Mountain Plains (HHS Region 8)
MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Training and Technical Assistance Needs:

Findings from a Survey of Professionals Who Serve Individuals with Mental Illness in Region 8

U.S. Department of Health & Human Services, Region 8 States:
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming

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Introduction

The Mountain Plains Mental Health Technology Transfer Center (MHTTC)[i] serves the states of Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming (HHS Region 8) and began offering services on August 15, 2018. Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA),[ii] the Mountain Plains MHTTC is a five-year collaboration among:

- College of Nursing and Professional Disciplines at the University of North Dakota[iii]
- Western Interstate Commission for Higher Education[iv]
- Center for Rural Health at the University of North Dakota School of Medicine & Health Sciences[v]
- Center for the Application for Substance Abuse Treatment at the University of Nevada-Reno[vi]

The primary focus of the Mountain Plains MHTTC is to provide training, develop products, ensure access to evidence-based resources, and provide technical assistance to individuals serving persons with mental health disorders, especially those with serious mental illness or a serious emotional disturbance. Particular attention is given to serving providers with limited access to mental health resources and providing supports for workforce development, especially in rural communities. By providing innovative and accessible learning opportunities on research-based practices, the Mountain Plains MHTTC team seeks to help individuals in Region 8 to better serve their communities, staff, and clients/patients.

Goals of the Mountain Plains MHTTC

- Accelerate the adoption and implementation of mental health related evidence-based practices.
- Heighten the awareness, knowledge, and skills of the workforce addressing the needs of individuals living with mental illness.
- Foster regional and national alliances among culturally diverse practitioners, researchers, policy makers, family members, and consumers of mental health services.
- Ensure availability and delivery of publicly available, free-of-charge training and technical assistance to the mental health field.

Identifying Training and Technical Assistance Needs of Region 8

The Mountain Plains MHTTC team conducted an electronic survey in March 2019. The survey, developed by grant personnel, was distributed electronically to a myriad of providers to include, but not limited to, the following groups:

- A listserv developed for the Mountain Plains MHTTC
- Single State Authority (SSA) offices
- State Offices of Rural Health (SORHs)
- Area Health Education Centers (AHECs)
- Public Health Units in Region 8
- Community Health Centers
- Relevant Center for Rural Health contact lists

Results from this survey will help the Mountain Plains MHTTC staff better collaborate with providers and stakeholders throughout the region. Additionally, the survey results will inform the development of new products, training materials, and technical assistance requests. Approval to conduct the assessment was provided by the University of North Dakota Institutional Research Board.

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Survey Respondants

A total of 505 individuals who serve persons with mental illness in HHS Region 8 began to complete the survey; 22 of these individuals did not respond beyond two demographic questions. After removing the 22 incomplete responses, data collected from 483 participants were reviewed. Respondents were predominantly:

- Between the ages of 40 and 59 (52%)
- Residing in rural communities (49%)
- Working in a Community Health Center, Federally Qualified Health Center, or other clinic (38%)
- Providing direct care (front-line staff) (42%)
- Working in their current fields for 16 years or more (39%). See Figures 1-5

Figure 1. Survey Respondents by Age Category

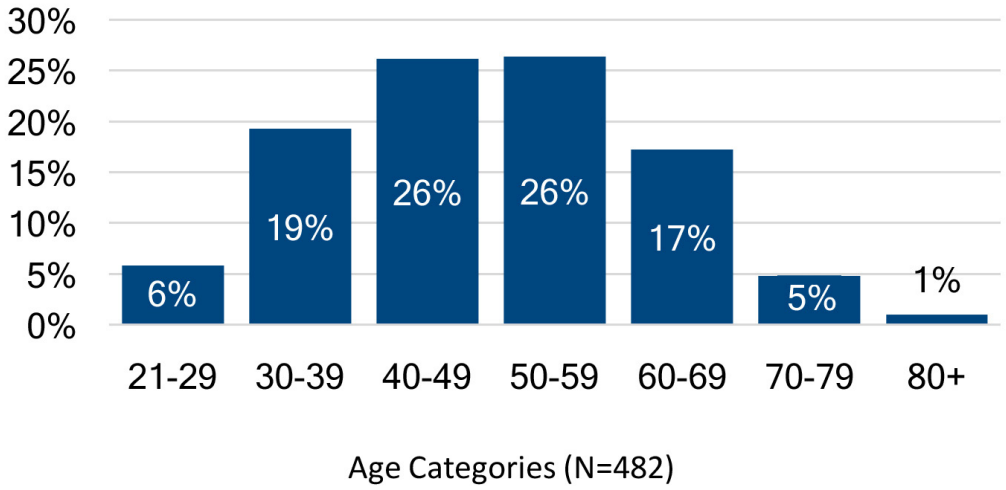


Figure 2. Respondents' Primary Job Locations and Geographical Settings

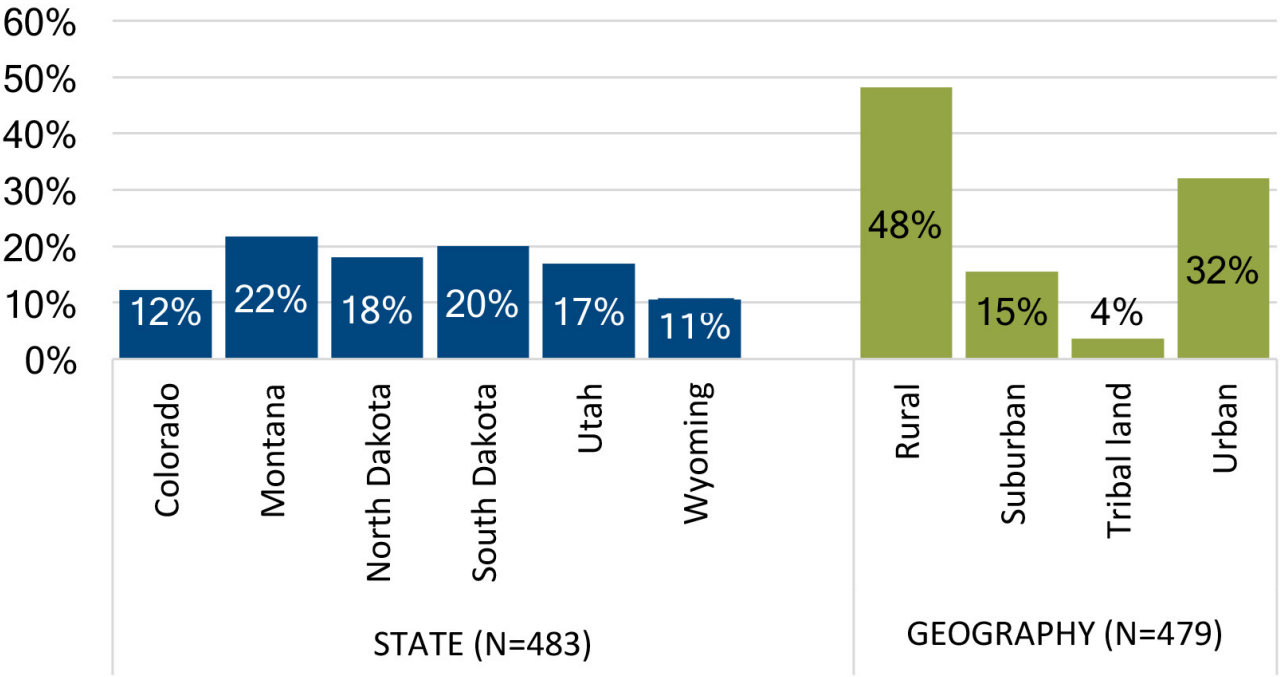


Figure 3. How Long Respondents Have Been Working in the Field of Mental Health

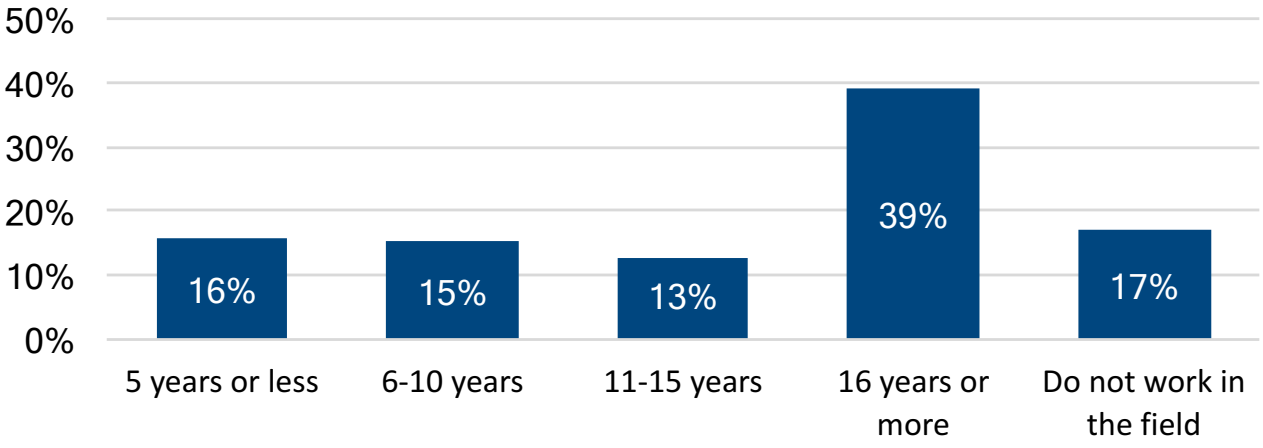
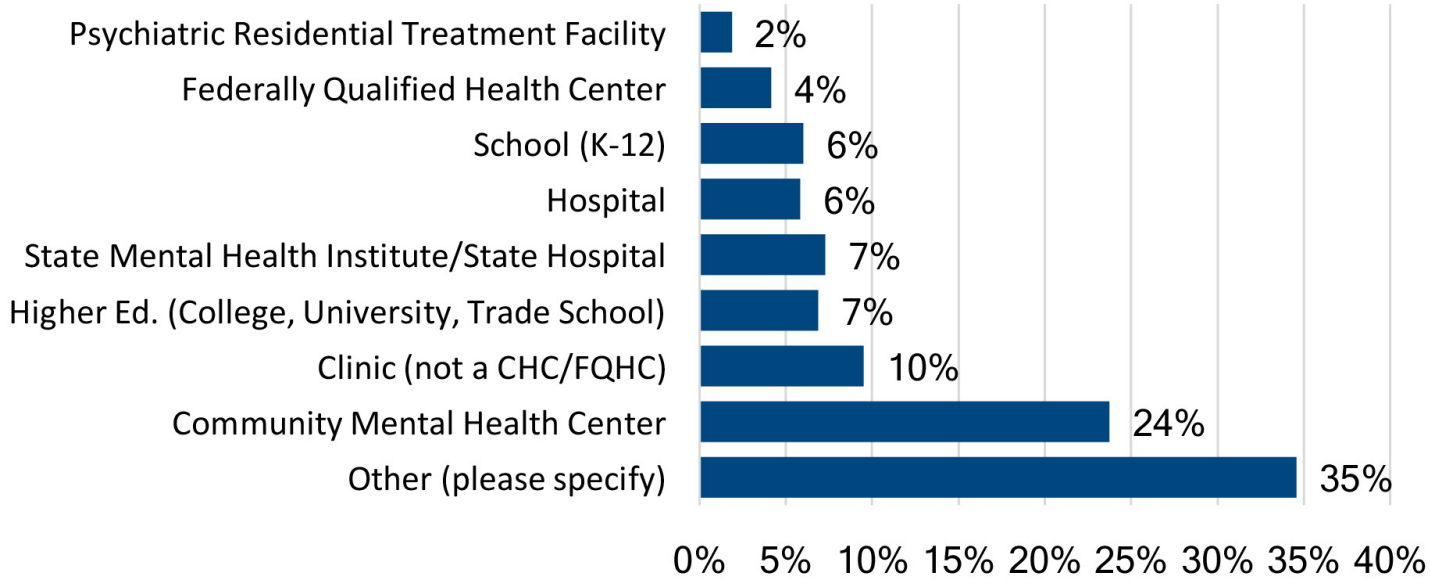


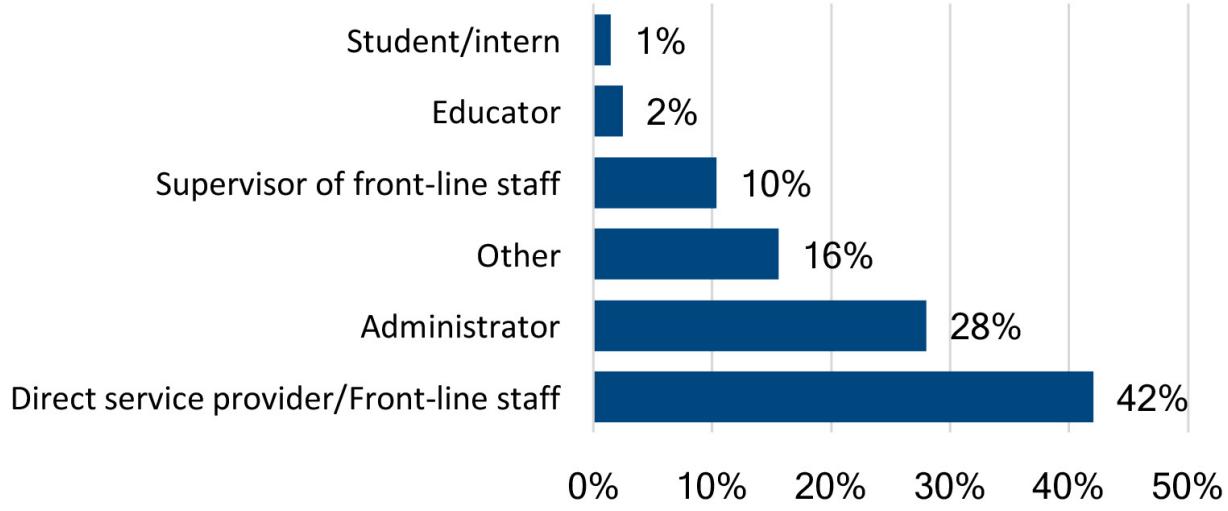
Figure 4. Participants' Primary Job Settings, N=480



Roughly 35% (162) of respondents indicated "Other" as their primary job setting. A majority of the "Other" job settings included:

- State or other government agencies (26/162) including state offices of rural health, Human Service centers, state behavioral health divisions, and other state agencies.
- Private practice (21/162).
- Addiction treatment centers (19/162), which include outpatient settings, residential programs, and community substance use disorder providers.
- Criminal justice or correctional services (19/162), including drug courts, parole and probation services, juvenile jail, and local authorities.
- Local or public health departments/units (13/162).
- Crisis centers (8/162), or more specifically domestic violence and sexual assault crisis centers.
- Community services and nonprofits (18/162) including child and family services, housing and job supports, community education, advocacy agencies, and shelters.

Figure 5. Primary Job Roles, N=482

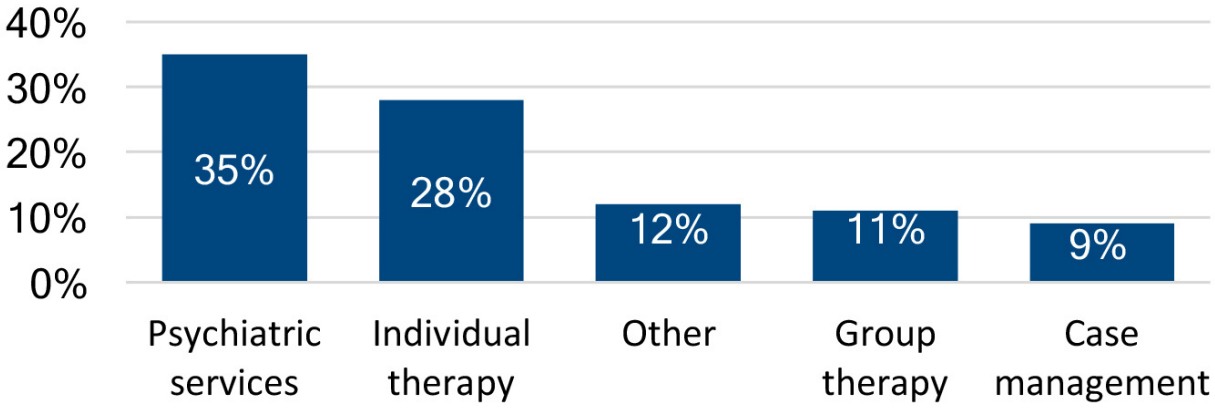


Roughly 16% (75) of respondents indicated "Other" as their primary job responsibility. A majority of the "Other" primary job responsibilities were identified as:

- Program or project directors/managers (13/75) listed as program director, clinical director, certified nursing officer, policy director, or prevention program supervisor.
- Counseling and therapy services (12/75), which were identified as counselors, therapists, and licensed addiction counselors.
- Clinicians (10/75), including nursing, physicians, clinical staff, and public health providers.
- Social workers (6/75).

Just more than one-third (171) of the participants indicated that their organizations currently provide telehealth services (36%). Respondents then indicated which telehealth services were provided by their organizations; they were asked to select all that apply. Choices included psychiatric services, case management, group therapy, individual therapy, or other. A majority of those providing telehealth services indicated that this medium of care delivery was being utilized for psychiatric services (35%). See Figure 6.

Figure 6. Types of Telehealth Services Delivered by Participants' Organizations



"Other" types of telehealth services included peer support, family therapy, trainings, evaluation (including drug and alcohol evaluations), integrated assessments, occupational therapy, crisis interventions, court proceedings, and emergency room/trauma response.

Training and Technical Assistance Needs: Topic Priorities

Participants were asked to indicate the priority/need for training and/or technical assistance (TA) on a variety of topics. Each topic was rated on a Likert scale: 1 = Not a Training Need at this Time; 2 = Training Would be Helpful; 3 = High Priority; and, NA = Not Applicable to my Work. The top five training needs based on the percentage of respondents indicating it as a "High Priority" included:

1. Mental health and substance abuse co-occurring disorders — 57% High Priority
2. Trauma-informed care — 53% High Priority
3. Compassion fatigue — 51% High Priority
4. Crisis de-escalation — 49% High Priority
5. Crisis management — 49% High Priority

When combining topics that were a "High Priority" and those identified as "Helpful," more than half of the training/TA topics were identified as a need by at least 75% of respondents. Additionally, mental health and substance abuse co-occurring disorders, trauma-informed care, compassion fatigue, crisis de-escalation, and crisis management remain in the top 10.

1. Mental health and substance abuse co-occurring disorders — 92%
2. Trauma-informed care — 90%
3. Strength-based approaches to treatment — 90%
4. Suicide prevention — 90%
5. Crisis de-escalation — 90%
6. Crisis management — 89%
7. Risk assessment tools — 89%
8. Compassion fatigue — 89%
9. Suicide assessment — 88%
10. Historical trauma — 88%
11. Stigma reduction — 87%
12. Working with diverse populations — 86%
13. Collaborative care — 86%
14. Mental health and intellectual disabilities co-occurring disorders — 85%
15. Recovery oriented systems of care — 85%
16. Shared decision making — 84%
17. Best practices in diagnosis — 82%
18. Integrated care (primary care and behavioral health) — 82%
19. Use of technology to support behavioral health services — 80%
20. Cognitive behavioral therapy (CBT) — 80%
21. Psychotropic medications — 79%
22. Using data for continuous quality improvement — 79%
23. Motivational interviewing — 79%
24. Leadership skills development — 76%
25. Confidentiality and ethics (including HIPAA) — 75%
26. Screening, Brief Intervention and Referral to Treatment (SBIRT) — 75%

No proposed topic had even a near majority (50%) of respondents indicate that it was "Not a need at this time;" instead, every proposed topic had at least half of participants indicate that it would either be "Helpful" or was a "High Priority." See Table 1.

Table 1. Training and Technical Assistance Needs by Priority Ranking

Topic	Combination: High priority and helpful	High priority	Training would be helpful	Not a need at this time	NA	N
Mental health and substance abuse co-occurring disorders	92%	57%	34%	5%	3%	422
Trauma-informed care	90%	53%	37%	6%	3%	419
Strength-based approaches to treatment	90%	44%	46%	7%	3%	416
Suicide prevention	90%	47%	43%	9%	1%	429
Crisis de-escalation	90%	49%	41%	7%	4%	423
Crisis management	89%	48%	41%	7%	4%	419
Risk assessment tools	89%	40%	49%	9%	2%	416
Compassion fatigue	89%	50%	38%	9%	3%	416
Suicide assessment	88%	43%	45%	10%	2%	421
Historical trauma	88%	44%	44%	9%	3%	416
Stigma reduction	87%	38%	49%	11%	2%	414
Working with diverse populations	86%	37%	49%	13%	1%	408
Collaborative care	86%	31%	55%	11%	4%	412
Mental health and intellectual disabilities co-occurring disorders	85%	35%	50%	9%	6%	414
Recovery oriented systems of care	85%	40%	45%	9%	6%	425
Shared decision making	84%	28%	56%	13%	4%	413
Best practices in diagnosis	82%	39%	43%	10%	7%	419
Integrated care (primary care and behavioral health)	82%	40%	42%	12%	7%	412
Use of technology to support behavioral health services (i.e., text messaging/apps/other platforms)	80%	35%	45%	13%	7%	408
Cognitive behavioral therapy (CBT)	80%	34%	46%	14%	7%	426
Using data for continuous quality improvement	79%	24%	55%	16%	5%	416
Psychotropic medications	79%	29%	50%	13%	9%	416
Motivational interviewing	79%	35%	44%	19%	3%	422
Leadership skills development	76%	35%	41%	20%	4%	411
Confidentiality and ethics (including HIPAA)	75%	25%	50%	23%	2%	411
Screening, Brief Intervention and Referral to Treatment (SBIRT)	75%	24%	51%	20%	5%	413
Assertive community treatment (ACT)	74%	23%	51%	15%	11%	410
First episode psychosis (FEP)	73%	22%	52%	16%	11%	409
Mental health courts	73%	21%	51%	18%	10%	411
Use of telehealth services to deliver behavioral healthcare	71%	31%	40%	17%	12%	410
Assisted outpatient therapy	71%	20%	51%	16%	13%	406
Employment issues and solutions for individuals with mental illness (Individual Placement and Support services)	70%	21%	49%	20%	11%	409
National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care	69%	16%	54%	25%	5%	409
Permanent supportive housing resources	69%	25%	44%	19%	12%	408

Topic	Combination: High priority and helpful	High priority	Training would be helpful	Not a need at this time	NA	N
Organizational change strategies	69%	25%	44%	24%	7%	410
Patient and staff safety practices (ex. anti-ligature facilities)	69%	24%	45%	21%	11%	411
Pregnant and postpartum depression	68%	22%	46%	19%	13%	416
Clinical supervision	67%	30%	38%	20%	13%	415
Staff retention	64%	32%	32%	21%	15%	411
Mental health services for students in higher education	63%	23%	39%	17%	21%	416
Psychiatric advanced directives	61%	15%	46%	22%	17%	414
Technology-based clinical supervision	61%	24%	37%	24%	15%	408
Community services and supports for seniors (example, Senior Reach programs)	60%	18%	42%	24%	17%	405
Staff recruitment	56%	27%	29%	27%	17%	412
School-based mental health (k-12)	55%	27%	28%	20%	25%	421

"Other" topics requiring training or TA that were most commonly listed by participants included topics related to youth services and school-based services as well as training around medication assisted treatment (MAT). Topics listed include:

- Access to mental health services for children
- Early childhood behavior health stigma
- Brain spotting
- Play therapy
- Trauma informed schools
- Youth transition from high school
- Using ASAM with adolescents
- Billing, coding, insurance
- Staff team building and burnout prevention
- Peer support expansion, integration
- Community coalition building
- Nutrition and alternative healing
- Treatment following sexual abuse
- Veterans and veterans' families
- Agricultural families
- Acceptance and commitment therapy
- Awareness of privilege and oppression, power and safety

Rural Training and Technical Assistance Needs

The Mountain Plains MHTTC's rural mental health focus area supports increased access to providers of behavioral health services for the more than 60 million Americans living in rural communities. To achieve this vision, the Mountain Plains MHTTC develops and promotes training and technical assistance that supports the rural behavioral health workforce in HHS Region 8. As a result, the survey was designed to gain a better understanding of the unique training needs and technical assistance priority areas for rural providers and communities. Learn more about the Mountain Plains MHTTC's rural mental health focus at mhttcnetwork.org/centers/mountain-plains-mhttc/area-focus.

The top five rural training needs based on the percentage of rural respondents indicating it as a "High Priority" included (suicide prevention and crisis de-escalation tied at fifth):

1. Compassion fatigue	56% High Priority
2. Mental health and substance abuse co-occurring disorders	54% High Priority
3. Trauma-informed care	51% High Priority
4. Crisis management	47% High Priority
5. Suicide prevention	46% High Priority
Crisis de-escalation	46% High Priority

This list of top five topics based on high priority need mirror the top five list for all respondents. However, among rural participants suicide prevention was tied for the fifth highest priority area. When combining topics that were a "High Priority" and those identified as "Helpful," the 10 leading topics with a near majority of rural participants indicating interest (between 87%-92%) included:

1. Mental health and substance abuse co-occurring disorders	92%
2. Trauma-informed care	89%
3. Compassion fatigue	89%
4. Crisis de-escalation	89%
5. Strength-based approaches to treatment	89%
6. Crisis management	89%
7. Risk assessment tools	88%
8. Suicide prevention	88%
9. Suicide assessment	87%
10. Working with diverse populations	85%

There was some variability in the training and TA needs between rural and urban respondents (Table 2). Topics where a larger proportion of rural identified a need for training compared to urban included:

- Pregnant and postpartum depression (74% of rural respondents indicated this topic as either a high priority or helpful compared to 62% of urban respondents)
- Patient and staff safety practices (ex. anti-ligature facilities) (72% of rural and 66% of urban)
- Staff retention (67% of rural compared to 60% urban)
- Psychiatric advanced directives (65% rural and 56% urban)
- Mental health services for students in higher education (65% of rural and 59% urban)
- Community services and supports for seniors (Ex. Senior Reach programs) (64% of rural compared to 53% urban)

Table 2. Rural and Urban Respondents Indicating Topics as "High Priority" or "Helpful"

Topic	Rural	Urban
Mental health and substance abuse co-occurring disorders	92%	91%
Trauma-informed care	89%	91%
Compassion fatigue	89%	89%
Crisis de-escalation	89%	90%
Strength-based approaches to treatment	89%	90%
Crisis management	89%	89%
Risk assessment tools	88%	90%
Suicide prevention	88%	91%
Suicide assessment	87%	90%
Working with diverse populations	85%	86%
Historical trauma	84%	91%
Stigma reduction	84%	89%
Recovery oriented systems of care	84%	85%
Collaborative care	84%	88%
Shared decision making	83%	84%
Mental health and intellectual disabilities co-occurring disorders	83%	88%
Integrated care (primary care and behavioral health)	82%	82%
Use of technology to support behavioral health services (i.e. texting/apps)	81%	79%
Best practices in diagnosis	80%	85%
Cognitive behavioral therapy (CBT)	79%	79%
Psychotropic medications	79%	80%
Leadership skills development	78%	74%
Using data for continuous quality improvement	77%	81%
Motivational interviewing	77%	80%
Assertive community treatment (ACT)	75%	71%
Pregnant and postpartum depression	74%	62%
Assisted outpatient therapy	73%	68%
Confidentiality and ethics (including HIPAA)	73%	76%
First episode psychosis (FEP)	73%	74%
Screening, Brief Intervention and Referral to Treatment (SBIRT)	72%	76%
Use of telehealth services to deliver behavioral healthcare	72%	70%
Patient and staff safety practices (ex. anti-ligature facilities)	72%	66%
Organizational change strategies	70%	67%
Employment issues and solutions for individuals with mental illness	69%	69%
Permanent supportive housing resources	69%	68%
Mental health courts	68%	76%
Staff retention	67%	60%
Clinical supervision	66%	68%
Mental health services for students in higher education	65%	59%
Psychiatric advanced directives	65%	56%
Community services and supports for seniors (Ex. Senior Reach programs)	64%	53%
National Standards for Culturally and Linguistically Appropriate Services (CLAS)	64%	74%
Staff recruitment	58%	53%
Technology-based clinical supervision	57%	63%
School-based mental health (k-12)	56%	51%

Priority Populations

In addition to priority topics, the survey asked respondents in Region 8 to identify which populations (if any) they would like additional training or consultation about to assist in improving their professional efforts in the field of mental health. Participants could select multiple populations from a list of 23. Overall, the top priority populations were:

1. Rural — 67% of all respondents
2. Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) — 58% of all respondents
3. Individuals with serious mental illness (SMI) — 54% of all respondents
4. American Indian/Alaska Natives — 53% of all respondents
5. Individuals with serious emotional disturbance (SED) — 52% of all respondents

The same populations were identified in the top five population priorities among rural and urban communities. However, the proportion of individuals identifying each as a need varied. For example, both rural and urban respondents indicated they would like more information on rural populations. However, 84% of rural respondents indicated this was a population of interest compared to only 48% of urban respondents. See Table 3 for a complete list of training populations.

Top Five Urban Priority Populations Based on Percentage of Respondents

1. Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) — 63% of urban respondents
2. Individuals with serious mental illness (SMI) — 55% of urban respondents
3. Individuals with serious emotional disturbance (SED) — 54% of urban respondents
4. American Indian/Alaska Natives — 53% of urban respondents
5. Rural — 48% of urban respondents

Top Five Rural Priority Populations Based on Percentage of Respondents

1. Rural — 83% of rural respondents
2. Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) — 54% of rural respondents
3. Individuals with serious mental illness (SMI) — 53% of rural respondents
4. American Indian/Alaska Natives — 50% of rural respondents
5. Individuals with serious emotional disturbance (SED) — 50% of rural respondents

Table 3. Populations Respondents Would Like Addressed in Trainings or TA by Geography

Population	All Respondents	Urban	Rural
Rural	67%	48%	83%
Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ)	58%	63%	54%
Individuals with serious mental illness (SMI)	54%	55%	53%
American Indian/Alaska Natives	53%	53%	50%
Individuals with serious emotional disturbance (SED)	52%	54%	50%
Low income	47%	46%	46%
Adults (ages 18-64)	46%	44%	47%
Homeless/transient	45%	46%	43%
Children (ages 0-17)	44%	42%	44%
Seniors (ages 65 +)	39%	32%	46%
Veterans	37%	36%	39%
Women	34%	38%	28%
Hispanic/Latino	30%	35%	26%
Men	29%	28%	28%
White/Caucasian	25%	19%	30%
African American/Black	22%	33%	13%
Urban	19%	32%	9%
Secondary school	18%	17%	18%
Primary school	17%	13%	20%
Higher education	16%	17%	16%
Migrant workers	13%	15%	12%
Asian	12%	18%	7%
Native Hawaiian/Pacific Islander	12%	19%	6%

Training Modality Preferences

The Mountain Plains MHTTC provides education, training, and technical assistance through a variety of modalities including videoconferences, asynchronous and synchronous webinars, in-person intensives, conference presentations, and more. To identify the preferred mode(s) and time(s) to attend trainings, respondents were asked to identify the time(s) of day that work best to attend synchronous (live) trainings, their preferred training length, and preferred modes of web training. In general, participants indicated they preferred a combination of live and recorded trainings (62%), trainings that are offered between 60 to 90 minutes (49%), and those that are scheduled during midday. See Figures 7-9.

Figure 7. Participants' Preferred Modes of Web Training Delivery (N=456)

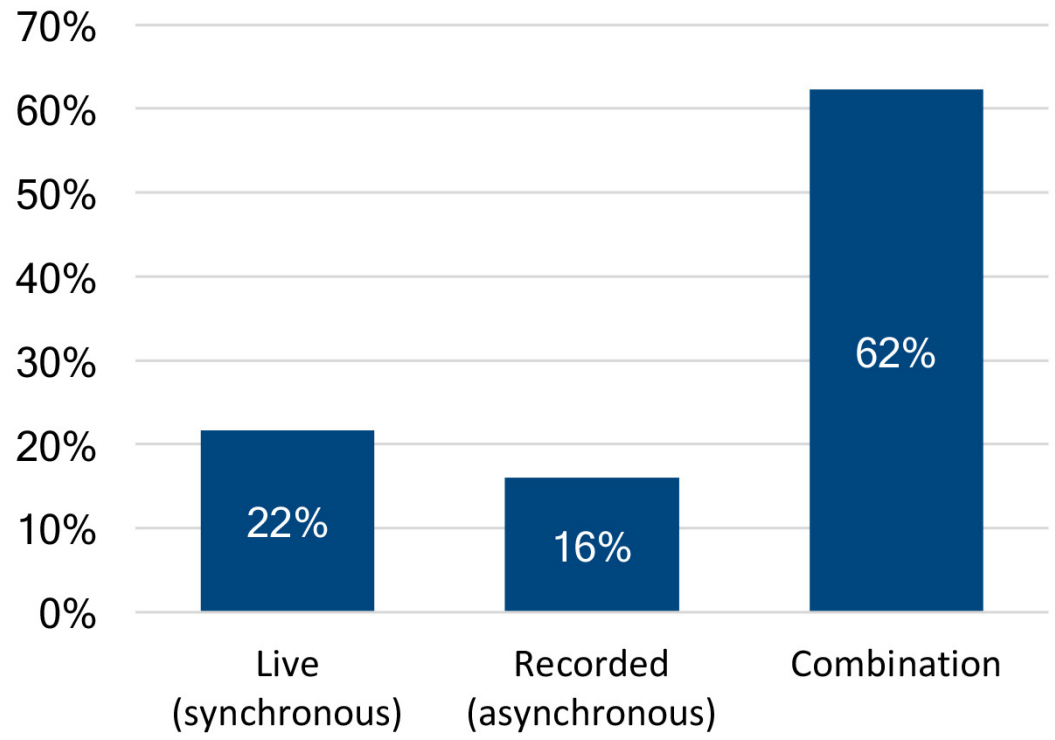


Figure 8. Participants' Preferred Length of Time for Scheduled Live (Synchronous) Trainings (N=456)

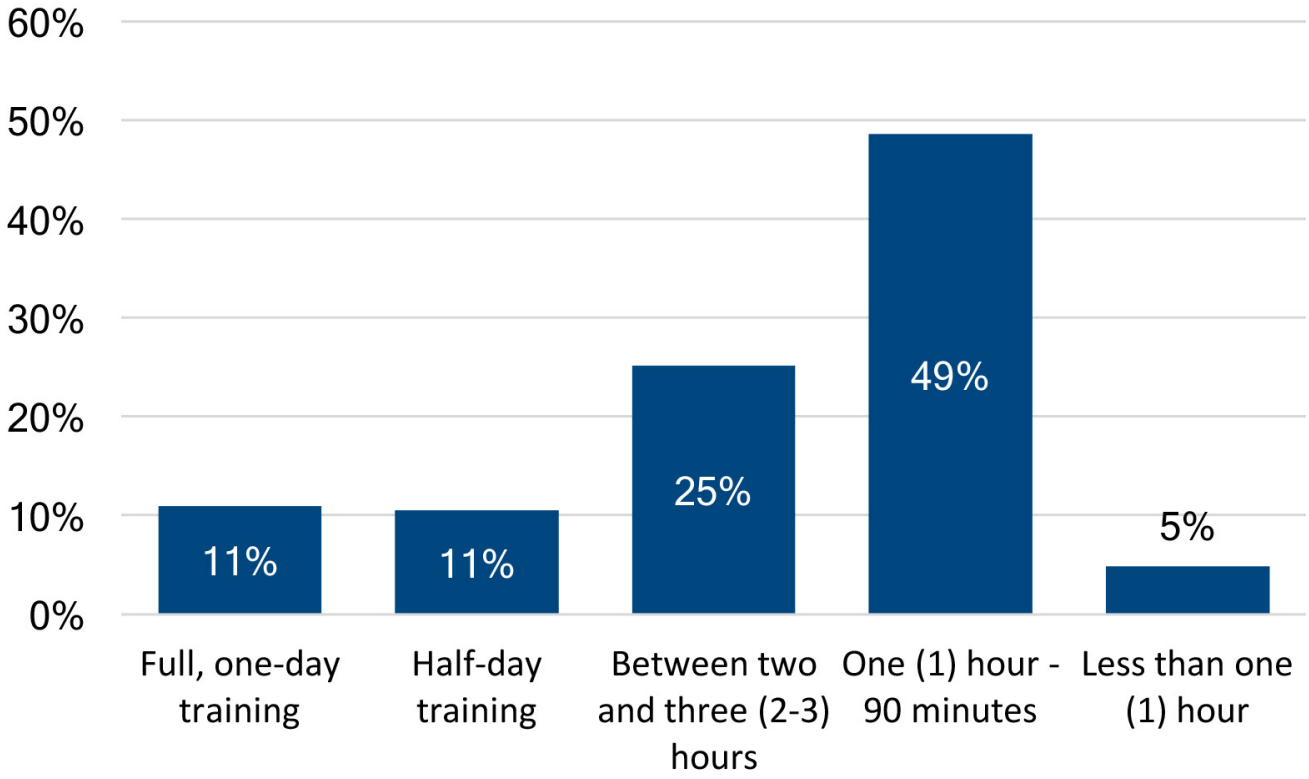
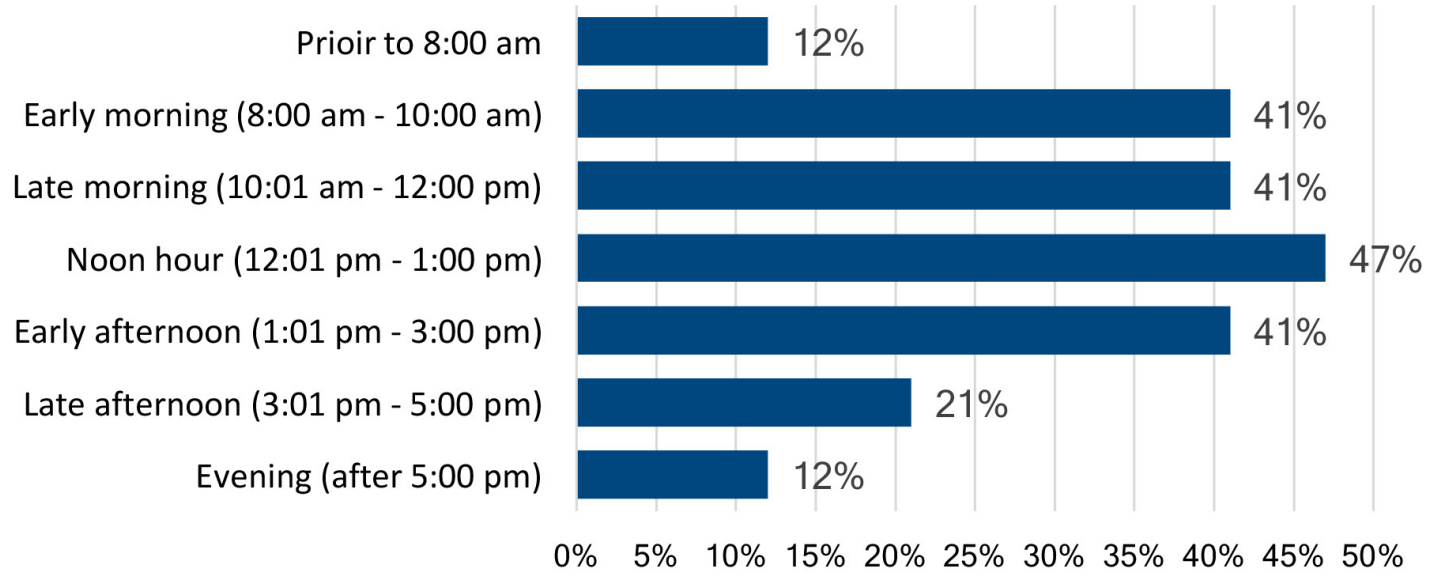


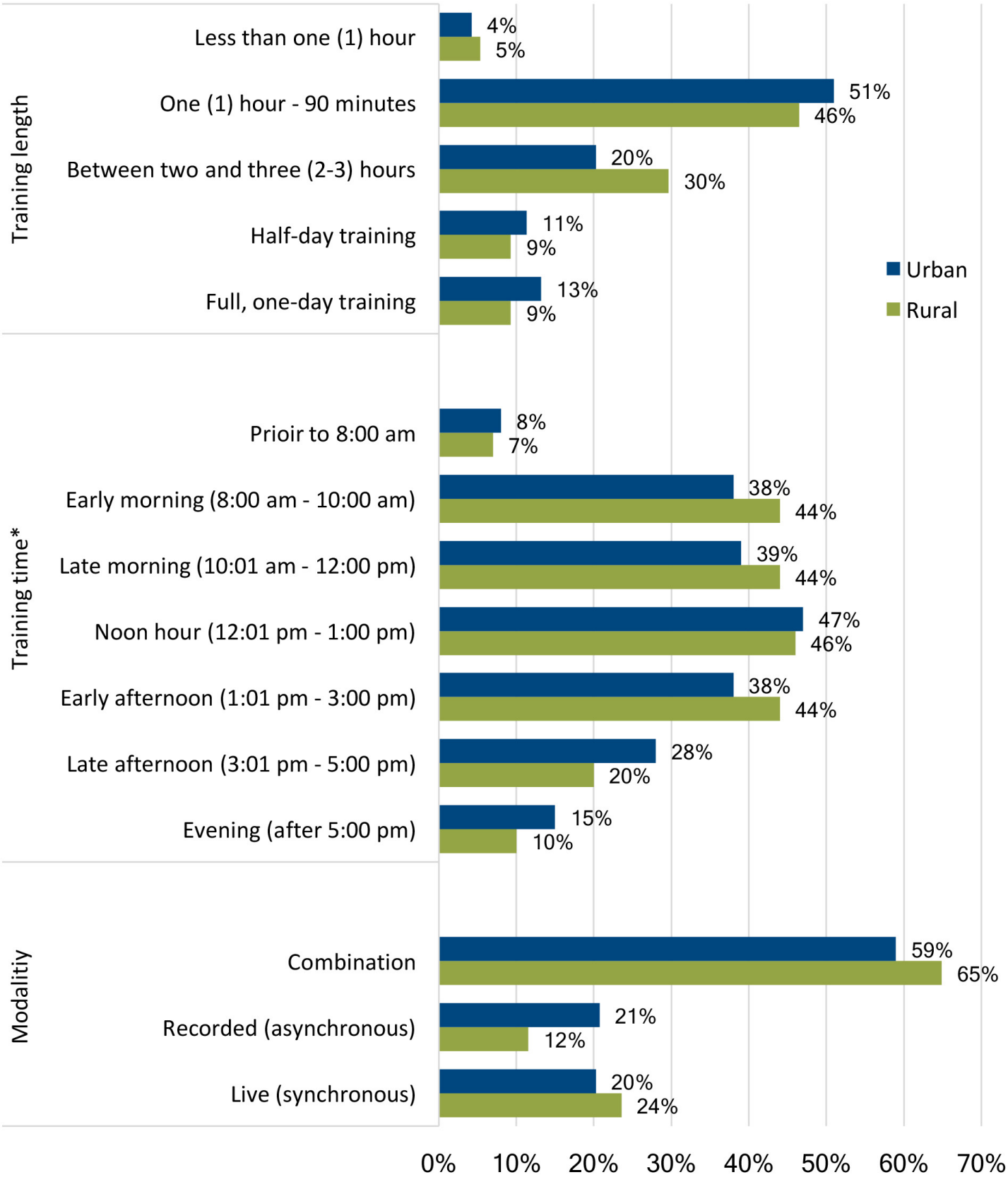
Figure 9. Participants' Preferred Times of Day for Scheduled Live (Synchronous) Trainings (N=456) *



* Participants could select more than one time of day (totals will not equal 100%).

In both rural and urban areas, the greatest percentage of respondents indicated the noon hour (12:00-1:00) as the preferred time of day for synchronous (live) trainings. There was no significant variability in preferred modalities and times for training between rural and urban respondents except in one area. A greater proportion or urban providers (21%) than rural (12%) indicated a preference for recorded trainings. In fact, more rural participants preferred live trainings (24%) over recorded (12%), while the opposite was true for urban where a greater percentage indicated preference for recordings (21%) than live (20%) trainings. For both rural and urban, however, combined strategies utilizing both live and recorded trainings were the primary preference. See Figure 10.

Figure 10. Participants' Preferred Times of Day and Training Modalities by Geography (N=456)



* Participants could select more than one time of day (totals will not equal 100%).

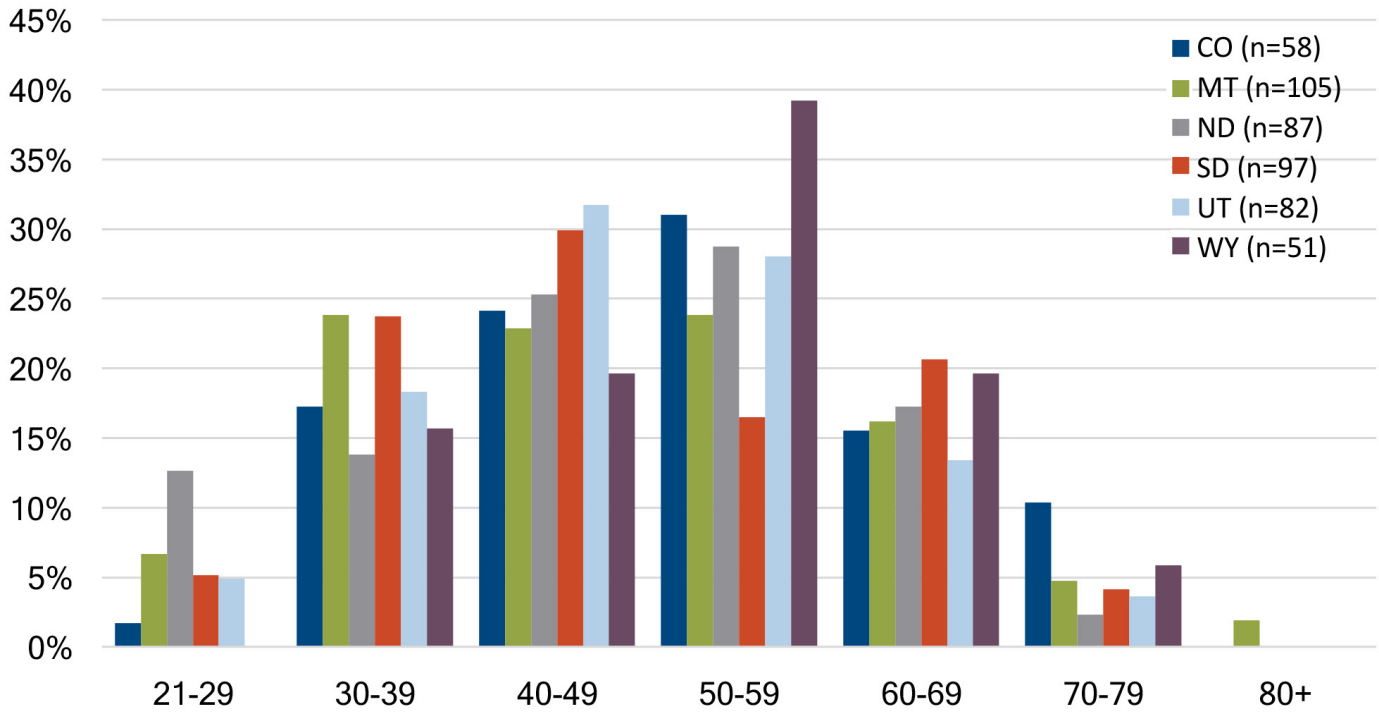
State Specific Training and Technical Assistance Needs

The Mountain Plains MHTTC serves Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming. While these state populations share similar attributes and borders, their priority populations, behavioral health training, and TA needs, as well as preferred modalities may vary. Below is the number of respondents for each state who provided both their age and employment state:

• Colorado	58 respondents	5.696 million, 2018 population
• Montana	105 respondents	1.062 million, 2018 population
• North Dakota	87 respondents	760,077, 2018 population
• South Dakota	97 respondents	882,235, 2018 population
• Utah	82 respondents	3.161 million, 2018 population
• Wyoming	51 respondents	577,737, 2018 population

The participants' demographics varied by state. For example, 39% of participants from Wyoming were between the ages of 50-59 (the largest age group response for Wyoming) compared to South Dakota where only 17% of respondents were between the ages of 50-59. See Figure 11.

Figure 11. Participants' Age Categories by State



A larger percentage of respondents worked in rural settings in Wyoming (76%) than any other state; for example, only 32% of respondents in Colorado and 37% in Utah worked in rural settings. See Table 4. Additionally, there was variability by state in the proportion of participants who worked in organizations providing telehealth services. Although 49% of respondents worked in organizations providing telehealth services in North Dakota, the same was true for only 26% of respondents in Utah. See Table 4.

Table 4. Participant Demographics by State

	CO	MT	ND	SD	UT	WY	TOTAL
GEOGRAPHY							
Rural	32%	49%	41%	60%	37%	76%	49%
Suburban	20%	15%	9%	10%	26%	14%	15%
Tribal land	2%	6%	2%	8%	0%	0%	4%
Urban	46%	30%	48%	21%	38%	10%	32%
JOB SETTING							
Clinic (not a Community Mental Health Center or Federally Qualified Health Center)	22%	11%	8%	3%	6%	14%	10%
Community Mental Health Center	15%	28%	21%	37%	15%	22%	24%
Federally Qualified Health Center	3%	5%	5%	5%	2%	4%	4%
Higher Education (e.g. College, University, Trade School, etc.)	3%	3%	8%	2%	22%	2%	7%
Hospital	7%	6%	9%	2%	6%	6%	6%
Other (please specify)	37%	30%	41%	26%	30%	49%	35%
Psychiatric Residential Treatment Facility	0%	1%	1%	6%	0%	2%	2%
School (K-12)	3%	16%	3%	5%	1%	2%	6%
State Mental Health Institute/State Hospital	8%	1%	3%	13%	17%	0%	7%
JOB ROLE							
Administrator	36%	18%	29%	21%	41%	31%	28%
Direct service provider/Front-line staff	34%	48%	40%	42%	44%	39%	42%
Educator	3%	3%	2%	4%	1%	0%	2%
Other	19%	15%	13%	20%	7%	22%	16%
Student/intern	0%	3%	3%	1%	0%	0%	1%
Supervisor of front-line staff	8%	13%	13%	12%	6%	8%	10%
YEARS WORKING IN MENTAL HEALTH							
5 years or less	12%	19%	13%	20%	16%	10%	16%
6-10 years	10%	19%	6%	19%	18%	18%	15%
11-15 years	12%	16%	8%	13%	13%	14%	13%
16 years or more	52%	28%	33%	42%	44%	44%	39%
I do not work directly in mental health	14%	17%	40%	6%	9%	14%	17%
TELEHEALTH SERVICES							
No	73%	62%	51%	58%	74%	74%	64%
Yes	27%	38%	49%	42%	26%	26%	36%

Colorado

Although the state of Colorado had a relatively low response rate (n=58), it is important to recognize the technical assistance and trainings needs of those individuals who are aware of the Mountain Plains MHTCC and who have completed this assessment. Future assessments will be conducted during the duration of this program to reassess needs, and larger response rates will be sought at that time. The five topics identified as a "High Priority" by the greatest proportion of Colorado respondents included:

Top Five Topics Identified as "High Priority"

1. Mental health and substance abuse co-occurring disorders	60%
2. Compassion fatigue	50%
3. Suicide prevention	49%
4. Historical trauma	47%
5. Trauma-informed care	45%

When combining the response categories for topics that were identified as "Helpful" or a "High Priority" among Colorado respondents, trauma-informed care fell from the list and collaborative care jumped to the topic with the greatest proportion of interest.

Top 10 Topic Priorities Indicated as "Helpful" Topics or "High Priority"

1. Collaborative care	92%
2. Suicide assessment	92%
3. Compassion fatigue	90%
4. Suicide prevention	88%
5. Crisis de-escalation	88%
6. Historical trauma	88%
7. Mental health and substance abuse co-occurring disorders	88%
8. Best practices in diagnosis	88%
9. Strength-based approaches to treatment	88%
10. Using data for continuous quality improvement	86%

When participants were asked to identify priority populations, Colorado respondents indicated interest in learning more about providing mental health services for (N=46):

1. Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ)	59%
2. Homeless/transient	57%
3. Rural	50%
4. Seniors (ages 65 +)	48%
5. Low income	44%
Individuals with serious mental illness (SMI)	44%
Individuals with serious emotional disturbance (SED)	44%

Three population groups tied in fifth with 44% of respondents indicating interest or wanting more information.

Montana

The five topics identified as a "High Priority" by the greatest proportion of Montana respondents (N=105) included:

Top Five Topics Identified as "High Priority"

1. Trauma-informed care	60%
2. Mental health and substance abuse co-occurring disorders	58%
3. Suicide prevention	52%
4. Motivational interviewing	52%
5. Compassion fatigue	51%

When combining the response categories for topics that were identified as "Helpful" or a "High Priority" among Montana respondents, compassion fatigue fell from the list. However, 84% of respondents still indicated this topic as "Helpful" or a "High Priority." There was a tree-way tie for tenth priority topic. The top 10 topics included:

Top 10 Topic Priorities Indicated as "Helpful" Topics or "High Priority"

1. Mental health and substance abuse co-occurring disorders	96%
2. Suicide prevention	95%
3. Trauma-informed care	94%
4. Historical trauma	94%
5. Risk assessment tools	93%
6. Crisis management	91%
7. Mental health and intellectual disabilities co-occurring disorders	91%
8. Suicide assessment	91%
9. Crisis de-escalation	91%
10. Strength-based approaches to treatment	89%
Stigma reduction	89%
Motivational interviewing	89%

When participants were asked to identify priority populations, Montana respondents indicated interest in learning more about providing mental health services for (N=92):

1. Rural	73%
2. American Indian/Alaska Natives	62%
3. Children (ages 0-17)	59%
4. Adults (ages 18-64)	55%
5. Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ)	53%

North Dakota

The five topics identified as a "High Priority" by the greatest proportion of North Dakota respondents (N=87) included:

Top Five Topics Identified as "High Priority"

1. Mental health and substance abuse co-occurring disorders	62%
2. Crisis de-escalation	54%
3. Crisis management	53%
4. Suicide prevention	53%
5. Recovery oriented systems of care	51%

When combining the response categories for topics that were identified as "Helpful" or a "High Priority" among North Dakota respondents, the top 10 topics included:

Top 10 Topic Priorities Indicated as "Helpful" Topics or "High Priority"

1. Mental health and substance abuse co-occurring disorders	95%
2. Suicide prevention	95%
3. Stigma reduction	95%
4. Suicide assessment	92%
5. Crisis management	92%
6. Trauma-informed care	92%
7. Risk assessment tools	90%
8. Crisis de-escalation	89%
9. Recovery oriented systems of care	89%
10. Working with diverse populations	89%

When participants were asked to identify priority populations, North Dakota respondents indicated interest in learning more about providing mental health services for (N=75):

1. Rural	63%
2. Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ)	57%
3. Individuals with serious mental illness (SMI)	57%
4. Homeless/transient	53%
5. American Indian/Alaska Natives	53%

South Dakota

The five topics identified as a "High Priority" by the greatest proportion of South Dakota respondents (N=97) included (there was a tie for the fifth highest priority):

Top Five Topics Identified as "High Priority"

1. Mental health and substance abuse co-occurring disorders	59%
2. Compassion fatigue	55%
3. Trauma-informed care	55%
4. Crisis de-escalation	51%
5. Suicide prevention	49%
Crisis management	49%

When combining the response categories for topics that were identified as "Helpful" or a "High Priority" among South Dakota respondents, the top 10 topics included (three topics tied at number 10):

Top 10 Topic Priorities Indicated as "Helpful" Topics or "High Priority"

1. Strength-based approaches to treatment	97%
2. Mental health and substance abuse co-occurring disorders	92%
3. Suicide prevention	92%
4. Trauma-informed care	92%
5. Crisis management	91%
6. Working with diverse populations	91%
7. Compassion fatigue	90%
8. Shared decision making	89%
9. Crisis de-escalation	89%
10. Risk assessment tools	88%
Suicide assessment	88%
Stigma reduction	88%

When participants were asked to identify priority populations, South Dakota respondents indicated interest in learning more about providing mental health services for (N=88):

1. Rural	75%
2. American Indian/Alaska Natives	70%
3. Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ)	60%
4. Individuals with serious mental illness (SMI)	56%
5. Individuals with serious emotional disturbance (SED)	51%
Children (ages 0-17)	51%

Both children (ages 0-17) and individuals with SED recieved interest from 51% of respondents in South Dakota.

Utah

The five topics identified as a "High Priority" by the greatest proportion of Utah respondents (N=82) included:

Top Five Topics Identified as "High Priority"

1. Crisis de-escalation	56%
2. Trauma-informed care	54%
3. Crisis management	54%
4. Mental health and substance abuse co-occurring disorders	51%
5. Compassion fatigue	49%

When combining the response categories for topics that were identified as "Helpful" or a "High Priority" among Utah respondents, the top 10 topics with four topics tied with 88% at number 10 included:

Top 10 Topic Priorities Indicated as "Helpful" Topics or "High Priority"

1. Crisis management	97%
2. Crisis de-escalation	97%
3. Trauma-informed care	94%
4. Risk assessment tools	91%
5. Suicide prevention	90%
6. Mental health and substance abuse co-occurring disorders	89%
7. Suicide assessment	89%
8. Stigma reduction	89%
9. Working with diverse populations	88%
10. Compassion fatigue	88%
Historical trauma	88%
Collaborative care	88%
Strength-based approaches to treatment	88%

When participants were asked to identify priority populations, Utah respondents indicated interest in learning more about providing mental health services for (N=68):

1. Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ)	65%
2. Rural	59%
3. Individuals with serious emotional disturbance (SED)	59%
4. Individuals with serious mental illness (SMI)	54%
5. Low income	54%

Wyoming

The five topics identified as a "High Priority" by the greatest proportion of Wyoming respondents (N=51) included:

Top Five Topics Identified as "High Priority"

1. Best practices in diagnosis	57%
2. Trauma-informed care	55%
3. Mental health and substance abuse co-occurring disorders	55%
4. Strength-based approaches to treatment	54%
5. Compassion fatigue	50%

When combining the response categories for topics that were identified as "Helpful" or a "High Priority" among Wyoming respondents, the top 10 topics with three listed at number 10 included:

Top 10 Topic Priorities Indicated as "Helpful" Topics or "High Priority"

1. Compassion fatigue	89%
2. Strength-based approaches to treatment	88%
3. Historical trauma	85%
4. Working with diverse populations	85%
5. Risk assessment tools	84%
6. Mental health and substance abuse co-occurring disorders	84%
7. Shared decision making	81%
8. Trauma-informed care	81%
9. Crisis de-escalation	80%
10. Pregnant and postpartum depression	79%
Best practices in diagnosis	79%
Mental health and intellectual disabilities co-occurring disorders	79%

When participants were asked to identify priority populations, Wyoming respondents indicated interest in learning more about providing mental health services for (N=42):

1. Rural	74%
2. Individuals with serious emotional disturbance (SED)	62%
3. Individuals with serious mental illness (SMI)	62%
4. Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ)	55%
5. American Indian/Alaska Natives	43%
Seniors (ages 65 +)	43%

State Comparisons: Training and TA Topic Priorities

A large proportion of respondents indicated interest in the trainings listed; 26 of the 45 listed topics had 75% or more of the respondents indicate that training would be "Helpful" or a "High Priority." There was some state variability. For example, 82% of North Dakota participants indicated that Screening, Brief Intervention, and Referral to Treatment (SBIRT) would be a "Helpful" or "High Priority" training topic compared to only 62% of respondents in Wyoming. See Table 5.

Table 5. Percentage of Respondents Indicating Topics as "High Priority" or "Helpful" by State

Topics	TOTAL	CO	MT	ND	SD	UT	WY
Mental health and substance abuse co-occurring disorders	92%	88%	96%	95%	92%	90%	84%
Crisis de-escalation	90%	88%	91%	89%	89%	97%	80%
Strength-based approaches to treatment	90%	88%	89%	88%	97%	88%	88%
Suicide prevention	90%	88%	95%	95%	92%	90%	67%
Trauma-informed care	90%	84%	94%	92%	92%	94%	81%
Compassion fatigue	89%	90%	89%	86%	90%	88%	89%
Crisis management	89%	84%	91%	92%	91%	97%	72%
Risk assessment tools	89%	86%	91%	90%	88%	91%	84%
Historical trauma	88%	88%	92%	88%	85%	88%	85%
Suicide assessment	88%	92%	91%	92%	88%	89%	71%
Stigma reduction	87%	78%	89%	95%	88%	89%	74%
Collaborative care	86%	92%	84%	88%	85%	88%	77%
Working with diverse populations	86%	78%	82%	89%	91%	89%	85%
Mental health and intellectual disabilities co-occurring disorders	85%	80%	91%	83%	87%	85%	79%
Recovery oriented systems of care	85%	80%	87%	89%	87%	83%	77%
Shared decision making	84%	86%	83%	83%	89%	77%	81%
Best practices in diagnosis	82%	88%	86%	75%	86%	80%	79%
Integrated care (primary care and behavioral health)	82%	83%	84%	88%	80%	81%	74%
Cognitive behavioral therapy (CBT)	80%	67%	84%	75%	84%	86%	76%
Use of technology to support behavioral health services (i.e. texting/apps)	80%	80%	81%	75%	84%	86%	69%
Motivational interviewing	79%	71%	84%	78%	74%	86%	77%
Psychotropic medications	79%	78%	79%	76%	79%	84%	74%
Using data for continuous quality improvement	79%	86%	71%	77%	84%	79%	78%
Leadership skills development	76%	75%	73%	75%	82%	79%	71%
Confidentiality and ethics (including HIPAA)	75%	76%	71%	68%	78%	85%	71%
Screening, Brief Intervention and Referral to Treatment (SBIRT)	75%	68%	78%	82%	77%	73%	62%
Assertive community treatment (ACT)	74%	70%	79%	76%	72%	74%	66%
First episode psychosis (FEP)	73%	68%	74%	68%	75%	83%	70%
Mental health courts	73%	72%	78%	73%	71%	70%	67%
Assisted outpatient therapy	71%	73%	69%	71%	70%	70%	74%
Use of telehealth services to deliver behavioral healthcare	71%	66%	75%	67%	74%	71%	74%

Topics	TOTAL	CO	MT	ND	SD	UT	WY
Employment issues and solutions for individuals with mental illness (Individual Placement and Support services)	70%	68%	63%	75%	68%	80%	63%
National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care	69%	66%	60%	70%	71%	78%	74%
Organizational change strategies	69%	73%	70%	75%	67%	70%	56%
Patient and staff safety practices (ex. anti-ligature facilities)	69%	64%	69%	73%	72%	69%	56%
Permanent supportive housing resources	69%	64%	64%	79%	67%	74%	67%
Pregnant and postpartum depression	68%	72%	64%	57%	74%	67%	79%
Clinical supervision	67%	65%	65%	52%	78%	79%	62%
Staff retention	64%	70%	64%	59%	67%	58%	67%
Mental health services in higher education	63%	54%	67%	66%	67%	52%	64%
Psychiatric advanced directives	61%	59%	66%	61%	58%	62%	52%
Technology-based clinical supervision	61%	71%	60%	49%	65%	66%	50%
Community services and supports for seniors (example, Senior Reach programs)	60%	57%	56%	64%	62%	59%	57%
Staff recruitment	56%	59%	56%	52%	61%	49%	57%
School-based mental health (k-12)	55%	47%	61%	66%	63%	37%	41%

Training Priority Populations by State

Variability existed in participants' interest in receiving trainings or technical assistance related to various populations by state. These interests appear to reflect the general state composition. For example, nearly one in three respondents in Montana, South Dakota, and Wyoming indicated wanting more information on rural populations compared to only 50% in Colorado. Similarly, 70% of South Dakota respondents wanted more information on American Indian/Alaska Native populations compared to only 26% of individuals in Colorado. See Table 6.

Table 6. Populations Respondents Would Like Addressed in Trainings or Technical Assistance by State

Population	TOTAL	CO	MT	ND	SD	UT	WY
Rural	67%	50%	73%	63%	75%	59%	74%
Lesbian, Gay, Bisexual, Transgender, Queer/ Questioning (LGBTQ)	58%	59%	53%	57%	60%	65%	55%
Individuals with serious mental illness (SMI)	54%	43%	51%	57%	56%	54%	62%
American Indian/Alaska Natives	53%	26%	62%	53%	70%	46%	43%
Individuals with serious emotional disturbance (SED)	52%	43%	53%	48%	51%	59%	62%
Low income	47%	43%	48%	45%	49%	54%	40%
Adults (ages 18-64)	46%	37%	55%	43%	45%	51%	38%
Homeless/transient	45%	57%	42%	53%	35%	46%	40%
Children (ages 0-17)	44%	33%	59%	41%	51%	32%	31%
Seniors (ages 65 +)	39%	48%	42%	39%	36%	29%	43%
Veterans	37%	41%	45%	29%	34%	38%	40%
Women	34%	28%	32%	35%	35%	47%	21%
Hispanic/Latino	30%	41%	17%	23%	24%	53%	38%
Men	29%	26%	28%	29%	23%	41%	29%
White/Caucasian	25%	20%	25%	21%	32%	24%	29%
African American/Black	22%	35%	14%	24%	6%	41%	24%
Urban	19%	28%	17%	19%	15%	28%	12%
Secondary school	18%	17%	24%	23%	16%	13%	5%
Primary school	17%	15%	25%	23%	17%	7%	5%
Higher education	16%	20%	11%	19%	14%	25%	12%
Migrant workers	13%	22%	13%	17%	7%	16%	2%
Asian	12%	24%	4%	17%	5%	24%	2%
Native Hawaiian/Pacific Islander	12%	13%	5%	12%	5%	35%	2%

Preferred Training Modalities and Times by State

Regardless of state, participants strongly preferred trainings midday, between one hour and 90 minutes, and those that combine live trainings with recordings. See Figures 12-14.

Figure 12. Participants' Preferred Length of Time for Scheduled Live (Synchronous) Trainings by State

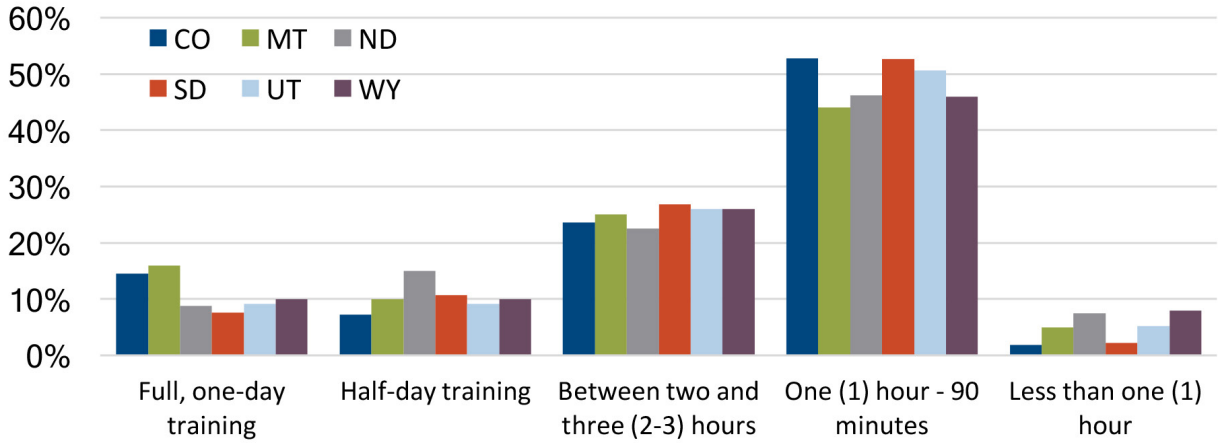


Figure 13. Participants' Preferred Modes of Web Training Delivery by State

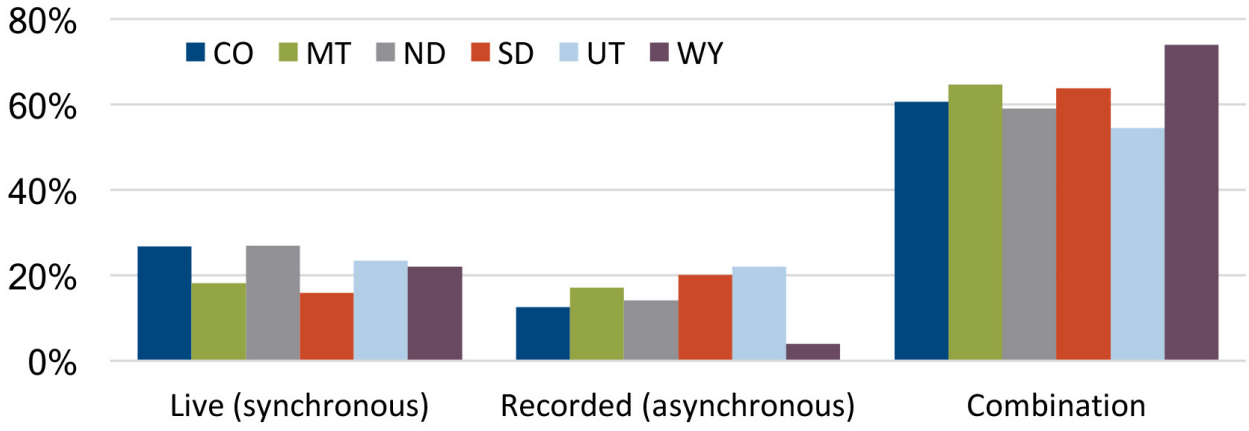
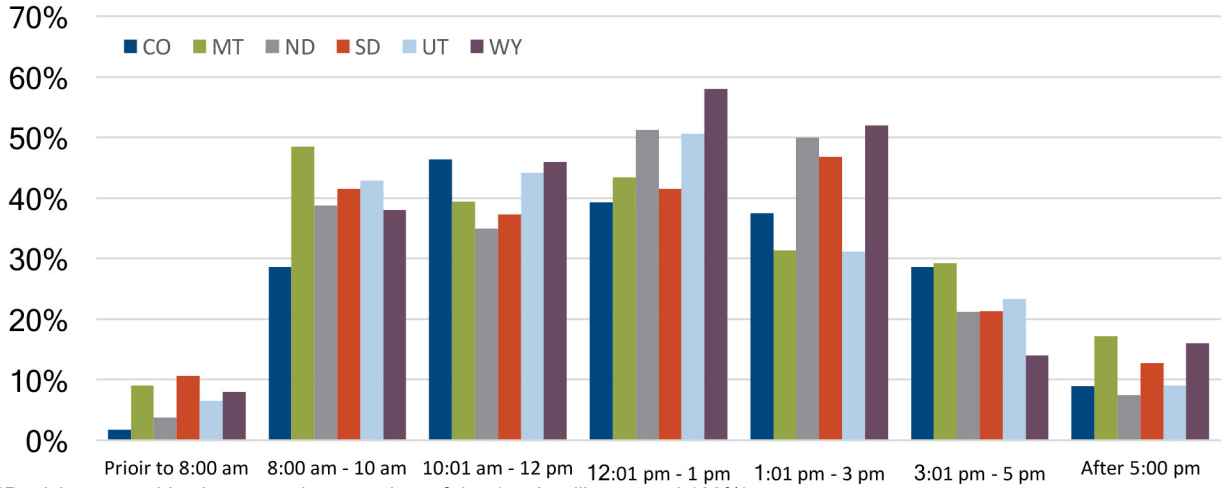


Figure 14. Participants' Preferred Times of Day for Scheduled Live (Synchronous) Trainings by State



*Participants could select more than one time of day (totals will not equal 100%).

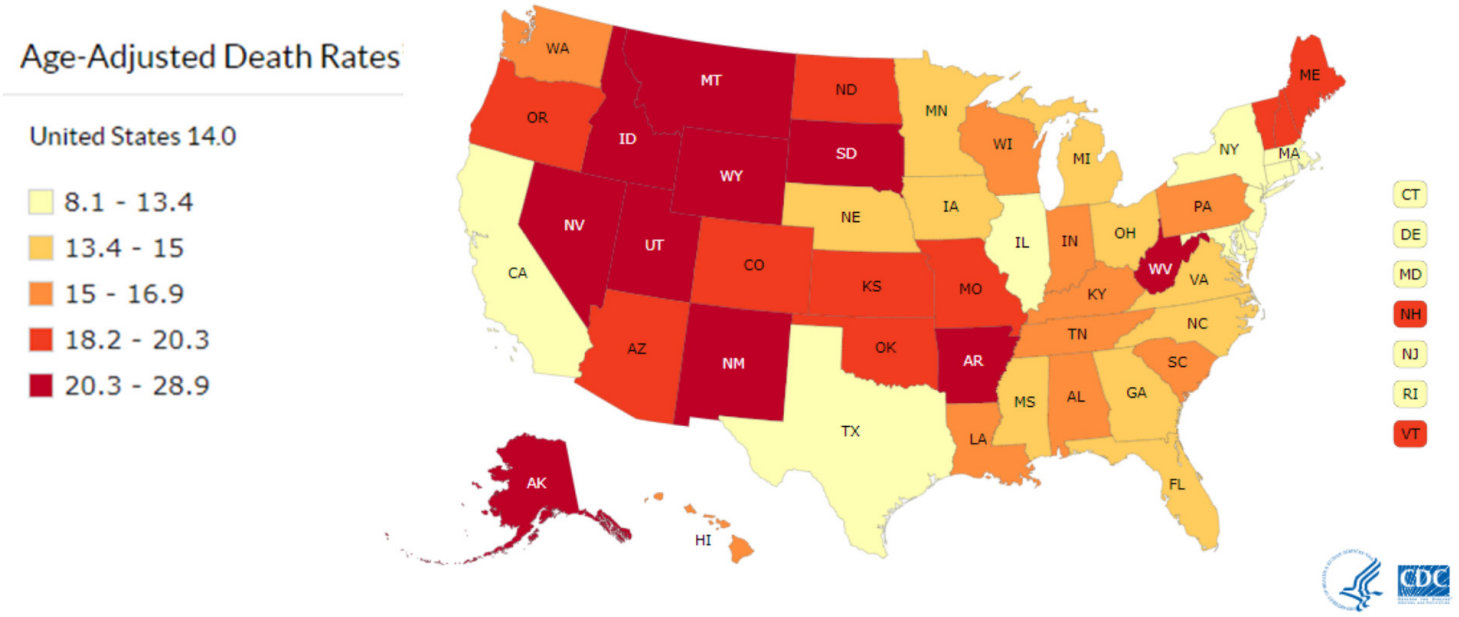
Summary and Implications

The findings from this survey will guide future activities of Mountain Plains Mental Health Technology Transfer Center to ensure responsiveness to individuals in Region 8 who are providing services to persons with mental illness. Noteworthy is the consistency in training and technical assistance needs across the six states located in the region – with many of these topics identified as a need in the Region 8 Assessment of Substance Use Disorder Providers.[vii] This assessment was conducted by our sister agency, the Mountain Plains Addiction Technology Transfer Center (ATTC).[vii]

While a myriad of needs was identified, the greatest needs by topic area are: (1) mental health and substance abuse co-occurring disorders, (2) trauma-informed care, (3) compassion fatigue, (4) crisis de-escalation, and (5) crisis management. As a result, the Mountain Plains MHTTC will focus on these topics with products, training, and technical assistance supports throughout the six states. Efforts are underway to begin addressing many of the topics identified in the survey based on suggestions by the Single State Mental Health Authorities and other key stakeholders across the region. These groups provided feedback during face-to-face meetings in each of the six states, which were held in the fall of 2018 and winter of 2019. The Mountain Plains MHTTC advisory board met on February 5, 2019, and identified many of these same barriers regarding support for workforce.

Not surprising, the majority of participants indicated they serve clientele from rural communities and were interested in a focus on rural populations. This was anticipated, given that Region 8 consists largely of remote and rural areas. As a result, these findings provide data to assist Mountain Plains MHTTC staff to address topics that were requested by rural respondents, rank ordered as follows: (1) compassion fatigue, (2) co-occurring disorders of substance abuse and mental health, (3) trauma-informed care, (4) crisis management, (5) suicide prevention, and (6) crisis de-escalation. In addition to the needs identified by survey participants, the Centers for Disease Control and Prevention also reports a dramatic increase in deaths by suicide in rural areas. States in Region 8 report some of the highest age-adjusted suicide mortality rates. See Figure 15.

Figure 15. Suicide Mortality by State, 2017 (Deaths per 100,000 Total Population)[ix]



The lack of resources in rural communities can place additional stress on providers and result in increased compassion fatigue. TA topics unique to rural communities, in comparison to those identified by urban participants, were: (1) pregnant, postpartum women, (2) patient and safety practices, (3) staff retention, (4) psychiatric advanced directives, (5) mental health services in higher education, and (6) services to support seniors. Again, Single State Mental Health Authorities identified these topics as needs relative to training and TA.

There was significant interest in serving populations of LGBTQ among participants in both rural and urban areas and the SED/SMI populations. The interest in serving American Indian/Alaskan Native populations was not surprising, given that 33 tribal nations are located in Region 8. The Mountain Plains MHTTC will adhere to standards outlined in the National Standards for Culturally and Linguistically Appropriate Services in health and healthcare: https://www.thinkculturalhealth.hhs.gov/clas.

The focus of additional trainings, based on these findings, is to offer content between the hours of 9:00 am and prior to 3:00 pm, with an emphasis on trainings over the noon hour and trainings that are no longer than 90 minutes. This is to be anticipated because professionals wish to learn at their workplaces, especially for providers who have expectations of billable hours. As a result, to the degree possible, trainings will be offered during the noon hour, which provides the best opportunity to shore up skills and knowledge through trainings while meeting work expectations. Full-day trainings were not desired. Two of the states in Region 8 are on Central Time and four states are on Mountain Time so accommodations will need to be provided relative to training times. A focus of the trainings will be a combination of asynchronous and synchronous training that allow for interaction, which was noted particularly among survey participants from rural areas.

In summary, these findings provide guidance to the Mountain Plains MHTTC in next steps relative to addressing needs in topical areas, format of training, and structure of the trainings. They largely mirror the findings from the Mountain Plains ATTC assessment, emphasizing the need for cross coordination of the technology transfer center. A follow-up Mental Health Technology Transfer survey will be conducted in spring of 2021.

Acknowledgements

We would like to thank all those who responded to, and disseminated, the survey. The time that you took will help the Mountain Plains MHTTC better serve the needs of all of the individuals in Region 8 who are serving persons with mental illness.

i. Mountain Plains Mental Health Technology Transfer Center: https://mhttcnetwork.org/centers/mountain-plains-mhttc/home

ii. Substance Abuse and Mental Health Services Administration: https://www.samhsa.gov

iii. College of Nursing and Professional Disciplines, University of North Dakota: https://cnpd.und.edu

iv. Western Interstate Commission for Higher Education: https://www.wiche.edu

v. Center for Rural Health, University of North Dakota School of Medicine & Health Sciences: https://ruralhealth.und.edu

vi. Center for the Application for Substance Abuse Treatment at the University of Nevada-Reno: https://casat.org

vii. Region 8 Substance Use Disorders Treatment and Recovery Providers Survey: https://attcnetwork.org/node/3507

viii. Mountain Plains Addiction Technology Transfer Center: https://attcnetwork.org/centers/mountain-plains-attc/home

ix. Centers for Disease Control and Prevention, Suicide data: https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

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At the time of this publication, Elinore F. McCance-Katz, served as SAMHSA Assistant Secretary. The opinions expressed herein are the views of Dr. Shawnda Schroeder, PhD and Professor Thomasine Heitkamp, LCSW and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this document is intended or should be inferred.