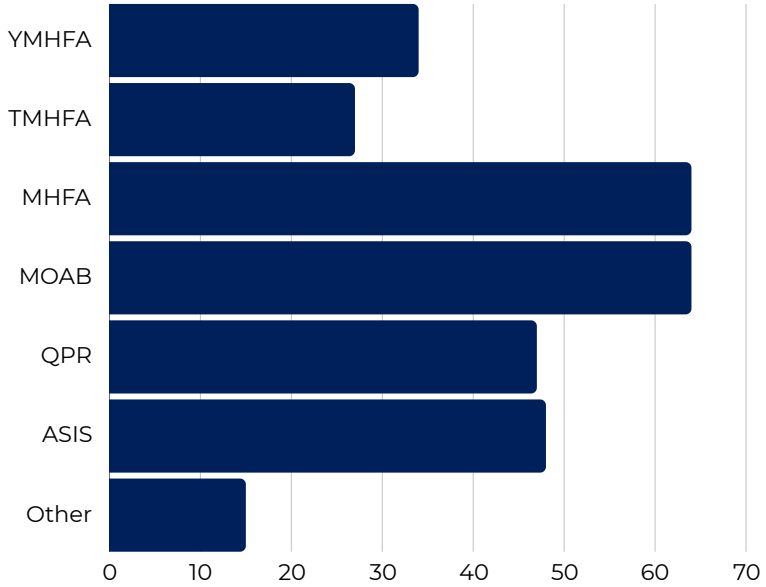
Other Trainings

Those who selected "Other" on question 1 were asked to elaborate upon this answer in a provided. Their answers were:

- CPI
- I'm a Psych NP who has a private practice in [name] County with 2 other psych NP providers. All of us are trained and provide services locally in [name] County
- AHEC webinars
- Aegis
- SBIRT
- Suicide Safe Care, YAM
- I am not familiar with any of these
- None (8 respondents wrote this)

Trainings for Communities (Question 2)

Respondents were asked about which trainings they felt would benefit their communities. Nearly two-thirds (n=110; 63.22%) of respondents answered this question. Thirty-four (n=34; 30.91%) respondents indicated that Youth Mental Health First Aid (YMHFA) would be beneficial, and twenty-seven (n=27; 24.55%) chose Teen Mental Health First Aid (TMHFA). Over half (n=64; 58.18%) of the respondents chose Mental Health First Aid (MHFA), and twenty-seven (n=27; 24.55%) selected Management of Aggressive Behaviors (MOAB). Forty-seven (n=47; 42.73%) respondents selected Question, Persuade, Refer (QPR), forty-eight (n=48; 43.64%) chose Applied Suicide Intervention SKills (ASIS), and fifteen (n=15; 13.64%) selected "other".



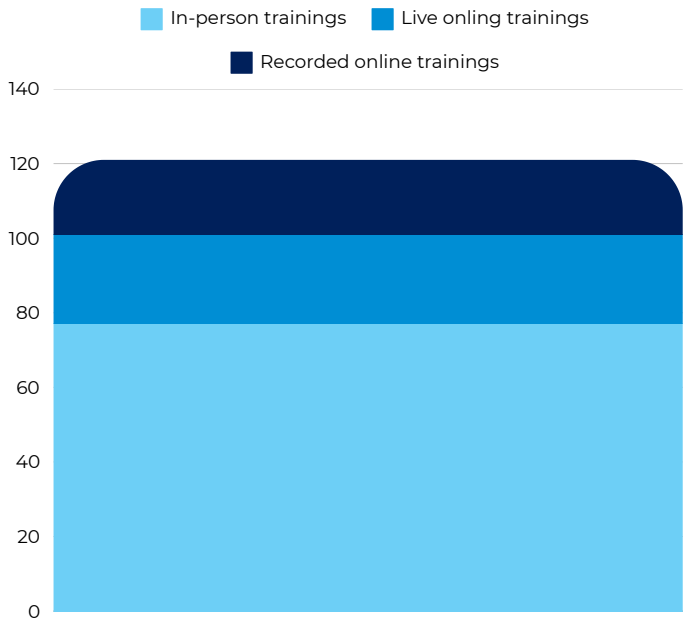
Other Trainings (Question 2)

Those who selected "Other" on question 2 were asked to elaborate upon this answer in a provided. Their answers were:

- Language cultural
- De-escalation of individuals not just MOAB training, but de-escalation techniques.
- N/A or none (three respondents wrote this)
- Transgender/pronouns 101
- Have had most of these

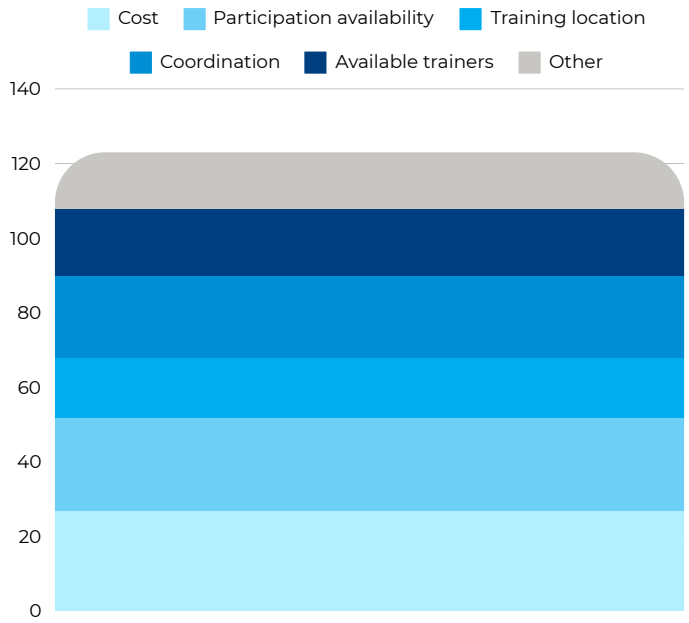
Delivery of Trainings (Question 3)

Respondents were asked about their preferred mode of delivery of behavioral health training. Most (n=121; 69.54%) respondents answered this question. The majority (63.64%) of respondents selected in-person trainings, twenty-four (n=24; 19.83%) chose live online trainings, and twenty (n=20; 16.53%) selected recorded online trainings.



Barriers to Participation (Question 4)

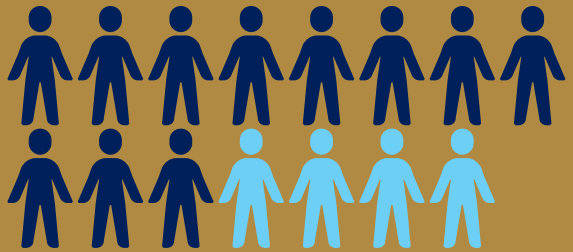
Respondents were asked about their perceived barriers that could limit community participation in behavioral health trainings. Most (n=123; 70.69%) respondents answered this question. Twenty-seven (n=27; 21.95%) respondents selected cost, twenty-five (n=25; 20.32%) chose participation availability, and sixteen (n=16; 13.01%) chose the training location. Twenty-two (n=22; 17.89%) respondents indicated that coordination was a barrier, eighteen (n=18; 14.63%) selected available trainers, and fifteen (n=15; 12.19%) chose “other”.



Other Barriers (Question 4)

Those who selected “Other” on question 4 were asked to elaborate upon this answer in a provided. Their answers were:

- All of the above (Eleven respondents selected this)
- I don't know
- Time, taking paid time off
- Cost, transportation, time of day, location, quality of trainer
- They are not required training in all jobs. Lack of access has to do with cost of living and time constraints. If they were required as job onboarding and annual training for all Montana; there would be more engagement



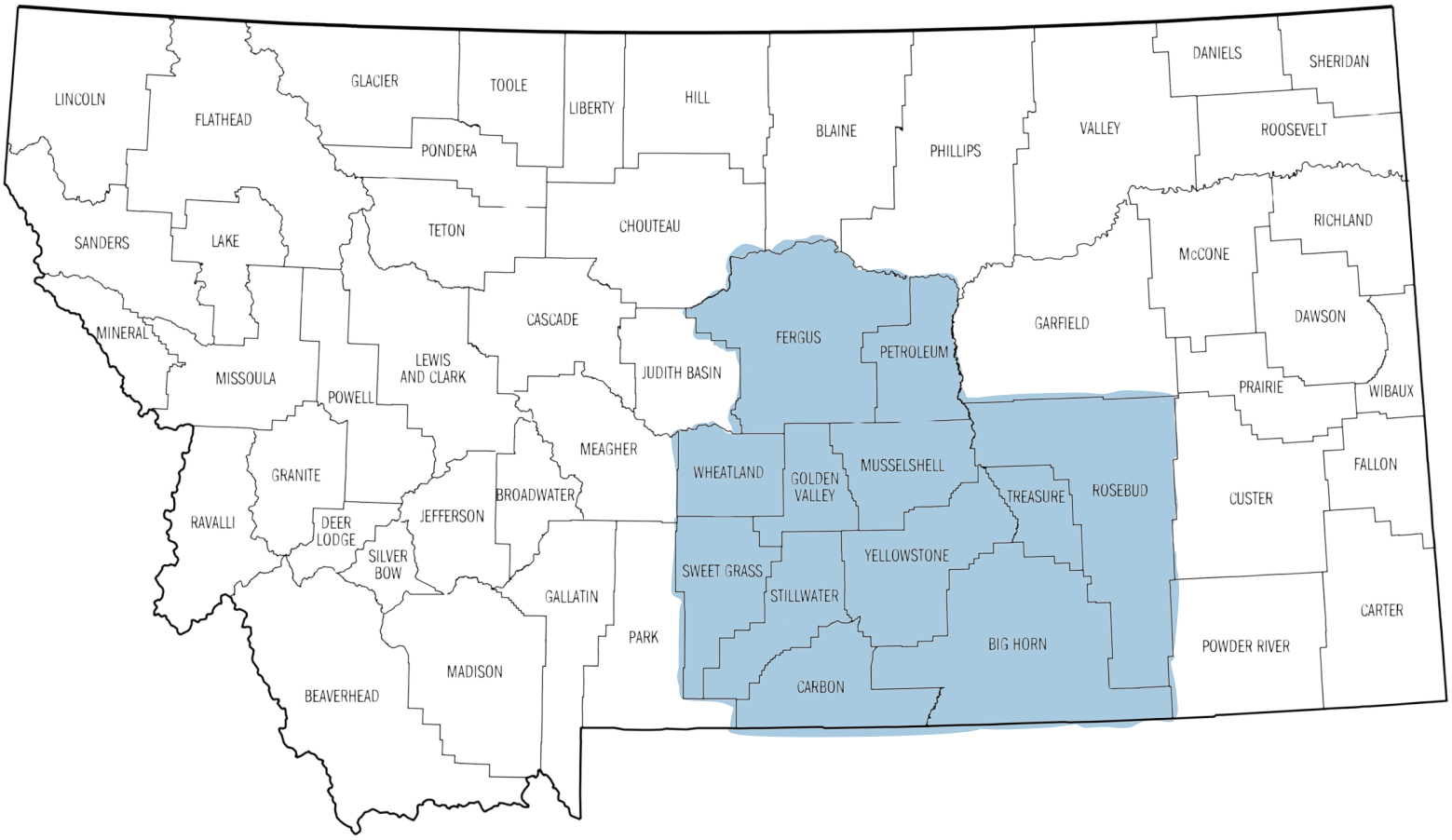
The most common response among the respondents who selected “Other” was “All of the above”, with **11** out of **15** writing it.

FOCUS GROUPS

ALL AHEC REGIONS

Focus Group Summary

Two focus groups were each conducted in the Eastern, South Central regions, and Western and three focus groups were conducted in the Northeastern region. The North Central region conducted one focus group and one key informant interview. Participants included members of Health Equity Task Forces, students from local universities, and AHEC Advisory Councils.



FOCUS GROUP

EASTERN MONTANA AHEC

Eastern Montana

LACK OF RESOURCES

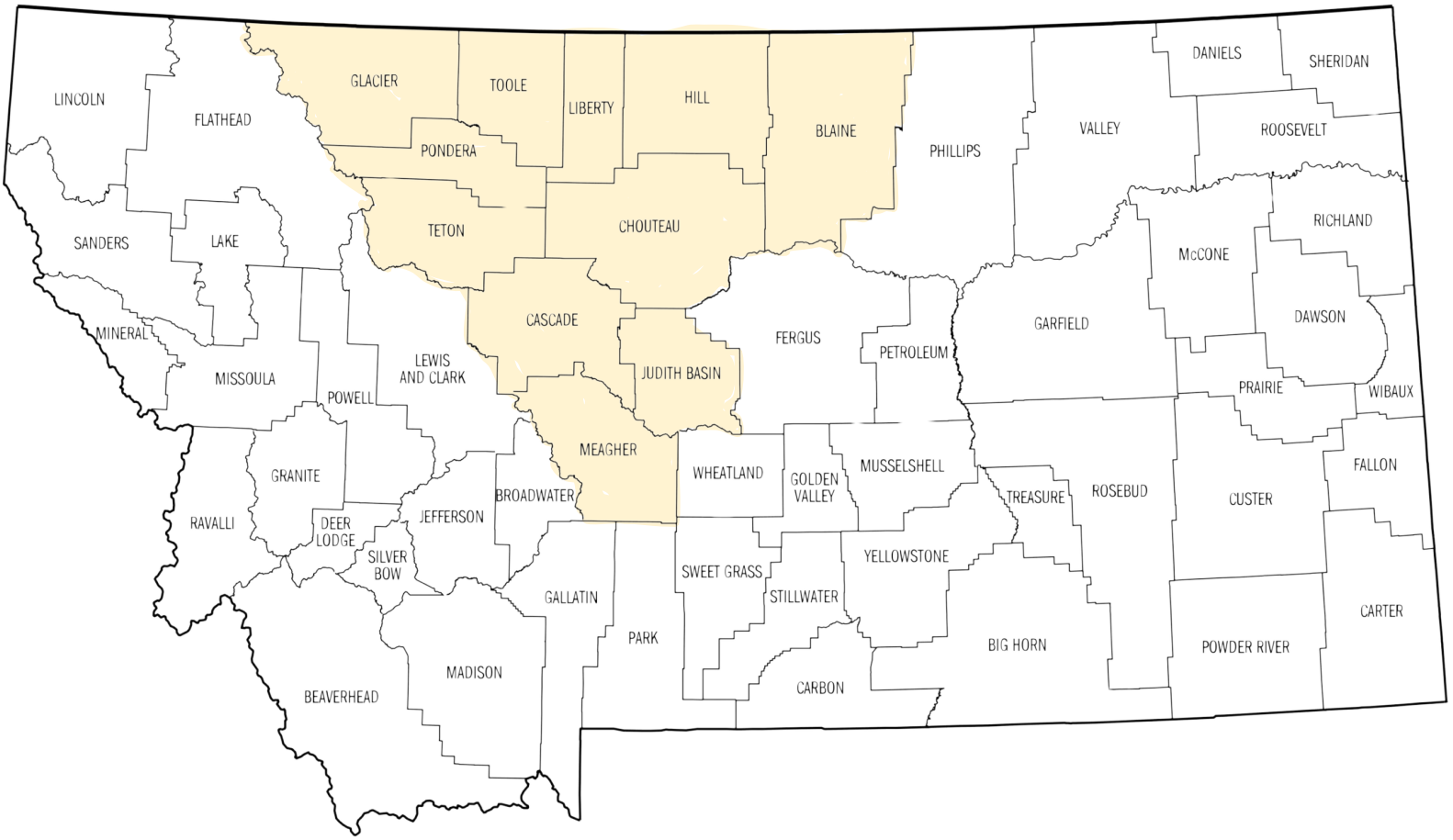
The two focus groups discussed the lack of available resources, including behavioral healthcare providers. Participants discussed the need for increased recruitment and retention of behavioral healthcare providers, as the small number of providers currently practicing in the state limits accessibility to services. Participants stated that emergency situations are prioritized, which decreases focus on preventative interventions. Additionally, there are not resources that inform people of the services available, which decreases usage. Participants also touched on the fact that most of Montana is considered rural or frontier, creating long travel distances for some to see providers.

CARE COORDINATION

Participants discussed the need for care coordination regarding mental health. It was mentioned that patients often feel more comfortable initiating conversations about their need for behavioral healthcare services with a primary care provider than starting by seeking out a behavioral healthcare provider. Participants felt care coordination would also benefit behavioral healthcare providers, as they could work with primary care providers on medication management to ensure the best outcomes for patients. Additionally, to assist primary care providers in helping their patients find a provider, it was suggested that a resource list containing the names and contact information for counselors and therapists be created for them.

STIGMA

Throughout the focus groups, participants brought up the existing stigma surrounding behavioral health in Montana. In one group, the stigma that providers feel surrounding behavioral health was discussed. Participants stated that medical providers and their staff felt discomfort around asking patients questions about behavioral health and felt unsure of where patients could receive further care. They also brought up that the older generations in Montana tend to feel more stigma surrounding mental health than the younger ones. The other group discussed the stigma that some may feel when seeking help if they must take time off work to do so. Due to fears about job security, people may not want their employers to know about their behavioral health needs. There was also a discussion about the need for education on behavioral health throughout the state, with the intention of increasing knowledge and decreasing stigma. Participants stated that the stigma in Montana may originate from the “keep it together” attitude prevalent in rural and agricultural communities, and felt that there should be increased discussions about the importance of behavioral health in these communities.



FOCUS GROUP

NORTH CENTRAL MONTANA AHEC

North Central Montana

NAVIGATION AND COMMUNICATION

The focus group and the key informant focused on the difficulty residents of Eastern Montana have when attempting to navigate various systems to receive mental health services. The group mentioned that when people initially receive care at the emergency room, they then struggle to find non-emergency mental health services following the visit. The implementation of a care coordinator was discussed as a potential solution to this, as was the use of an LCPC or LCSW to help people navigate the emergency room to improve their overall experience. The key informant discussed the need for existing services to clearly communicate what they provide, so that residents can be informed of what is available to them. They also mentioned a need for the various providers in the region to improve communication amongst themselves to improve patient experiences.

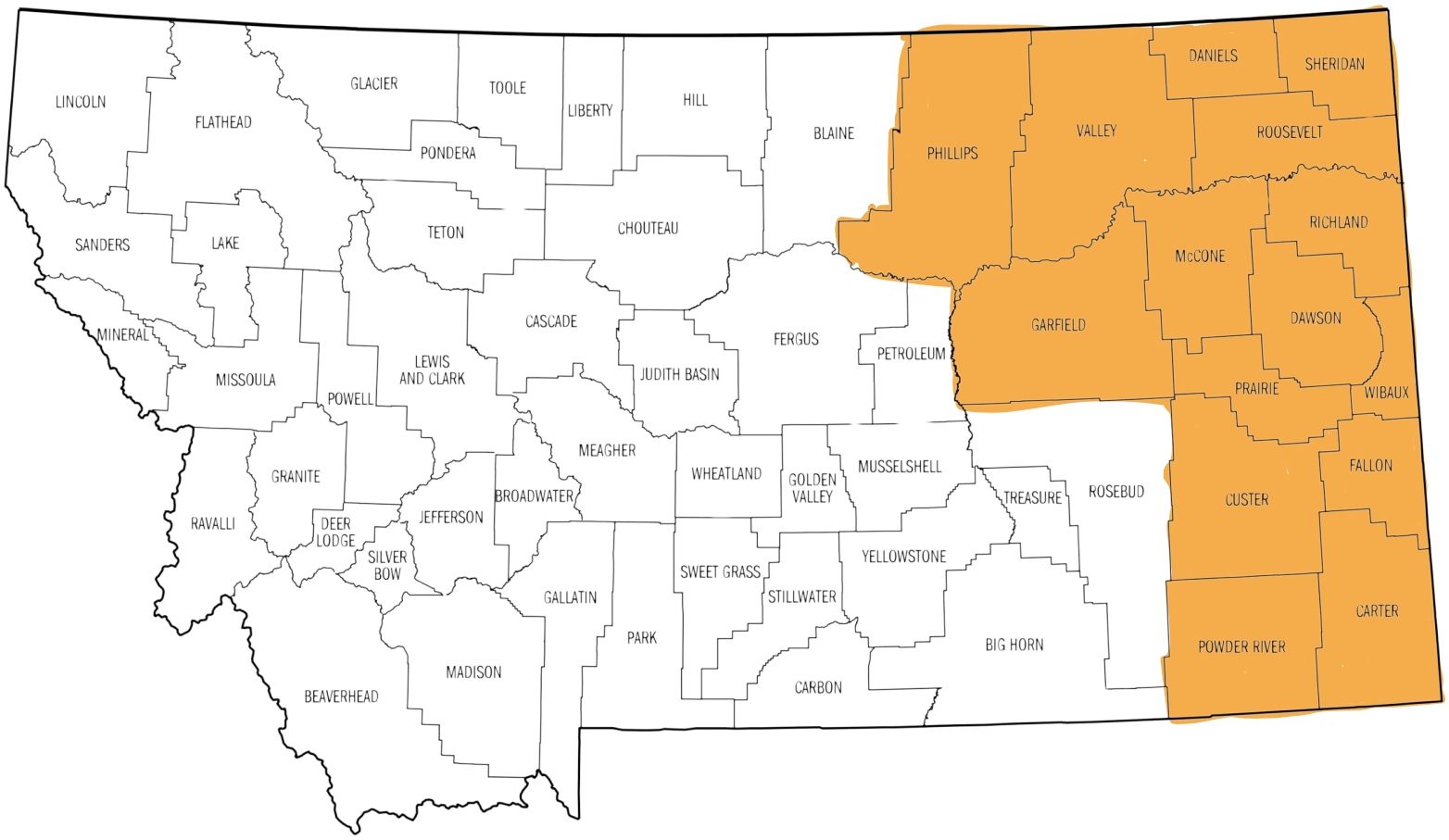
COST

Both the focus group and the key informant stated that cost was a barrier to people's ability to access mental health services. For those without insurance, mental health services can be expensive. Oftentimes, the cost is a major deterrent for people when deciding whether to seek treatment. The focus group brought up the need for assistance for people when working to obtain Medicaid. The key informant discussed the differences that often exist when billing for mental health services, as opposed to services for physical health, and the difficulty that creates. The region includes the Blackfeet reservation, which has an Indian Health Service (IHS) clinic. While those who are eligible to use IHS can see providers for mental health without a charge, the difficulties in navigating IHS are also often a barrier. Additionally, while it was acknowledged that various mental health trainings would be useful, they are often costly, creating a barrier for communities who need the education. A potential solution the focus group proposed was seeking out and promoting free trainings.

STIGMA

The focus group reported that the existing stigma surrounding mental health in the region prevents people from seeking services. They mentioned that, in addition to the outside community, stigma is prevalent in hospitals and clinics, making it difficult for patients to ask for help. To decrease the stigma within the community, the focus group suggested normalizing discussing mental health in schools and workplaces, promoting that seeking help shows that a person is strong, and encouraging people to share their stories about reaching out for help. Additionally, they suggested that education to decrease stigma should be included in healthcare education programs.

The key informant stated that in their community, the stigma surrounding mental health has decreased. Youth have been supportive of each other, and have conversations where they speak openly about their mental health. Older generations have also experienced decreasing stigma. The key informant has found that changing her language around the older generations to eliminate the use of specific diagnoses has been helpful when talking to them about mental health. Overall, the key informant felt that stigma was not much of a barrier; rather, the shortage of mental healthcare providers, and difficulty obtaining available services served as more significant barriers.



FOCUS GROUP

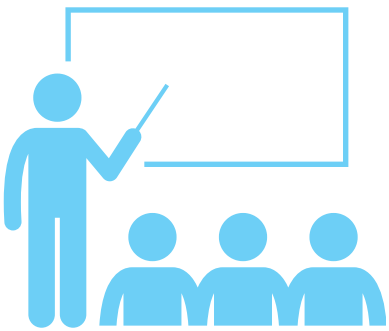
NORTHEASTERN MONTANA AHEC

Northeastern Montana

LACK OF RESOURCES

All three of the focus groups discussed the lack of resources available in Montana. One focus group stated that more providers and more services are needed to meet the mental health needs of Montana. They also brought up the need for services created for youth. Potential solutions include CHWs (Community Health Worker) and peer support to provide assistance to those needing mental health services. Additionally, mobile crisis units were discussed as a way to meet needs in rural areas. Another focus group discussed the lack of communication about existing resources. While there are some available resources, they are not being utilized to the extent that they could be due to lack of communication. Potential solutions, as stated by the group, include flyers, social media, and a website listing all the area's resources.

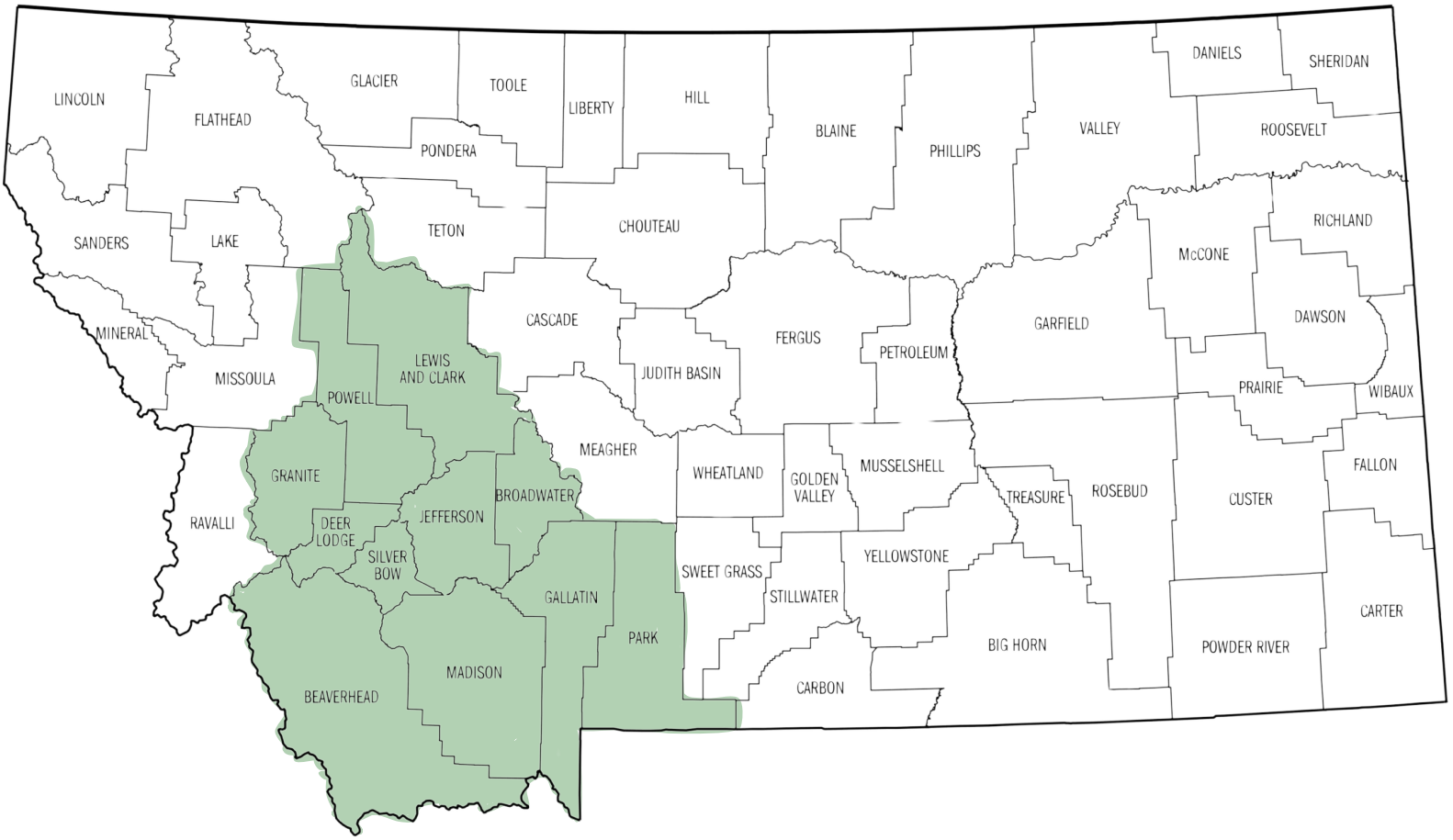
NEED FOR EDUCATION



The focus groups reported that they saw a need for education on mental health in the region. One group felt that there should be educational opportunities for various services and businesses so that they could have a better understanding of mental health needs, and how to respond appropriately during a crisis. They also felt that there should be additional education for communities that would be tailored to address their specific needs. Another group felt that there should be educational opportunities available online, to increase accessibility. They also stated that there should be a version of Mental Health First Aid that is tailored toward rural communities. The third focus group felt that a training on de-escalation should be available to everyone, and mentioned some additional trainings they considered to be useful. They also brought up that isolation often negatively affects people's wellbeing, so they suggested opportunities for connection, both in-person and virtually.

STIGMA

The groups focused on the stigma about mental health present in the region. People are often concerned about maintaining anonymity in smaller communities, and do not want others to know that they are receiving services. People are afraid that if others knew, they would be labeled, which would negatively impact their wellbeing. Although youth are more willing to discuss mental health than other generations, there is still a region-wide reluctance to discuss mental health topics openly. The region has an attitude of "cowboy up", meaning that people should be tough, and just "get over it" when they are struggling, which makes it difficult for people to seek help.



FOCUS GROUP

SOUTH CENTRAL MONTANA AHEC

South Central Montana

CRISIS STABILIZATION

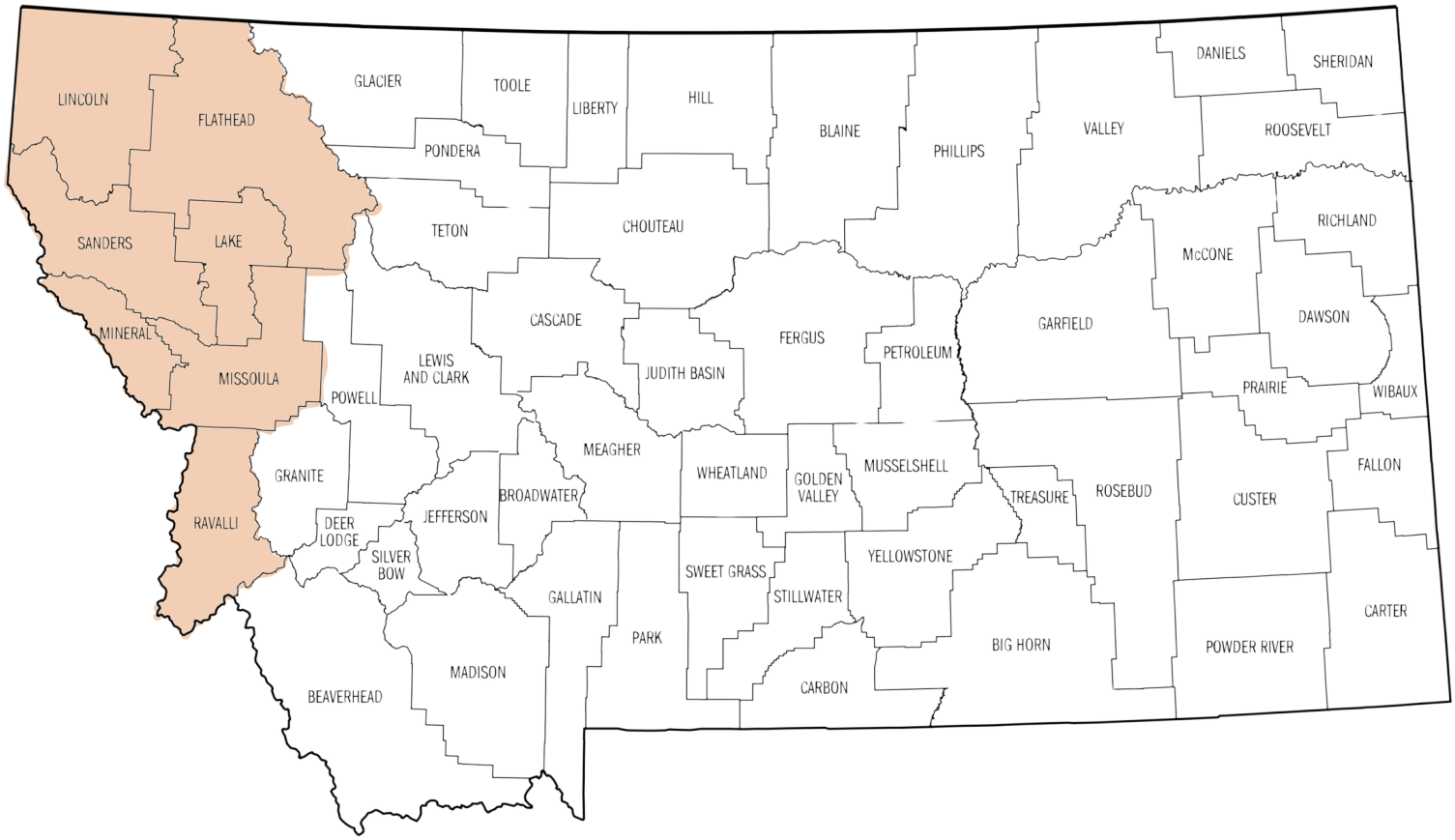
Both focus groups brought up the lack of crisis stabilization units in the region. Ideally, this entity would help those in crisis until they are determined to be stable enough to be released, with the hope that they would seek outpatient mental health services after. This region has never had a service of this type; however, focus group participants felt it would be beneficial to communities. Focus groups also touched on the need for detoxification services when discussing crisis stabilization services, indicating that they should perhaps be integrated.

COST

One focus group discussed the fact that many providers do not accept Medicaid or Medicare, making it difficult for patients with these insurances to afford them. There are issues of inaccessibility due to the cost of services across the region, creating a barrier for people seeking help. The other focus group discussed the inability to hire a safety net workforce for mental health services the region currently does not have, due to the cost of living in the region's larger cities. The salaries that organizations can afford to pay are not sufficient for the cost of living, making it so that these jobs cannot be filled. This focus group also discussed the funds needed to increase the number and variety of services in the region to better serve residents. Without external funding, the region's needs cannot be fully met.

SUPPORT FOR PROVIDERS AND FIRST RESPONDERS

Due to the sometimes heavy nature of their jobs, mental health providers and first responders need support. Mental health providers need supervision to become fully licensed, and to act as a source of support. After the supervision period, those in private practice often do not have support from other providers that those working in mental health centers or other group settings may benefit from. First responders often assist in handling mental health crises, as well as other difficult situations. However, due to fear of being treated differently for seeking help, they may be hesitant to see a mental health provider. A potential solution was to create a program where retired first responders provide support, as they understand the difficulties of the job, and spending time with them carries less stigma than a mental health provider.



FOCUS GROUP

WESTERN MONTANA AHEC

Western Montana

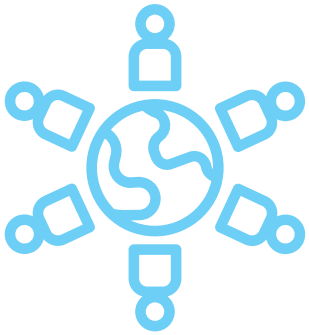
LACK OF RESOURCEES IN SCHOOLS

The focus groups both felt that the region had a shortage of resources. They both discussed the shortage of providers, as well as issues in schools. One participant reported that school counselors in their community were not available to meet one-on-one with students. The group also discussed a program that they perceived to be successful. In this program, students in mental health-focused degree programs could earn some of their needed hours of practice in schools, which allowed youth to have additional support during the school day. However, this program was only funded for a limited time, and has since ended. Both groups recognized the lack of mental health education available in schools, and both individually proposed that there should be trainings on various mental health topics in schools starting when children are young.

NEED FOR FREE EDUCATION

Both focus groups stated that free education on mental health topics was needed in the regions. To make trainings truly accessible to all community members, the focus groups recommended that they be offered free of charge. One group stated that training was needed in the community specifically on suicide prevention. Both groups felt that free training would allow community members who do not work in mental health to assist their peers during a crisis. One group felt that the costs and time needed to obtain a degree in the mental health field may be prohibitive to some, and felt that free trainings would allow this barrier to be reduced.

NEED FOR DIVERSITY IN PROVIDERS



Both focus groups discussed the need for a more diverse mental health workforce. They recognized that patients may feel more comfortable with a culturally congruent provider. Ideas to remedy this included free trainings for those wanting to work in mental health, and continued support to encourage them to stay in the field. For providers from non-historically underrepresented backgrounds, education could be used to help them become knowledgeable about cultural approaches and practices.

Shared Concerns Among Focus Groups

STIGMA

LACK OF RESOURCES

NEED FOR EDUCATION

COST

APPENDIX A

SURVEY QUESTIONS

As a community member, please identify your MT AHEC Region.

- ○ **Eastern Montana (blue):** Bighorn, Carbon, Golden Valley, Musselshell, Fergus, Petroleum, Rosebud, Stillwater, Sweetgrass, Treasure, Wheatland & Yellowstone counties
- ○ **North Central Montana (yellow):** Blaine, Cascade, Choteau, Glacier, Hill, Judith Basin, Liberty, Meagher, Pondera, Teton & Toole counties
- ○ **Northeastern Montana (orange):** Carter, Custer, Daniels, Dawson, Fallon, Garfield, McCone, Phillips, Powder River, Prairie, Richland, Roosevelt, Sheridan, Valley, and Wibaux counties
- ○ **South Central Montana (green):** Beaverhead, Broadwater, Deer Lodge, Gallatin, Granite, Jefferson, Lewis and Clark, Madison, Park, Powell, and Silverbow counties
- ○ **Western Montana (purple):** Flathead, Lake, Lincoln, Mineral, Missoula, Ravalli, and Sanders counties

Assessing Mental Health Care in Montana

1. Which topics concern you the most when thinking about mental health in Montana? (Check all that apply)

- Access to mental health services
- Integration of physical and mental health care
- Suicide prevention services
- Violence support services
- Cost of healthcare
- Attitudes of healthcare workers toward mental health
- Prevention of mental illness
- Availability of crisis services
- Number of mental health providers
- Quality of mental health providers
- Addiction and substance use services
- Lack of culturally safe care
- None of the above
- Other – comment box

2. Which mental health services are needed to better serve Montanans? (Check all that apply)

- Treatment in schools
- Suicide prevention
- Introduction of/more mental health providers in communities
- More friendly counselors
- Daycare services available
- Residential treatment facilities
- Community/culture-based programs
- Case management services available
- Peer support groups for community members
- Crisis support
- Home health
- Transportation to appointments
- Mental health screenings by primary care providers
- Mental health education in the community
- Volunteer crisis support services
- Addiction and substance use prevention and education
- None of the above
- Other – comment box

3. What do you consider to be barriers that keep Montanans from accessing care for their mental health? (Check all that apply)

- Counselors who do not accept certain insurance
- Lack of funding
- Houselessness
- Resistance from family members, friends, or others in their lives
- Lack of prevention services
- Lack of crisis support services
- Lack of transportation to appointments
- Lack of mental health specialists
- Not having insurance
- Counselors not being available in the evenings or weekends
- Issues with continuity of care
- Shortage of mental health professionals
- Lack of awareness of the mental health services available
- Lack of affordable mental health care
- The stigma surrounding mental health
- Inability to get an appointment to see a mental health professional
- Distance from mental health provider
- Lack of knowledge of culture and/or Traditional Ceremonial Practices (TCPs) as a protective factor.
- None of the above

Availability and Utilization of Care

1. Montana's mental health needs are being met
- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

2. I feel comfortable seeking mental health services
- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

3. I know where to seek help for mental health concerns
- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

4. I am educated on substance use and addiction
- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

5. I know where I can get help for substance use and addiction concerns
- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

6. Veterans in my community have adequate resources for their mental health needs
- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

7. Schools in my community have adequate mental health services for their students
- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

8. Nursing homes and assisted living facilities in my community have adequate mental health care for their patients
- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

9. My community has adequate mental health resources for children aged 11 and younger
- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

10. My community has adequate mental health resources for youth ages 12-18
- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

11. My community has adequate mental health resources for seniors ages 65 and above
- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

12. My community has adequate mental health resources for members with disability and accessibility needs
- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

13. There are affordable mental health services for low-income individuals in my community

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

15. Clients of local mental health providers have access to follow-up services should they need them

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

17. I know one or more people in my community who have not been able to access the mental health care that they needed

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

19. I am comfortable recommending mental health services in a nearby community to members of my own community

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

19. I am comfortable recommending mental health services in a nearby community to members of my own community

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

14. During the treatment process, clients are adequately supported by their mental health provider

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

16. There is a mental health provider in my community that I trust

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

18. I am comfortable recommending local mental health services to others in my community

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

18. I am comfortable recommending local mental health services to others in my community

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

20. There are adequate online or telehealth services for behavioral health in my community

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

Accessibility

1.Various peer support groups
- ◯ No accessibility
- ◯ Moderate accessibility
- ◯ Adequate accessibility
- ◯ Outstanding accessibility
- ◯ Unknown

2. Affordable and safe housing options
- ◯ No accessibility
- ◯ Moderate accessibility
- ◯ Adequate accessibility
- ◯ Outstanding accessibility
- ◯ Unknown

3. Employment services (support and job placement)
- ◯ No accessibility
- ◯ Moderate accessibility
- ◯ Adequate accessibility
- ◯ Outstanding accessibility
- ◯ Unknown

4. Local transportation services
- ◯ No accessibility
- ◯ Moderate accessibility
- ◯ Adequate accessibility
- ◯ Outstanding accessibility
- ◯ Unknown

5. Mobile crisis services
- ◯ No accessibility
- ◯ Moderate accessibility
- ◯ Adequate accessibility
- ◯ Outstanding accessibility
- ◯ Unknown

6. Addiction and substance use services (rehabilitation, detox, etc.)
- ◯ No accessibility
- ◯ Moderate accessibility
- ◯ Adequate accessibility
- ◯ Outstanding accessibility
- ◯ Unknown

7. Psychiatry services
- ◯ No accessibility
- ◯ Moderate accessibility
- ◯ Adequate accessibility
- ◯ Outstanding accessibility
- ◯ Unknown

8. Mental health services (outpatient)
- ◯ No accessibility
- ◯ Moderate accessibility
- ◯ Adequate accessibility
- ◯ Outstanding accessibility
- ◯ Unknown

9. Prevention services and screenings
- ◯ No accessibility
- ◯ Moderate accessibility
- ◯ Adequate accessibility
- ◯ Outstanding accessibility
- ◯ Unknown

10. Crisis intervention services
- ◯ No accessibility
- ◯ Moderate accessibility
- ◯ Adequate accessibility
- ◯ Outstanding accessibility
- ◯ Unknown

Potential Barriers to Service

1. Long wait time to get appointments
- ◯ Never a barrier
- ◯ Sometimes a barrier
- ◯ Often a barrier
- ◯ Always a barrier
- ◯ Do not know

2. Lack of outreach to those who experiencing homelessness
- ◯ Never a barrier
- ◯ Sometimes a barrier
- ◯ Often a barrier
- ◯ Always a barrier
- ◯ Do not know

3. Language or cultural barriers

- ◯ Never a barrier
- ◯ Sometimes a barrier
- ◯ Often a barrier
- ◯ Always a barrier
- ◯ Do not know

4. Restrictive medication policies

- ◯ Never a barrier
- ◯ Sometimes a barrier
- ◯ Often a barrier
- ◯ Always a barrier
- ◯ Do not know

5. Limited hours of availability

- ◯ Never a barrier
- ◯ Sometimes a barrier
- ◯ Often a barrier
- ◯ Always a barrier
- ◯ Do not know

6. Lack of transportation to appointments

- ◯ Never a barrier
- ◯ Sometimes a barrier
- ◯ Often a barrier
- ◯ Always a barrier
- ◯ Do not know

7. Lack of adequate training for medical staff on behavioral health

- ◯ Never a barrier
- ◯ Sometimes a barrier
- ◯ Often a barrier
- ◯ Always a barrier
- ◯ Do not know

Behavioral Health Training

1. Please select trainings you are familiar with:

- Youth Mental Health First Aid
- Teen Mental Health First Aid
- Mental Health First Aid
- Management of Aggressive Behaviors (MOAB)
- Question, Persuade, Refer with Substance Abuse (QPR)
- Applied Suicide Intervention Skills Training (ASIST)
- Other (please explain)

2. Which trainings would your community benefit from:

- Youth Mental Health First Aid
- Teen Mental Health First Aid
- Mental Health First Aid
- Management of Aggressive Behaviors (MOAB)
- Question, Persuade, Refer with Substance Abuse (QPR)
- Applied Suicide Intervention Skills Training (ASIST)
- Other (please explain)

3. My community would benefit from the delivery of behavioral health training through:

- ◯ In-person trainings
- ◯ Live online trainings
- ◯ Recorded online trainings
- ◯ None of the above

4. Which of the following are barriers to participation in behavioral health training(s):

- ◯ Cost
- ◯ Participation availability
- ◯ Training location
- ◯ Coordination
- ◯ Available trainers
- ◯ Other (please explain)

APPENDIX B
FOCUS GROUP QUESTIONS

Questions Asked by All Regions

Eastern | North Central | North Eastern | South Central | Western

- What are the main sources of information for you about behavioral health services in your area?
- If you could change one aspect of the behavioral health services in your area, what would it be?
- What types of additional services or programs do you think would benefit the community's behavioral health?
- What services or programs would you recommend be added or improved upon in your community?
- What are the most common challenges people in your community face when accessing behavioral health services?
- How does the stigma surrounding mental health affect those in your community accessing behavioral health services?
- What are your community's general attitudes and perceptions about behavioral health education and seeking training opportunities?
- What could be done to improve behavioral health education in your community?
- What gaps do you see in behavioral health care in your community?

Questions Asked by Some Regions

- What are your community's general attitudes and perceptions about mental health and seeking care for it?

Eastern | North Central | South Central | Western

- What could be done to improve behavioral health services in your community?

North Central | North Eastern | South Central | Western

Appendix C - Request for Comments

Written comments on this 2024 Behavioral Health Needs Assessment can be submitted to the Montana Office of Rural Health/Area Health Education Center at

Montana Office of Rural Health/Area Health Education Center

Montana State University
P.O. Box 170520
Bozeman, MT 59717-0520

Please contact Kailyn Mock at kailyn.mock@montana.edu with questions.