



Mental Health Needs Assessment of Sioux Falls, SD

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Commissioned by Family Service, Inc. in collaboration with Lost & Found, the Link Community Triage Center, Avera Behavioral Health, Falls Community Health, and 211 Helpline Center



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Executive Summary


This report presents the results of a study of mental health needs in the Sioux Falls, SD area. It was commissioned by a collaborative group made up of Family Services Inc., Lost & Found, The Link Community Triage Center, Avera Behavioral Health, the 211 Helpline Center, and Falls Community Health. Researchers compiled existing data and conducted focus groups and interviews with service providers and community members. The purpose of the report is to better understand perceived strengths, barriers, and challenges to accessing mental health care.

Background Literature

Mental health has been a popularized discussion around the globe in recent years, especially due to the COVID-19 pandemic. During the COVID-19 pandemic, isolation, as well as uncertainty surrounding the COVID-19 virus, pushed mental health to the forefront of public attention. Mental health is also a significant issue because of the prevalence of mental illness and its effects on public health. In the United States, in 2020 alone, about one in five adults experienced a mental illness, and suicide was among the most common causes of death for young adults.

Various social determinants affect the prevalence of mental illness and access to mental health care. Racial and ethnic groups who identify as non-white tend to have worse outcomes when it comes to mental health care. Houselessness is another factor that affects mental illness. People who are involved with the justice system are more likely to suffer from negative mental health or a mental illness. The social determinants emphasized in this report are: racial and ethnic identity, region, class, housing situation, stigma, and justice involvement.

The perceptions of mental health in the United States are positively changing towards acceptance and tolerance, though attitudes towards mental health and access to mental health care depend on the location where the individual resides. The effects of mental health provider shortages are greatly felt by rural communities. In South



Dakota, the suicide rate tends to be disproportionately higher than national averages, and half of adults with any mental illness go without treatment.


For this project, many mental health needs assessments that were conducted in other similar communities were reviewed. The methodology and some of the findings from previous mental health needs assessments deeply informed the methods used for this project as well as anticipated findings. Other communities' efforts to facilitate a community-wide mental health needs assessment had diverse objectives that were accomplished with a variety of methods. The various mental health needs assessment found common barriers and provided knowledge about the many facets to the issue of mental health needs.

Methods

For this study, data collection consisted of focus groups and interviews, which took place in March through June 2022. Two distinct populations were recruited: stakeholders/providers and community members. In total, 89 participants took part in focus groups and interviews. Participants in stakeholder/provider focus groups and interviews also partook in a voting activity to reflect on and prioritize needs they identified. Community member focus groups were held in both English and Spanish. Participants in community member focus groups were asked to complete a demographic questionnaire. Recruitment for stakeholder/providers and community members followed different protocols: For stakeholders/providers, the 211 Helpline Center's "Mental Health Guide: Sioux Falls 2021" and word of mouth were used for recruitment. For the community members, Spanish and English flyers were displayed in public areas and businesses as well as on social media. The transcripts from the focus groups and interviews were thematically coded using Taguette.

Findings

A range of themes emerged as the transcripts were thematically coded; themes were split into three categories: Strengths, Barriers and Challenges, and Needs.



Strengths identified by participants included abundant resources and generosity, decreasing stigma, collaboration, and the Helpline Center. Barriers and challenges to accessing care included the impact of the COVID-19 pandemic on mental health services, remaining stigma, lack of providers, licensure difficulties, waiting lists, lack of awareness, cost and insurance, basic needs, mental health legitimacy, transportation, and childcare. Mental health needs included diversity of providers, education of the public and professional development for providers, youth and family services, medication and psychiatric services, funding, mental health provider support, and long-term mental health care.


Recommendations

Based on the analysis of focus groups and interviews with mental health providers, key stakeholders, and community members, researchers have several recommendations for the Sioux Falls community in order to increase accessibility of mental health services by breaking down barriers and empowering key members of the community. These recommendations include the following:

- Ensure accessible transportation connects clients and mental health providers,
- Increase insurance coverage and access to affordable mental health care,
- Increase the diversity and number of mental health care providers,
- Educate community members and stakeholders/providers to increase mental health literacy,
- Provide basic needs of community members in addition to mental health care, and
- Increase support to mental health care professionals.

Conclusions

Overall, mental health care in Sioux Falls has a shortage in providers, creating long waiting lists. Additionally, the sector faces community members' lack of awareness



of services and a lack of diversity among service providers. Barriers such as unmet basic needs and unreliable transportation make it difficult for community members to reach services that do exist. Commissioned by Family Service, Inc. in collaboration with Lost & Found, The Link Community Triage Center, Avera Behavioral Health, Falls Community Health, and 211 Helpline Center, this report hopes to raise awareness of the many needs and barriers that the Sioux Falls community faces in regards to mental health care. The many barriers highlighted in this report represent the perceived needs in the Sioux Falls community and should be considered as a starting point to further understanding of the needs and barriers of the Sioux Falls community.

I. Introduction


Over the years, the discussion surrounding mental health needs has received an increasing focus, largely due to the effects the COVID-19 pandemic has had on accessing mental health care and maintaining mental health itself. Just as mental health needs ramped up during the pandemic, the veil that hid the restricted access to mental health resources fell, making the barriers to accessing mental health resources apparent. The extensive needs and systemic barriers to mental health access need to be deeply understood in order to alleviate the stress community members feel when trying to access mental health resources. This report outlines the needs and barriers community members of the Sioux Falls area experience when trying to access mental health resources.

Objectives

This needs assessment was commissioned in collaboration with Family Services Inc., Lost & Found, The Link Community Triage Center, Avera Behavioral Health, the 211 Helpline Center, and Falls Community Health. Its intended purpose is to evaluate what mental health care services are currently available in the Sioux Falls area, who is utilizing these services, and who is providing services. Another aspect of this project entails investigating community needs and what unmet needs exist. Using focus groups and interviews with service providers and community members, the researchers assessed barriers to accessing mental health services and community attitudes surrounding mental health.

The research plan was designed in collaboration with and approved by the commissioning organizations. The plan focused on five detailed research questions:

1. **Available services:** Who provides mental health and/or addiction services in the Sioux Falls area? How much do these services cost? Where are the services located? What types of services are being offered? What credentials do the providers have?

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2. **Current clients:** Who is accessing mental health services now? How do the demographics of people who are accessing mental health services compare to overall community demographics?
 3. **Community attitudes:** What are community attitudes around mental health? Is there stigma surrounding mental health and its treatment?
 4. **Mental health needs:** What challenges do community members face now? What coping methods do they utilize?
 5. **Barriers:** What are the barriers to seeking out and accessing mental health services? How do barriers vary across demographic groups? Are there cultural barriers? Are there logistical barriers? Are there disparities in the accessibility of mental health services?

The research activities undertaken for this report consist of original data collection as well as reviewing relevant literature, including previous community mental health needs assessments, research regarding barriers among diverse groups, and impacts of culturally sensitive practices. The compilation of existing data includes identifying and analyzing data about mental health services within the Sioux Falls area, Minnehaha County, and the state of South Dakota. Along with compiling existing data, focus groups with service providers and community members were facilitated in order to understand perceived strengths, barriers, and needs when it comes to accessing mental health care. The data collected from the focus groups was analyzed by thematically coding the transcripts.

II. Background Literature

A. Mental Health Conversations: Global to Rural

Mental health is important to study because mental health and substance abuse problems are serious, common, and widespread health issues. According to the World Health Organization, depression is the leading cause for disability worldwide, and suicide is the fourth leading cause of death among individuals aged 15-29 years globally. Before the COVID-19 pandemic, individuals who had a mental health diagnosis died around 20 years earlier than those who did not.¹

Mental illness is widespread, and the COVID-19 pandemic has increased demand for care. Internationally, in 2019, the prevalence of mental illnesses ranged from 9.52% through 19.35% of a country's population having one or more mental or substance use disorders.² The continuous education and acknowledgment of mental health exponentially expanded the understanding and acknowledgment of experiencing mental illness symptoms. As the COVID-19 pandemic began to rise, mental health concerns also were on the rise: both isolation and virus exposure contributed to mental health needs. Amongst individuals with a COVID-19 diagnosis, the risk of depression was higher than the general population.³ Healthcare workers are not only highly exposed to the COVID-19 virus, but they are at high risk of psychiatric symptoms.⁴ The COVID-19 pandemic has also affected the general public as the prevalence of depression and mood disorder symptoms increased from pre-pandemic rates.⁵ Facing the stress of the pandemic and of grieving loved ones, not everyone was


¹ World Health Organization, "Mental Health," World Health Organization, 2022, https://www.who.int/health-topics/mental-health#tab=tab_1.

² Global Burden of Disease Collaborative Network, "Prevalence - Mental Disorders - Sex: Both - Age: Age-Standardized (Percent)," *Global Burden of Disease Study 2019 Results*. Seattle, WA: Institute for Health Metrics and Evaluation (IHME), 2021, <http://ghdx.healthdata.org/gbd-results-tool>.

³ Vindegaard, N. & Benros, M. E., "COVID-19 Pandemic and Mental Health consequences: Systematic Review of the Current Evidence," *Brain, Behavior, and Immunity*, 89 (2020): 531-542, <https://doi.org/10.1016/j.bbi.2020.05.048>.

⁴ Vindegaard, N. & Benros, M. E., 2020.

⁵ Robinson, Sutin, Daly, Jones, "A Systematic Review and Meta-analysis of Longitudinal Cohort Studies Comparing Mental Health Before Versus During the COVID-19 Pandemic in 2020," *Journal of Affective Disorders*, 296 (2022): 567-576, <https://doi.org/10.1016/j.jad.2021.09.098>.



equipped with healthy coping mechanisms. Consequently, the prevalence of substance use disorders is estimated at 2% of the world population having an alcohol or illicit drug disorder. Different regions of the world have various alcohol or illicit drug addictions, ranging from as low as .70% all the way through 6.52% of a country's population.⁶

In the United States, in 2020 alone, about one in five adults experienced a mental illness, including one in twenty individuals living with a serious mental illness. Suicide was the second leading cause of death for people aged 10-24.⁷ Suicide accounted for the loss of more than 45,979 American lives in 2020.⁸ In regards to marijuana use and methamphetamine use, the United States national average of usage for these substances reached rates of 18.7% and 1.0%, respectively, in 2019 to 2020.^{9,10} When it comes to Substance Use Disorder for both alcohol and pain relievers, the national average is 11% and 0.9%, respectively.¹¹

In recent years, awareness of mental health issues has grown; awareness increased dramatically in light of the COVID-19 pandemic, but efforts to raise awareness of mental health were beginning even before the pandemic. The WHO launched The WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health in 2019 detailing ways to reduce mental health stigma, increase the understanding of how mental health affects people everyday, increase

⁶ Global Burden of Disease Collaborative Network, "Prevalence - Substance Use Disorders - Sex: Both - Age: Age-Standardized (Percent)," *Institute for Health Metrics and Evaluation, Global Burden of Disease, 2019*, <http://ghdx.healthdata.org/gbd-results-tool>.


⁷ NAMI, "Mental Health Numbers."

⁸ NAMI, "Mental Health Numbers."

⁹ Center for Behavioral Health Statistics and Quality, "Results from the 2020 National Survey on Drug use and Health: Detailed Tables, Table 1.12B Methamphetamine Use in Lifetime, Past Year, and Past Month: Among People Aged 12 or Older; by Detailed Age Category, Percentages, 2019 and 2020," SAMHSA, January 11, 2022, <https://www.samhsa.gov/data/>.

¹⁰ Center for Behavioral Health Statistics and Quality, "Results from the 2020 National Survey on Drug use and Health: Detailed Tables, Table 1.7B Marijuana Use in Lifetime,, Past Year, and Past Month: Among People Aged 12 or Older; by Detailed Age Category, Percentages, 2019 and 2020," SAMHSA, January 11, 2022, <https://www.samhsa.gov/data/>.

¹¹ Center for Behavioral Health Statistics and Quality, "Results from the 2020 National Survey on Drug use and Health: Detailed Tables, Table 5.1B Substance Use Disorder for specific Substances in Past Year: Among People Aged 12 or Older; by Detailed Age Category, Percentages, 2019 and 2020," SAMHSA, January 11, 2022, <https://www.samhsa.gov/data/>.



accessibility of effective and efficient mental health care, and further research to improve mental health treatments.¹² In 2022, the WHO published the “World Mental Health Report: Transforming Mental Health for All,” which details the various social determinants that contribute to mental illness and negative mental health outcomes. The report also detailed ways in which the world can improve mental health efforts through effective governance and leadership, increase in funds, increase in public awareness, and an increase in mental health care competencies.¹³ At the same time, mental health efforts in the U.S. are positively changing as the effects of the pandemic uncovered the many perils individuals faced during the quarantine and shutdown periods. For example, in his 2022 State of the Union, President Biden announced a strategic plan to address the national mental health crisis, including plans to improve the capacity of the mental health system, connect more Americans to care, and support Americans by creating healthy environments through various programs, funding, and policies.¹⁴ Nevertheless, significant work still needs to be done to understand and address barriers to accessing mental health care.


B. High Risk Groups and Social Determinants of Mental Health

Various social determinants affect the prevalence of mental illness and access to mental health care. Holistically, understanding mental health and mental health issues means acknowledging social determinants of mental health. Different social factors affect the way individuals interact with mental health care institutions. Factors such as race and ethnicity, gender, sex, geography, class, housing situation, educational attainment, stigma, and judicial involvement all affect the way that various individuals

¹² World Health Organization, “The WHO special initiative for mental health (2019-2023): universal health coverage for mental health,” *World Health Organization*, 2019, <https://apps.who.int/iris/handle/10665/310981> (accessed October 16, 2022).

¹³ World Health Organization, “World Mental Health Report: Transforming Mental Health for All,” *World Health Organization*, 2022, <https://www.who.int/publications/i/item/9789240049338>.

¹⁴ “FACT SHEET: President Biden to Announce Strategy to Address Our National Mental Health Crisis, As Part of Unity Agenda in his First State of the Union,” The White House, March 1, 2022, <https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/>.



interact with mental health care. It is important to note that these various social factors can and sometimes will intersect and interact with each other.

When it comes to the prevalence of mental illness in the United States, rates vary by race and ethnicity as well as sexual orientation. Across racial and ethnic groups, all groups have rates of mental illness above 13%, but groups with the highest rate of mental illness have nearly three times the prevalence as groups with the lowest rate. Starting from least to greatest, rates of mental illness are estimated at 13.9% among non-Hispanic Asians, 16.6% among non-Hispanic Native Hawaiian or Other Pacific Islander, 17.3% among non-Hispanic Black or African-American, 18.4% among Hispanic or Latino, 18.7% among non-Hispanic American Indian or Alaska Native, 22.6% among non-Hispanic white, and 35.8% among non-Hispanic mixed/multiracial. Sexual minorities also have a relatively high rate of mental illness compared to their straight counterparts: lesbian, gay, or bisexual individuals have a mental illness prevalence rate of 47.4%.¹⁵

Not only does the prevalence of mental illness vary across racial and ethnic groups; so does access to mental health care. Overall, in the United States, 56% of all adults with any mental illness received no treatment from 2018 through 2019.¹⁶ However, access to and effectiveness of treatment is not equally distributed: Racial and ethnic groups who identify as non-white tend to have worse outcomes when it comes to mental health care.


The various factors that contribute to disparities in treatment include the lack of cultural and racial knowledge from the therapist.¹⁷ Many Black, Indigenous, and people of color (BIPOC) would prefer a therapist who looks like them due to a level of comfort when it comes to bringing up stressors that are related to race.¹⁸ A phenomenon called the error of omission happens in therapy when the client does not want to bring

¹⁵ NAMI, "Mental Health Numbers."

¹⁶ Byer, Colleen and Glaser, Tiffany, "Mental Health and Substance Use in South Dakota," South Dakota Department of Social Services, February 9, 2022, [Mental Health and Substance Use in South Dakota, February 9th, 2022 \(sd.gov\)](https://www.sd.gov/mental-health-and-substance-use-in-south-dakota).

¹⁷ Meyer, O.L. and Zane, N., "The Influence of Race and Ethnicity in Clients' Experiences of Mental Health Treatment," *J. Community Psychol.*, 41 (2013): 884-901, <https://doi.org/10.1002/jcop.21580>.

¹⁸ Myer, O.L. and Zane, N., 2013.



up race in order to not make the different raced therapist uncomfortable and the therapist does not want to bring up race so that they do not make their client uncomfortable; there is a disconnect between what should and should not be talked about in therapy, which leads to delays in therapeutic goals and even the relationship.

¹⁹ Other factors that affect access to care for BIPOC individuals are cultural stigmas (different groups view mental health and mental illness differently), racial and ethnic discrimination (high levels of discrimination lead to higher levels of stress which are linked to mental illness or poor mental health), and language barriers (individuals for whom English is not their first language or who have limited English proficiency are less likely to seek out and access resources).²⁰ Overall, individuals who are non-white tend to have a different experience in mental health care than those who are white.


Another factor is housing, with approximately 30% of the chronically unhoused population suffering from mental health conditions.²¹ Homelessness and mental illness are often thought of as a two-way street with one affecting the other. The primacy of meeting basic needs like shelter and food pushes the urgency of mental health concerns down the list, making it harder for individuals to access mental health care. The implementation of housing programs with a case management component tends to help alleviate stressors regarding housing. Individuals report lower levels of psychological distress as they follow through experimental programs that assist individuals with housing, employment, and education and remain housed for at least one year or experienced more days housed than a comparison group.²²

¹⁹ Cardemil, E.V., and Battle, C.L., "Guess Who's Coming to Therapy? Getting Comfortable with Conversations about Race and Ethnicity in Psychotherapy," *Professional Psychology: Research and Practice*, 34(3) (2003): 278-286, <https://doi.org/10.1037/0735-7028.34.3.278>.

²⁰ Bauer, A. M., Chen, C. N., & Alegría, M., "English language proficiency and mental health service use among Latino and Asian Americans with mental disorders," *Medical care*, 2010, 48(12), 1097-1104, <https://doi.org/10.1097/MLR.0b013e3181f80749>.

²¹ Substance Abuse and Mental Health Services Administration, "Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States," SAMHSA, 2011, https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/hr_c-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf.

²² Benston, A. E., "Housing Programs for Homeless Individuals with Mental Illness: Effects on Housing and Mental Health Outcomes," *Psychiatric Services*, 66(8) (2015): 806-816, <https://doi.org/10.1176/appi.ps.201400294>.



Age is also a social determinant of mental health. In regards to U.S. youth, 15% of them coped with at least one major depressive episode and 11% of them reported suffering from a severe major depressive episode.²³ Many do not access treatment. In 2018-2019, 60% of the teens who were diagnosed with major depressive disorder did not receive treatment within the past year. The impacts of the pandemic are felt by the youth as they try to come back to a sense of normalcy in their schools and studies.²⁴ From January to June 2021, in a survey for ninth through twelfth graders, approximately one in three high school students experienced poor mental health during the pandemic, and about 20% seriously considered suicide while 9% attempted suicide.²⁵ Family stress may be a contributor to the deteriorating mental health of the youth.²⁶ Other factors include, but are not limited to, regional access, lack of housing, lack of education, lack of food security, stigma surrounding mental health care, and judicial involvement.

People who are involved with the justice system are also more likely to suffer from negative mental health or a mental illness. The disparities are seen with incarceration, violent encounters with law enforcement, and punishment within the judicial system. Police are often first responders to people experiencing a mental health crisis, even though law enforcement officers are not necessarily equipped to manage individuals with a mental illness; as a result, one out of four people shot by law enforcement from 2015 to 2022 had a mental illness.²⁷ People with mental illness are also more likely to be incarcerated. About two million individuals who suffer from a mental illness episode are sent to jail each year. Not only are individuals sent to jail when they have a mental illness episode, but two out of five individuals incarcerated have a history of mental illness (including an estimated 37% of people in state and


²³ Byer and Glaser, "Mental Health in SD."

²⁴ Byer and Glaser, "Mental Health in SD."

²⁵ Jones et al., "Mental Health, Suicidality, and Connectedness Among High School Students During the COVID-19 Pandemic — Adolescent Behaviors and Experiences Survey, United States, January–June 2021" CDC, April 1, 2022, <https://www.cdc.gov/mmwr/volumes/71/su/su7103a3.htm>.

²⁶ Jones et al., "Mental health, Suicidality, and Connectedness Among High School Students During the COVID-19 Pandemic," 2022.

²⁷ NAMI, "Mental Health Numbers."



federal prisons and 44% of those in local jails).²⁸ The continued disparities are seen through the suicide rates, which is the leading cause of death in local jails.²⁹ Individuals with mental illness account for 4,000 individuals in solitary confinement in U.S. prisons, and non-white prisoners are more likely to go into solitary confinement, be injured, and stay longer in jail when they have a mental illness.³⁰

The judicial system as a whole is not designed to be a mental health institution. But due to a lack of available care in communities, there has been a transference of responsibility to these institutions, which complicates the lives of individuals who are unfortunately swept up by a system that was not intended for them. Not only are individuals who suffer from a mental illness more likely to be incarcerated, but 3 out of 5 prisoners with a history of mental illness do not receive mental health treatment while incarcerated in the state and federal prison.³¹ The prison environment itself is not conducive to mental health: Law enforcement within the prison system tends to use harsh language and more aggressive approaches to manage individuals who go through a mental health crisis.³²

Even after they are released from incarceration, people who have been justice-involved experience negative mental health risks. As a result of incarcerated individuals facing harsh treatment in state and local prisons, social reintegration becomes highly difficult. The stress of reintegration to society contributes to negative mental health. Recently released individuals must cope with the stress of following the strict rules of parole, the ostracism by family members, and the stigma associated with being recently reincarcerated.³³ Some individuals may cope by either abusing substances or falling back on older destructive behavior that got them involved with

²⁸ NAMI, "Mental Health Numbers."


²⁹ NAMI, "Mental Health Numbers."

³⁰ NAMI, "Mental Health Numbers."

³¹ NAMI, "Mental Health Numbers."

³² Miri Navasky & Karen O'Connor, "The New Asylums," PBS, (2005), Retrieved December 10, 2021, from <https://www.pbs.org/wgbh/frontline/film/showsasylums/>.

³³ Daniel C. Semenza & Nathan W. Link, "How does reentry get under the skin? Cumulative reintegration barriers and health in a sample of recently incarcerated men," *Social Science & Medicine*, 243 (2019): 1-9, <https://doi.org/10.1016/j.socscimed.2019.112618>.



the judicial system.³⁴ Difficulties meeting basic needs after incarceration contribute further to poor mental health. Once released from their sentence, individuals tend to not have many social programs they can access. This can be examined by individuals with incarceration status losing access to as SNAP (formerly known as food stamps.) The challenges faced by recently incarcerated individuals leave them with few employment opportunities due to family and community stigmatization and ostracism.³⁵ Even if incarcerated individuals are able to secure employment, they are more likely to work in low-skilled and low-paying occupations. Mental health is negatively impacted by the lack of social support and the stigma associated with being incarcerated.³⁶

Social determinants of mental health often intersect. For example, the challenges of incarcerated individuals compounds with racial and ethnic minority groups, lower incomes, lower educational attainment, and less access to housing. Likewise, for the youth who interact with the judicial system, about 70% have a diagnosable mental illness, and they are ten times more likely to suffer from psychosis than the youth in the community.³⁷ Juvenile detention centers are modeled after state and federal prisons and so are the disparities. Youth who are taken into the juvenile detention centers go through strenuous environments where their mental health, mental illness, and mental health care are not accounted for, nor are they receiving the help that they desperately need. The mental illness symptoms of youth in juvenile detention centers increase and are withheld from treatment, making the symptoms worse and the exhibition of behaviors worse.³⁸ The vicious cycle of the state and federal prison and the juvenile detention centers tends to leave individuals who suffer

³⁴ D.W. Seal, G.D. Eldrige, D. Kacanek, D. Binson, & R.j. MacGowan, "A longitudinal, qualitative analysis of the context of substance use and sexual behavior among 18- to 29-year-old men after their release from prison," *Social Science & Medicine*, 65 (2007): 2394-2406, <https://doi.org/10.1016/j.socscimed.2007.06.014>.

³⁵ United Nations Office on Drugs and Crime, "Introductory Handbook on The Prevention of Recidivism and the Social Reintegration of Offenders," *United Nations Office on Drugs and Crime*, 2018, https://www.unodc.org/documents/justice-and-prison-reform/18-02303_ebook.pdf.

³⁶ American Psychological Association, "From prisons to communities: Confronting re-entry challenges and social inequality," (2018), <https://www.apa.org/pi/ses/resources/indicator/2018/03/prisons-to-communities>.

³⁷ NAMI, "Mental Health Numbers."

³⁸ Miri Navasky & Karen O'Connor, "The New Asylums," *PBS*, 2005.



from negative mental health or mental illness in a worse situation than they originally were.

C. Declining Stigma

Although stigma remains a significant deterrent to seeking mental health care, the perceptions of mental health in the U.S. are positively changing towards acceptance and tolerance of discussions surrounding mental health. In 2019, 87% of adults agreed that having a mental health disorder is nothing to be ashamed of and 86% believed that people with mental health disorders can get better.³⁹ The decrease in stigma of mental health disorders could be due to increased awareness and familiarity with diagnoses, even through personal experience or that of a loved one.⁴⁰ When it comes to the topic of suicide, 91% of Americans surveyed believed that people who are suicidal can be treated and go on to live successful lives, 87% believed that suicide should be talked about more openly, and 79% believed that less stigma and shame around mental health disorders would lower suicide rates.⁴¹ The fostering of open and sincere discussions impacts the way that mental health and mental illness are perceived by the general population, and it also affects the way that policies are enacted, programs are conceived, and how effective mental health efforts can become.


Where it persists, stigma is a very strong social ideology that restricts access to mental health care. The way that stigma manifests itself is through the lack of seeking mental health care—for example, due to having attitudes of being able to handle a mental health crisis by themselves.⁴² Stigma looks different for various racial and ethnic groups, age groups, and gender groups; ethnic minorities, youth, and men are disproportionately affected by mental health stigma and they are less likely to seek out

³⁹ APA, “Americans Becoming More Open about Mental Health,” American Psychological Association, May 2019, <https://www.apa.org/news/press/releases/apa-mental-health-report.pdf>.

⁴⁰ APA, “Americans Opening Up About MH.”

⁴¹ APA, “Americans Opening Up About MH.”

⁴² Clement, S., Schauman, O., Graham, T, Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Thornicroft, G., “What is the Impact of Mental Health-Related Stigma on Help-Seeking? A Systematic Review of Quantitative and Qualitative Studies,” *Psychological Medicine*, 45(1) (2015): 11-27, <https://doi.org/10.1017/S0033291714000129>.



mental health care.⁴³ Stigma is also dependent on regional culture.⁴⁴ For example, rural communities tend to view mental health care in a more negative light.⁴⁵

Stigma derives from the lack of knowledge of mental health care. The specialized language used in mental health care, also, tends to lead to stigmatizing ideas. With the lack of knowledge and unfamiliarity with the vocabulary to follow the mental health professionals, stigmatizing paradigms are created in order to reject a socially unacceptable field. Overall, the lack of knowledge and understanding too often leads various groups to stigmatize and ostracize mental health care and individuals that seek out these resources.

D. Provider Shortages

The Health Resources and Services Administration (HRSA) identifies Health Professional Shortage Areas (HPSA) in order to provide awareness and urgency to address such shortages in primary care, dental health, and mental health. More than one-third of Americans live in mental health professional shortage areas—that is, communities that have fewer mental health providers than the minimum necessary given their population.

The effects of mental health provider shortages are greatly felt by rural communities. In U.S. nonmetropolitan areas in 2020, less than half (48%) of adults with a mental illness received treatment, and they had to travel, on average, twice as far to the nearest treatment center compared to residents of urban and suburban areas.⁴⁶


Telemental health promises to connect even the most remote households to services. However, when it comes to telemental health access, rural U.S. adults are twice as likely to lack broadband internet, which furthers the disparities in mental health care access. These geographical barriers to access contribute to the seeking of mental health care. To compound the rural effects, youth who live in more secluded

⁴³ Thornicroft, G., "Stigma and Discrimination Limit Access to Mental Health Care," *Epidemiologia e Psichiatria Sociale*, 17(1) (2008): 14-19, <https://doi.org/10.1017/S1121189X00002621>.

⁴⁴ Thornicroft, G., "Stigma and Discrimination".

⁴⁵ Thornicroft, G., "Stigma and Discrimination".

⁴⁶ NAMI, "Mental Health Numbers."



areas have an increased risk of suicide and tend to have fewer youth suicide prevention services.⁴⁷ The overall effects of mental health provider shortages lead to disproportionate rates of mental illness and access to mental health care.

E. Mental Health in South Dakota

In South Dakota, suicide rates tend to be higher than national averages. South Dakota has a suicide rate of 21 deaths/100,000 and Minnehaha county has a rate of 17.6 deaths/100,000 as compared to the national rate of 13.93 deaths/100,000.⁴⁸ In regards to adults who have been told that they have depression, 17.3% of South Dakota residents and 21% of Sioux Falls Metropolitan Statistical Area residents have been told about their diagnosis, while 19.9% of U.S. individuals have been told about their diagnosis.⁴⁹ The lack of help seeking, being able to afford mental illness treatments, and the lack of continuous preventative care among Major Depressive Disorder diagnoses are felt by lower income earners, unemployed, and American Indian populations in South Dakota, with deadly consequences. Among youth in South Dakota, 15% coped with at least one Major Depressive episode and 12% reported suffering from a severe major depressive episode in 2018-2019.⁵⁰

In 2020, the usage of substances in South Dakota such as methamphetamine and alcohol were greater than the national average: among South Dakotans, 1.5% used methamphetamines and 13.2% had an alcohol use disorder, compared to 0.9% and 11% (respectively) nationally.⁵¹ The only rates of substance use that were lower in South Dakota than the national average were marijuana at 13.4% (compared to 18.3% nationally) and pain relievers at 2.9% (compared to 3.6% nationally).⁵²

⁴⁷ NAMI, "Mental Health Numbers."


⁴⁸ Chima, C., Flicek, D., Hanson, P., Pendergrass, T. (2022), "2022 Community Health Assessment," <https://www.siouxfalls.org/community-health>.

⁴⁹ Sioux Falls Metro Area comprises Lincoln, McCook, Minnehaha, and Turner Counties. Chima et al., "2022 Community Health Assessment."

⁵⁰ Chima et al., "2022 Community Health Assessment."

⁵¹ Byer and Glaser, "Mental Health in SD."

⁵² Byer and Glaser, "Mental Health in SD."



When it comes to access to care, 52% of all adults in South Dakota with any mental illness received no treatment in 2018-2019.⁵³ The lack of access to care could be due to the shortage of mental health professionals, given that the whole state of South Dakota was designated as a Health Professional Shortage Area (HPSA) with a mean score of 17.82 (on a scale from 9 to 24).⁵⁴ Being designated any HPSA score means that the particular county area is suffering from a professional shortage; the higher the score, the worse the shortage. Another factor that affects access to care is insurance. In 2021, about 9.3% of Sioux Falls residents were not insured, and among uninsured individuals, about 50.9% were unemployed and 23.6% fell below the poverty threshold, making it unlikely they could afford to pay out-of-pocket for care.⁵⁵

Another social determinant shaping access to mental health care is socioeconomic class, including housing situation, education level, and the ability to meet basic needs. As previously established, in South Dakota, individuals who have a lower income, are unable to work, or who have a lower educational attainment tend to have higher rates of depression. Typically, individuals defined as a middle and upper class tend to have reliable income, which helps with meeting basic needs and reducing psychological distress.⁵⁶ Higher educational attainment tends to mean higher, more stable, and more reliable income, along with access to health insurance benefits. Alongside these factors, the ability to meet basic needs, such as food security, is another aspect that affects the distress levels of individuals. For example, people experiencing food insecurity tend to miss meals due to the high cost associated with food which is also associated with high reported levels of psychological distress.⁵⁷ The


⁵³ Byer and Glaser, "Mental Health in SD."

⁵⁴ Mean was found by using the HPSA Scores of the four facilities listed in Minnehaha county; the range is 11-19. "HPSA Find;" HRSA Data Warehouse, accessed November 2, 2022; <https://data.hrsa.gov/tools/shortage-area/hpsa-find>.

⁵⁵ U.S. Census Bureau; American Community Survey, 2021: ACS 1-Year Estimates Subject Tables, Table S2701.

⁵⁶ Swaziek, Z. and Wozniak, A. (2020), Disparities Old and New in U.S. Mental Health during the COVID-19 Pandemic*. *Fiscal Studies*, 41: 709-732. <https://doi.org/10.1111/1475-5890.12244>.

⁵⁷ Friel, S., Berry, H., Dinh, H., O'Brien, L., and Walls, H.L., "The Impact of Drought on the Association Between Food Security and Mental Health in a Nationally Representative Australian Sample," *BMC Public Health*, 14 (2014): 1102, <https://doi.org/10.1186/1471-2458-14-1102>.



financial strain is one aspect of food insecurity, but other contributing factors include food deserts, physical access to a grocery store, and the ability to get to the grocery store.

Social determinants such as race and ethnicity, gender, sexual orientation, age, region, justice involvement, , and socioeconomic status are critical to understanding mental health needs. The way that these factors influence mental illness and mental health care is an aspect that Sioux Falls is already noticing. The purpose of this report is to compile all of the social aspects that contribute to each other. One city problem is not more important than the other, but centering the conversation will help focus city-wide efforts to better understand, implement, and fund various programs. By no means are these factors the only contributors to the lack of access to mental health care, but several rose to prominence among participants, who found them important (see findings sections for more information).

F. Community Mental Health Needs Assessment

Various mental health needs assessments have been done around the world and the country, and they are a useful tool for learning more about needs and barriers to accessing mental health care. In response to limited local research on mental health in the Sioux Falls area, this project is intended to contribute to local understanding of strengths and needs around mental health. The following section focuses on how other needs assessments conceptualized their projects and the methodological insights that they offered for this current project.

1. Motives for Mental Health Needs Assessments

Community-wide mental health needs assessments have diverse objectives to accomplish. Many needs assessments focus on the deep understanding of particular communities by exploring the systemic and psychosocial barriers to accessing mental health services. Specifically focusing on the accessibility of mental health services, these studies attempt to conceptualize the various factors that impede access: factors

such as culture, stigma, insurance, language, and availability of services are major points of inquiry. Other social positioning variables are also points of study such as race/ethnicity, gender, and geographical region. The literature suggests a holistic approach is necessary in order to completely understand the nuances of accessibility of mental health services.

Needs assessments also explore various psychosocial and systemic barriers to accessing mental health services, sometimes focusing on specific subgroups within larger communities or root causes of specific barriers such as provider shortages. Other studies seek to understand the effectiveness of specific community mental health services and further the development of services to effectively respond to clients' needs.⁵⁸ For instance, in a mid-size city in Massachusetts, a mental health needs assessment explored mental health needs of a racially and ethnically diverse local community in order to help inform the planning and provision of mental health services.⁵⁹ Other efforts are exploring the inflated rate of psychopathology among refugees and their lack of help-seeking behaviors.⁶⁰ In a similar study, researchers wanted to understand the barriers to accessing mental health services in a fast growing immigrant population in the province of Alberta, Canada.⁶¹ Other researchers sought to deeply understand perceptions of mental health services among the Latino population through a collaborative effort with The Latino Mental Health Project.⁶² In

⁵⁸ Hanson, L., Houde, D., McDowell, M., & Dixon, L., "A Population-based Needs Assessment for Mental Health Services," *Administration and Policy in Mental Health and Mental Health Services Research*, 2006, 34(3), 233–242, <https://doi.org/10.1007/s10488-006-0103-x>.

⁵⁹ Torres Stone, R. A., Cardemil, E. V., Keefe, K., Bik, P., Dyer, Z., & Clark, K. E., "A Community Mental Health Needs Assessment of a Racially and Ethnically Diverse Population in New England: Narratives from Community Stakeholders," *Community Mental Health Journal*, 2020, 56(5), 947–958. <https://doi.org/10.1007/s10597-020-00562-2>.

⁶⁰ Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. "Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review," *Clinical Psychology Review*, 2020, 75, 101812. <https://doi.org/10.1016/j.cpr.2019.101812>.

⁶¹ Salami, B., Salma, J., & Hegadoren, K., "Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers," *International Journal of Mental Health Nursing*, 2018, 28(1), 152–161. <https://doi.org/10.1111/inm.12512>.

⁶² Cardemil, E. V., Adams, S. T., Calista, J. L., Connell, J., Encarnación, J., Esparza, N. K., Frohock, J., Hicks, E., Kim, S., Kokernak, G., McGrenra, M., Mestre, R., Pérez, M., Pinedo, T. M., Quagan, R., Rivera, C., Taucer, P., & Wang, E., "The Latino Mental Health Project: A Local Mental Health Needs Assessment," *Administration and Policy in Mental Health and Mental Health Services Research*, 2007, 34(4), 331–341. <https://doi.org/10.1007/s10488-007-0113-3>.

another study, researchers explored barriers of mental health treatment engagement in Latina adolescents who have a history of depressive symptoms during their adolescent years.⁶³ Broadly, another study explored the various perceptions of adolescents in order to increase their engagement in treatments.⁶⁴ In a study conducted in the state of Georgia, researchers explored the shortages of mental health professionals.⁶⁵ Globally, the WHO analyzed world data sets in order to understand the various correlations between low-, mid-, and high-income countries and the determinants of mental health service dropout rates.⁶⁶ In another study, the researchers focused their efforts to understand the barriers to seeking help from five different universities in the UK.⁶⁷ In a similar study in Australia, researchers explored mental health service use and access by adolescents and the various determinants that impede help seeking behavior.⁶⁸ Other studies investigate perceived barriers men have to accessing mental health services in a city like Vancouver.⁶⁹ Overall, the main focus of these needs assessments is to holistically understand the various systemic and psychosocial factors that affect access to mental health services. Although Sioux

⁶³ Stafford, A. M., & Draucker, C. B., "Barriers to and Facilitators of Mental Health Treatment Engagement Among Latina Adolescents," *Community Mental Health Journal*, 2019 56(4), 662–669. <https://doi.org/10.1007/s10597-019-00527-0>.

⁶⁴ Roberts, M., Jones, J., Garcia, L., & Techau, A., "Adolescents' perceptions of barriers and facilitators to engaging in mental health treatment: A qualitative meta-synthesis," *Journal of Child and Adolescent Psychiatric Nursing*, 2021, Published. <https://doi.org/10.1111/jcap.12354>.


⁶⁵ Walker, E. R., Berry, F. W., Citron, T., Fitzgerald, J., Rapaport, M. H., Stephens, B., & Druss, B. G., "Psychiatric Workforce Needs and Recommendations for the Community Mental Health System: A State Needs Assessment," *Psychiatric Services*, 2015 66(2), 115–117. <https://doi.org/10.1176/appi.ps.201400530>.

⁶⁶ Fernández, D., Vigo, D., Sampson, N. A., Hwang, I., Aguilar-Gaxiola, S., Al-Hamzawi, A. O., Alonso, J., Andrade, L. H., Bromet, E. J., de Girolamo, G., de Jonge, P., Florescu, S., Gureje, O., Hinkov, H., Hu, C., Karam, E. G., Karam, G., Kawakami, N., Kiejna, A., & Haro, J. M., "Patterns of care and dropout rates from outpatient mental healthcare in low-, middle- and high-income countries from the World Health Organization's World Mental Health Survey Initiative," *Psychological Medicine*, 2020, 51(12), 2104–2116. <https://doi.org/10.1017/s0033291720000884>.

⁶⁷ Broglia, E., Millings, A., & Barkham, M., "Student mental health profiles and barriers to help seeking: When and why students seek help for a mental health concern," *Counseling and Psychotherapy Research*, 2021, 21(4), 816–826. <https://doi.org/10.1002/capr.12462>.

⁶⁸ Platell, M., Martin, K., Fisher, C., & Cook, A., "Comparing adolescent and service provider perceptions on the barriers to mental health service use: A sequential mixed methods approach," *Children and Youth Services Review*, 2020, 115, 105101. <https://doi.org/10.1016/j.childyouth.2020.105101>.

⁶⁹ Seidler, Z. E., Rice, S. M., Kealy, D., Oliffe, J. L., & Ogrodniczuk, J. S., "What gets in the way? Men's perspectives of barriers to mental health services," *International Journal of Social Psychiatry*, 2019, 66(2), 105–110. <https://doi.org/10.1177/0020764019886336>.



Falls differs demographically from the communities in some of the aforementioned studies, the variables they included should also be considered in order to conceptualize the current mental health situation of Sioux Falls residents.

Meta-analyses have explored and evaluated methodologies used to acquire data for mental health needs assessments. An Australian report evaluates methodologies to conduct mental health needs assessments in a culturally diverse population.⁷⁰ Another study wanted to explore a multi-state effort to facilitate collaboration and identify deficiencies in public mental health systems for training improvements and foster collaboration and information exchange across the southeastern United States.⁷¹ Another study focused on evaluating how other mental health needs assessments are conducted around the world, building up the importance of mixed method approaches to data collection.⁷² It is important to understand the various methods that are effective at understanding the perceptions of mental health services and accessing these services. The following section summarizes methodological insights derived from this literature, which guided the design of the present mental health needs assessment for Sioux Falls.

2. Methodology of Mental Health Needs Assessments

Mental health needs assessments have many ways of collecting data from a diverse range of participants. Depending on the nature of the needs assessment, some methods would be more appropriate than others. Methods include (but are not limited to) interviews, surveys, specific valid mental health/mental illness inventories, focus groups, public data sets, and coding of previous mental health needs assessments. Depending on the nature of the mental health needs assessment,

⁷⁰ Larson, A., Frkovic, I., van Kooten-Prasad, M., & Manderson, L., "Mental Health Needs Assessment in Australia's Culturally Diverse Society," *Transcultural Psychiatry*, 2001, 38(3), 333–347. <https://doi.org/10.1177/136346150103800304>.

⁷¹ Walker, E. R., Moore, E., Tapscott, S., Alperin, M., Cummings, J. R., & Druss, B. G., "Developing Regional Mental Health Priorities: Mixed-Methods Needs Assessment of Eight States in the Southeastern United States," *Psychiatric Services*, 2021, 72(3), 358–361. <https://doi.org/10.1176/appi.ps.202000141>.

⁷² Joska, J., & Flisher, A. J., "The assessment of need for mental health services," *Social Psychiatry and Psychiatric Epidemiology*, 2005, 40(7), 529–539. <https://doi.org/10.1007/s00127-005-0920-3>.

different methods may be used individually or investigators may invoke a mixed methods approach. The following table lists various methods along with their pros and cons for mental health needs assessments. It should be noted that one method is not always better than the other; they each have their own strengths and weaknesses. Therefore, it is encouraged to adopt a mixed method approach.


Table 1. Comparison of research methods for mental health needs assessments

Method		Pros	Cons	Use
Interviews (Qualitative)	One-on-one method, usually following a guided questionnaire that encourages the individual being interviewed to answer in a loquacious manner	Good for mental health needs assessments that want to deeply understand the nuances of various facets of the topic surrounding mental health	Findings may be unique to the individuals being interviewed and may not represent a whole population; it is usually not generalizable	Common for mental health needs assessments that want to begin to understand the factors of the topic of mental health
Focus Groups (Qualitative)	Usually, a group of four to twelve participants who are interviewed at once	Good for mental health needs assessments that want to deeply understand the nuances of mental health with a group; it can be (to an extent) broadly generalizable to greater populations	Group discussions can deter certain participants; some participants can be overbearing of the discussion; some perceptions and opinions can be left out due to trying to fit in with the group	Common for mental health needs assessments that want to understand how various populations perceive mental health needs

Surveys (Both Qualitative and Quantitative)	A questionnaire of variable length that asks diverse factors of a research topic; questions can be both open or closed as well as have Likert scales	Good for mental health needs assessments that have a basis of understanding of mental health needs and want quantifiable information; surveys can be generalizable with a representative sample and sufficient sample size	Surveys are limited to the depth of the understanding of the researchers who created the survey	Common for mental health needs assessments that would like to understand a representation of individual views and life experiences; they are usually used to implement or evaluate some sort of policy change or program
Mental Health/Mental Illness inventories (Quantitative)	Utilization of reliable and valid questionnaires that tend to yield similar results	Good for mental health needs assessments that seek to associate various psychosocial phenomena to mental health/mental illness	Results are extremely restricted to the inventories and associations made; can be generalizable, only if the association is strong enough and statistically significant; various factors of mental health could be lost due to the tight boundaries of the inventories used	Common for mental health needs assessments that would like to associate specific factors to mental health and mental health need

Public Data Sets (Quantitative)	Utilization of public data sets, such as the U.S. Census and the General Social Survey, that collect various representative data from the whole United States in order to run various statistical analyses to infer specific associations between variables	Good for mental health needs assessments that would like to seek associations between specific factors and mental health and mental health needs	Results can be generalizable to specific geographical regions, though many data sets are unreliable at small geographic scale; some public data sets could miss important populations	Common for mental health needs assessments that want to associate various factors to mental health needs; usually used in the context of influencing policy change or program implementation on a larger scale
Coding of Previous Mental Health Needs Assessments (Quantitative)	Using databases in order to acquire previous mental health needs assessments and code for specific factors that relate to the research question	Good for mental health needs assessments that would like to analyze previous results in order to look for patterns, in relation to the research question(s)	Analysis and results are limited to the previous data collected; usually, cannot be generalized to view the present	Common for mental health needs assessments that would like to understand the trajectory of mental health and mental health needs

Overall, the various methodology used in mental health needs assessments highly depend on the nature of the needs assessment. Mental health needs assessments that seek to understand the perceptions of mental health and mental health needs tend to use more qualitative methods such as interviews and focus groups in order to gain a deep, nuanced understanding. Other types of mental health



needs assessments seek to change policies or implement programs, and such mental health needs assessments tend to use a mixed methods approach, combining surveys, interviews, and focus groups. Other mental health needs assessments seek to associate various factors to mental health and mental health needs in order to better understand the strength of such associations. Depending on the nature of the mental health needs assessment, different methods may be used. For the purpose of the current project, the research is intended to deeply understand the various factors that affect mental health and mental health needs. Accordingly, the methods used for this project are both interviews and focus groups.


3. Other Community Findings

The many mental health needs assessments conducted in other communities found common barriers and provided a new facet to the issue of mental health needs. Commonly uncovered barriers range from socioeconomic barriers (i.e. insurance coverage, affordability of services, etc.) to industry barriers (i.e. culturally competent providers, appropriate services, etc.) and even cultural barriers (i.e. services not offered in a different language, cultural stigma, etc.). The various barriers found by many of the mental health needs assessments have a strong relevance to the local Sioux Falls community. Sioux Falls is growing in diverse populations and such populations require diverse services.

Across the literature, socioeconomic barriers tend to affect access to mental health services. A meta-analysis study of access to mental health care identified financial challenges, transportation difficulties, insecure housing, and immigration status as socioeconomic barriers.⁷³ In another mental health needs assessment that focused on Latina adolescents, one of the many barriers identified was the cost of seeking help or the fact that some insurance policies do not cover the treatment that individuals were seeking.⁷⁴ A mental health needs assessment focused on adolescents

⁷³ Byrow et al. 2020

⁷⁴ Stafford & Draucker 2020



found people struggled with not being able to take off work in order to attend a regular therapy session or being able to afford the high cost treatment.⁷⁵ In a global mental health needs assessment, the results suggest that insurance coverage affects the rate of dropping out of psychiatric treatment: this behavior was more common among individuals who did not have health insurance over those individuals who did.⁷⁶ These various socioeconomic factors all affect seeking and continuing treatment. Although the mental health needs assessments pooled data from extremely diverse communities, the growing diversity within the Sioux Falls community is expected to see similar patterns. Socioeconomic barriers are only one facet to the complex issue of mental health services accessibility.

Another facet that affects mental health service accessibility are industry barriers. In one mental health needs assessment done in New England that focused on ethnically diverse populations, two industry barriers were the difficulties of navigating the mental health services and the dearth of culturally competent providers that impeded access to mental health services.⁷⁷ In another mental health needs assessment that focused on the southeastern part of the U.S. (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee), the researchers found that the region suffers from shortages in psychiatric care that includes adult and child psychologists, mental health counselors, social workers, and school psychologists.⁷⁸ In a similar southeastern mental health needs assessment, the major findings were that mental health organizations had difficulty trying to find qualified candidates, filling open positions, and retaining staff, along with challenges with recruitment costs and psychiatrists' fees, extra time for training, and continuity of care. All of these factors affect the effectiveness and efficiency of mental health services.⁷⁹ Another study that primarily focused on refugees found industry barriers including the lack of culturally competent therapists and lack of outside resource


⁷⁵ Roberts et al. 2021

⁷⁶ Frenández et al. 2020

⁷⁷ Torres et al. 2020

⁷⁸ Walker et al. 2021

⁷⁹ Walker et al. 2015




support or delayed support.⁸⁰ Although these complex factors are largely seen in different geographical regions with diverse populations, the Sioux Falls community may also experience such factors within the industry of mental health services. The Sioux Falls community has been established to experience professional shortages as described by HRSA. Perhaps some of these findings contribute to the mental health professional shortage that the community is experiencing. However, the various factors that contribute to professional shortages could be due to the fact that Sioux Falls is located in a predominantly rural state and region, which makes it difficult for mental health organizations to recruit and retain mental health professionals. As the population in Sioux Falls keeps growing, the mental health system—which is already stretched thin—may experience further disparities as people try to navigate socioeconomic and industry barriers. However, the diverse populations and their diverse cultures may also be another complex factor adding on the already complex issue of mental health access.

The final facet that has been often found to affect access to mental health accessibility is cultural barriers. Previous mental health needs assessments tend to highlight diverse cultural conceptualizations of mental health and mental illness among different population groups, including youth, immigrants, and multilingual communities. Various regions and populations in the United States perceive mental health and its contributing factors differently. For example, in a study of adolescents, the researchers concluded that adolescents need flexibility, consistency, and trust in order for psychological treatments to be effective.⁸¹ Within the same study, they also found that the main barriers to access and use of mental health services were the lack of guidance for services or previous negative experiences.⁸² Some of the major concerns in the same study were confusing intake processes and service entry, invalidating experiences, limited resources, non-youth friendly service features, and

⁸⁰ Salami, Salma, & Hegadoren 2018

⁸¹ Platell et al 2020.

⁸² Platell et al 2020.



cost.⁸³ Adolescents experience cultural barriers in the sense that they perceive mental health in a particular way that views mental health and mental health treatments in a stigmatizing manner. In a study that focused on U.S. adolescents, the researchers concluded that although stigma is declining, stigma was still a barrier for these adolescents, choice was integral to engagement in psychiatric treatments, the therapeutic relationship was crucial for engagement, and mental health literacy was significant in help-seeking behavior.⁸⁴ Diverse cultures also have different ways of viewing mental health and mental illness. In a study of U.S. Latina adolescents, the main barriers the researchers found were negative beliefs about depression and its treatments, negative experiences with treatment, and the inability to trust and connect with mental health professionals.⁸⁵ More broadly, in a study that consisted of individuals who spoke English, Spanish, and Vietnamese in a New England city, the researchers concluded that language barriers, cultural stigma within their ethnic groups, mental health literacy, and non-western conceptualizations of mental health all contributed to the lack of seeking help.⁸⁶ All of these cultural barriers affect the seeking of mental health services. Although the various studies were conducted in extremely diverse regions of the United States, the growing diversity of the Sioux Falls community will present similar challenges as the current mental health organization system adapts to keep up with change.

Overall, the three common barriers found in previous mental health needs assessments were socioeconomic, industry, and cultural barriers. Despite the various assessments being conducted in a different context than that of Sioux Falls, much of the past findings are expected to be seen in the Sioux Falls community.

⁸³ Platell et al 2020.

⁸⁴ Roberts et al 2021.

⁸⁵ Stafford & Drauker 2020.

⁸⁶ Torres et al 2020.

III. Methods

For the present study, researchers chose focus groups and interviews in order to gain a deeper understanding of the perceptions of strengths and needs in the Sioux Falls area. The researchers held a total of 13 focus groups and several interviews with two distinct groups: (1) stakeholders/providers and (2) community members (see Table 2). Community member focus groups and interviews were conducted in both English and Spanish. The stakeholder/provider and community members adhered to different recruitment protocols and discussion guides. The focus group guides were developed in consultation with Family Services Inc., the Link Community Triage Center, Lost & Found, Avera Behavioral Health, Falls Community Health, and the 211 Helpline Center. Each set of focus groups and interviews are described below.


In addition to focus groups and interviews, researchers analyzed the resources from 211 Helpline Center's 2021 Mental Health Guide Sioux Falls. Specifically, analyzing the range of costs and what types of insurance is accepted. Findings from analysis are integrated within the "Cost & Insurance" section in the "IV. Findings" section.

A. Focus Groups

(1) Stakeholder/Provider Focus Groups

The stakeholder/provider focus groups were initially divided by stakeholders and mental health providers. The initial division between stakeholders and providers was intended to keep the two groups homogeneous. The researchers believed that these two populations would have different perspectives on mental health needs in Sioux Falls. However, due to scheduling constraints, some initial focus groups had a mix of stakeholders and providers. The researchers determined that conversations from mixed groups did not differ significantly from homogenous groups; therefore, the remaining focus groups consisted of a mix between stakeholders and providers.

The stakeholder/provider focus groups followed a standard format where the facilitator started the group with informed consent, an orientation of the topics being



covered during the discussion, and brief introductions, then began a guided discussion with questions regarding the topics in the protocol. The stakeholder/provider groups were asked about their definitions of mental health, current resource strengths, community needs, common barriers to accessing mental health care, and future directions. A copy of the protocol is provided in the appendix.


During the discussion, researchers guided an activity where participants were given 10 stickers to award to topics displayed at the front of the room. As participants engaged in discussion, researchers noted main discussion themes under three broad topics: strengths, barriers, and needs. Facilitators wrote down these main themes on large pieces of paper and asked participants to award their 10 stickers based on their perceptions of the importance of the themes (see Table 3). The activity helped researchers determine which topics were most pertinent to each focus group.

The stakeholder/provider focus groups were hosted in a semi neutral location at Augustana University's Welcome Center in a medium size meeting room. The stakeholder/provider group participants did not receive any compensation. In total, 57 stakeholders/providers participated in 10 focus groups. Focus group size ranged from two to eight participants (see Table 2).

(2) Community Member Focus Groups

As for the community members, researchers determined that facilitating focus groups in Spanish and English would add varying perspectives from different cultural and language backgrounds to the conversation about the mental health needs in Sioux Falls. The Spanish community member groups were facilitated by the researchers in Spanish to encourage members to express their concerns in a language that is comfortable for this population. The English groups were facilitated by the researchers in English to encourage members to express their concerns in a language that is comfortable, as well.

The Spanish and English groups followed the same protocol, translated for their respective groups. Copies of both the Spanish and English community member



protocols are provided in the appendix. The community members were asked about their perceptions of mental health, their knowledge of substance use disorder, depression, and anxiety along with recognition of symptoms. They were also asked about their awareness of mental health resources in Sioux Falls, their experiences with mental health resources, and what types of resources they would like to see. At the end of the focus groups, participants were asked to fill out a demographic questionnaire, which is provided in the appendix (see Table 4, also in the appendix, for a summary of results).

The community member focus groups were held in a neutral location in a meeting room at the Downtown Library in Sioux Falls. The community members were each compensated with a \$25 gift card to a grocery store. A total of 13 community members participated in the English focus groups and a total of seven community members participated in the Spanish focus groups. In total, 20 community members participated in a focus group (see Table 2).

B. Interviews


In addition to focus groups, individual interviews were offered in order to maximize participation. The researchers also wanted to provide an accessible option for individuals who wished to participate but were unable to attend a focus group due to the fear of contracting the COVID-19 virus or who had a time conflict with the group meetings. Interviews followed the same script as the focus groups for each type of participant (i.e., a community member interview followed the community member focus group script). A total of seven individuals participated in the stakeholder/practitioner interviews; a total of five individuals participated in a Spanish or English community member interview (see Table 2).

Table 2. Focus groups and interview participation.

Focus Group	Date	Provider/Stakeholder (P/S) or Community Member (CM)	Number of Participants
1	March 16, 2022	P/S	8
2	March 17, 2022	P/S	5
3	March 18, 2022	P/S	5
4	March 23, 2022	P/S	2
5	March 23, 2022	P/S	7
6	March 24, 2022	P/S	5
7	June 7, 2022	P/S	3
8	June 7, 2022	P/S	8
9	June 9, 2022	P/S	7
10	June 10, 2022	P/S	7
11	June 14, 2022	CM - English	5
12	June 15, 2022	CM - English	8
13	June 28, 2022	CM - Spanish	7
Interviews	March - July 2022	P/S	7
Interviews	June - July 2022	CM - English/Spanish	5
Total CM:			25
Total P/S:			64

C. Recruitment

The stakeholder/provider focus groups and interviews followed different recruitment protocols than the Spanish and English community member groups. The provider recruitment consisted of utilizing the 211 Helpline Center's "Mental Health Guide: Sioux Falls 2021" to identify and solicit mental health care workers. Other



stakeholders are people who administer an organization that works with populations who may have unmet mental health needs. Stakeholders were recruited via recommendations from partner organizations and word of mouth. Researchers initially focused recruitment on stakeholders who work with specific groups: people in the justice system, with low socioeconomic status, immigrants, or children. However, participation was not strictly limited to people working with those populations. The groups consulted for the recruitment of the report were asked for recommendations and referrals from their professional networks. The stakeholders/providers who participated were also asked to encourage anyone they know who works in the same field to participate in future focus groups or interviews.


Recruitment for the Spanish and English community member focus groups and interviews consisted of displaying flyers in public areas and businesses. The flyers were also displayed on various social media sites. The stakeholders/provider participants were also asked to display flyers in their organizations and on their organizations' social media for clients and other constituents to see. The flyers were translated to Spanish and these flyers were displayed in Latin American businesses. The Spanish flyers were also displayed on various Hispanic and Latine social media sites and organizations that cater to such a population.

D. Analysis

Focus groups and interviews were audio recorded, with the verbal and written consent of the participants, and transcribed. The stakeholder/provider focus group transcripts were thematically coded using Taguette.⁸⁷

In order to ensure opinions, perspectives, and perceptions were fully captured, every single statement was tagged with a theme. Around one hundred tags were created to code the transcripts. The codes consisted of themes in awareness, barriers, challenges, demographics of participants, mental health definitions, needs, negative

⁸⁷ Rampin et al., "Taguette: open-source qualitative data analysis. *Journal of Open Source Software*", 2001, 6(68), 3522, <https://doi.org/10.21105/joss.03522>.



interactions with organizations or negative perceptions of community members, solutions, and positive interactions with organizations or positive perceptions of community members. The tags encompass the various topics discussed in the focus groups. The stakeholder/provider groups reached a point of saturation by the seventh focus group session; reaching saturation means that the eighth through tenth focus groups did not add significantly new information.

To increase consistency in tagging, the two researchers thematically coded two transcripts together; this helped to ensure the development of codes were in agreement with each other. For seven transcripts, the two researchers each coded half of every transcript and passed the latter half to each other in order to complete; this further helped to ensure interrater reliability. The researchers also coded another transcript together in the middle of the seven transcripts to ensure that codes were being applied consistently. A total of ten transcripts were coded.

In any research project, researchers' personal knowledge of the research questions may affect the way codes are created and applied. In the case of this project, both researchers have limited practical experience with the topics, but have a strong academic knowledge of the research questions. That being said, the way codes were created and applied may have a source of bias through the researchers' lack of practical knowledge.


In addition to coding and analyzing themes, researchers considered the results of an activity facilitated in the stakeholder/provider focus groups. The object of the activity was to further understand the participants' priorities. Participants were given 10 stickers to award to topics displayed at the front of the room regarding three general themes: strengths, barriers, and needs. The three general categories (strengths, barriers, and needs) were presented to the participants intentionally to force the participants to choose which subpoint within the general themes that they, personally, believed to be the most important point to address in the community. The number stickers awarded were counted in each category, and the activity supplemented the focus group discussion, which captured the main themes that were

being heard during the latter half of the discussion. The discussion did not stop during the activity as the researchers gave participants the opportunity to amend the themes and further reflect on topics that they were most interested in discussing; this portion of the discussion allowed for further qualitative data saturation as participants continued to talk about topics that were most salient to them and their organizations. The activity results provided a deeper insight to the coded themes from the transcripts (for a summary of results, see Table 3).

Table 3. Summary of poster activity results.

Strengths		Barriers		Needs	
Theme	Votes	Theme	Votes	Theme	Votes
Abundant Resources	14	Insurance/Cost	50	More Providers	45
Decreasing Stigma	13	Waitlists/Demand	40	Housing	27
Collaboration	9	Diversity	35	Funding	26
Crisis Care	5	Lack of Awareness	18	Services for Youth	20
211 Helpline	5	Transportation	16	Provider Support	16
Anxiety/Depression Care	3	Stigma	15	Wraparound Services	15
Passionate Workers	3	Eligibility	13	Education	13
Community	1	Family Involvement	6	Long Term Care	12
-	-	Collaboration	4	Preventative Care	9
-	-	Childcare	4	Medication Access	7
Total:	53	Total:	201	Total:	190

Due to lower participation in the community members focus groups and interviews, the researchers did not thematically code the community member transcripts. Instead, the results of these focus groups and interviews were considered



in comparison to findings from the stakeholder/provider groups. In this report, excerpts and generalizations from community member transcripts are used to illustrate concordance or discrepancies between the perspectives of community members and stakeholders/providers where they arise. Note that whenever the community members' opinions are mentioned, they are not a holistic representation of the Sioux Falls community.

IV. Findings


This section summarizes the major themes that emerged in focus groups and interviews. The stakeholder/provider results are categorized into four themes: mental health definitions, strengths, barriers & challenges, and needs. Under each broader theme, the results from the focus groups are presented in the order of importance based on the perceptions of the researchers, the prevalence of themes across focus groups, and the weight given to topics during the sticker activity; for readability and clarity, related topics are presented together.

A. Mental Health Definitions

Stakeholders and providers defined mental health holistically and drew parallels to physical health while also emphasizing the universality of mental health. When asked to define mental health, stakeholders and providers most commonly related mental health to an aspect of wellbeing which encapsulates not only mental health, but physical, financial, cultural, spiritual, and emotional health. When describing this definition of mental health, participants often started off by comparing mental health to physical health and how there are varying levels of this type of health from person to person. Another common perspective related to wellbeing was looking at mental health holistically and how different aspects of wellbeing may affect mental health. Not only is mental health related to emotions, but it is affected by biological, social, and environmental factors. One provider defined mental health this way:

I think to me mental health is that the sum of all the things that are impacting a person, and it can be a positive impact, it can be a negative impact, it can be one area, it can be multiple areas, but it's really the sum of all the things that are around and within a person. They may not need us, they might do [...] wonderful, everything is great, or they might need us. So there's the sum of the whole of everything going on around them.

One unifying comment, which reflected a view that was mentioned several times by stakeholders and providers, is that everyone has mental health, whether it is positive



or negative. Everyone has their own unique journey with mental health that is ever changing on the continuum. As one stakeholder put it:


I also think it's something that's a journey and something that's constantly changing. You know, just like we experience all sorts of things every day that impact our mental health, just like everyone has mentioned, environmental and physical and all of those things, those things change daily, and so our mental health is a journey.

Although providers and stakeholders spoke mostly positively about mental health and its sources, the discussion often shifted negatively when mental illness, the other side of the continuum, was mentioned.

When asked to describe mental health, many participants from every type of focus group started listing mental illnesses like depression, anxiety, or bipolar disorder. This was typically followed with the notion that mental health has a negative connotation associated with it. One common tag that accompanied the descriptions of mental illness was criminality. Participants mentioned that many individuals struggling with mental illness are labeled as criminals and, therefore, treated as such. One stakeholder stated how this association is known amongst other group members, "So we work largely with a population that's been involved in the criminal justice system. And we all know that simply having mental health problems, like severe mental health problems, can get you incarcerated, basically." Participants from stakeholder/provider and community member groups alike believed that these associations between mental illness and criminality were unfounded and stem from problems of mental health stigma.

B. Strengths

Participants were asked what strengths they see in the community or within their own organization regarding mental health services. Stakeholders and providers could easily identify what was going well within their own organization; however, the conversation often lulled when asked about other resources or details about what is going well in the community. Many times when a participant would point out a




strength, they would also mention that it could still improve or list other needs and barriers that are associated with the resource. One example of a compliment paired with a need came from a stakeholder:

And I think there just needs to be more collaboration. All together with all the sources, and there's a lot of amazing people with amazing talents here in Sioux Falls. It's hard to figure out how to find all of those.

The stakeholder pointed out a need (collaboration), but still complimented the individuals providing resources. Overall, this portion of the discussion was fairly brief in every focus group and interview, as participants felt challenged to identify strengths, but there were a few common strengths that participants mentioned, including abundant resources and generosity, decreasing stigma, collaboration, and the Helpline Center.

Stakeholders and providers identified abundant community resources and a spirit of support and generosity as strengths, but they kept their comments very general. Several participants mentioned that in comparison to other communities, Sioux Falls has an abundance of resources and is more supportive of mental health efforts as a whole. When asked to think of other organizations to highlight within the community, participants would list many resources in a row or say there are lots of resources out there doing great work. When asked to give more detail about specific strengths in the community and other organizations, participants made very general comments. An example of this type of comment came from a stakeholder who said, "We have great services in Sioux Falls, I can name tons of people I know in the field that do great work." Most participants were more willing to compliment individuals on their accomplishments in the field, but not the system as a whole. Although Sioux Falls was praised for its current efforts, most participants noted that there is still work to be done to improve mental health services in the area.

They also described decreasing stigma as a strength. However, following the pattern discussed previously, stakeholders and providers often coupled the strengths they identified with a barrier or challenge, including stigma. Stakeholders and providers




noted that stigma has decreased significantly, especially among the younger generations. This has been evidenced by an increase in community members requesting services and more individuals willing to share their own struggles with mental health. Some providers mentioned large, local organizations reaching out to provide their employees with mental health education and training, which further illustrates the decreasing stigma. Recognizable public figures within the community have also come forward to bring awareness to mental health, which providers and stakeholders believed works to further raise the awareness of mental health. But stakeholders also pointed out that, although stigma has been decreasing, it still poses a significant barrier to many to seek out mental health care. This will be discussed further in the “Stigma” section under “Barriers & Challenges.”

Collaboration among resource providers was often noted as a strength. Many providers and stakeholders brought up collaborations between their own organizations and other resources in the area, and most agreed that collaboration has been positive. The main form of collaboration was through trusted referrals with other resources that ensured providers and stakeholders felt comfortable sending their client to someone else. Although most listed collaboration as a strength, almost all participants agreed that there is a need for even more collaboration. One provider shared this sentiment:

But I just think learning from each other in the community really helps us know what is a good fit, because I don't think anybody's competitive. There's more clients than any of us can handle and so I think making sure that there's a good fit for the person, I think that's the best thing that we can do as a community. Working together, working on the same side instead of against each other.

Collaboration would reduce duplicative services and help those in need receive the correct services more efficiently. Existing collaborations have reaped the benefits, and the community could use even more.

The most common resource that was praised was the Helpline Center (211). Almost every participant within the stakeholder and provider groups knew of 211 and mentioned using it often as a helpful resource. The Helpline Center seems to be well




connected with resources in Sioux Falls and has an extensive reach within the stakeholder and provider community. However, community members did not share this awareness; when asked about how to navigate mental health resources, community members did not mention 211 as an option to locate resources. Providers and stakeholders also mentioned that 211 may be overwhelming for community members to process with the large amount of resources and guidebooks they offer; even for professionals in the field, they reported, it is often difficult to know where to start.

C. Barriers & Challenges

The participants in the focus groups were quick to address the barriers, challenges, and needs of the community. Despite facilitators' efforts to elicit perspectives on the positive aspects of Sioux Falls mental health resources, the participants had more fruitful conversations regarding what needs to be changed to further improve the accessibility of mental health resources. The major barriers and challenges that the focus groups highlighted include the following: COVID-19, stigma, lack of providers, licensure difficulties, long waiting lists to see a mental health professional, lack of personal knowledge of resources, cost of mental health services, insurance difficulties, basic needs not being met, mental health legitimacy, transportation, childcare, and justice involvement. This is not an exhaustive list of every barrier or challenge mentioned, but highlights those deemed the most important and pertinent issues by focus group participants.

1. COVID-19

The most frequently mentioned challenge was complications surrounding the pandemic. Researchers specifically asked about challenges brought up by COVID-19, but most groups spontaneously spoke about the pandemic before the question was asked. The number of tags may be inflated due to the protocol asking specifically about pandemic effects, but most groups talked about it without prompting. The demand for




mental health services has grown since the start of the pandemic. The isolation and changes that came from COVID-19 caused many mental health problems to develop for those who may not have had any before and to worsen for those who were already struggling. According to stakeholders and providers, this surge has overwhelmed mental health services, resulting in burnout of providers and incredibly long waitlists for the services that are available.

One development from the pandemic is the expansion of telemental health, which has both been extremely helpful for mental health services as well as a challenge to deal with according to participants. Telemental health opened the doors for residents of rural communities to access mental health care without having to travel long distances. Even beyond rural areas, those who struggle with finding transportation now could easily access their mental health care from wherever they were. Workers no longer had to leave for their appointment during the work day; they could simply log on to their device in their car or at their workplace. One provider agreed that telemental health was helpful for rural communities:

I mean, you see the silver lining and it has helped with a lot of that telementalhealth for reaching some of those rural areas. Because I think that was a huge barrier for a long time but people out there in like Winner, SD, they would drive three hours any direction to get where they need to go.

Telemental health also allowed providers to deliver services safely while the ongoing pandemic inhibited everyone from going out in public.

Despite the advantages of telemental health, there are also many challenges. One major challenge as reported by providers and stakeholders is the accessibility of the internet and a device to make video calls. Many individuals do not have reliable access to the internet, which prohibits them from receiving telehealth services; even if individuals have access to internet services, they also need a device for video calls. Another challenge with telemental health that participants noted is the eligibility of services. At the beginning of the pandemic, one could access telemental health services across different states without concerns of limitations. However, now there



are restrictions on who can access telemental health and where. For example, one stakeholder described the restrictions:

And now, the legalities of it are that you can see people other places, but you should be licensed in the place where the client is- where the client is located at the time of the session. So if you have a Minnesota client, and they get in their car, and they cross the border into South Dakota, you're [provider] fine. But if they stay anywhere in Minnesota, and Minnesota finds out that you've [provider] provided services to them- So even if like if I was going to do telehealth with my therapist, and I was on vacation, that state could technically come after my license.


There are also safety concerns with telehealth like domestic violence situations, others listening in on therapy sessions, and youth. A provider described a safety issue they encountered:

There were some safety issues that we endured that we didn't really think about happening like a kid walking around with their cell phone doing a telehealth session at age four, and parent is just under the assumption that since they're in their telehealth session, they're safe. So they're not supervising them in the way that they would if the therapist wasn't with them.

Although telehealth has increased access to mental health for some, there are many challenges that come with it.

2. Stigma

Every provider/stakeholder and community member group associated stigma with the term mental health. Many layers of stigma were uncovered throughout the groups: cultural stigma (Midwest and others), generational stigma (higher among older adults), and stigma among providers. Midwesterners were described as very individualistic and needing to solve their problems on their own, a culture that was referred to by one participant as "rugged individualism." This description of Midwesterners translates to mental health stigma as these individuals would often delay seeking treatment because they believe they should be able to handle their struggles on their own. This delay results in more severe issues necessitating crisis treatment rather than preventative treatment according to stakeholders and providers.



Another group among whom participants reported stigma is prevalent was the older population. Much like Midwesterners, they explained, the older generation has the same mindset of solving their own problems and being unwilling to seek out help. Older individuals often do not want to talk about mental health and see it as a private matter. While older generations struggle to accept mental health needs, both stakeholders/providers and community members alike noted that younger generations are far more accepting and open to discussing mental health. One provider who works with seniors described the stigma seen in that population: “[Mental health] just wasn't part of their world and older men farmers, like it's so hard for them to accept help because of that stigma. Very much the ‘pull yourself up by the bootstraps’ mentality.”


Participants from both the stakeholder/provider groups as well as the community members reported that stigma is prevalent among the Hispanic population. Community members described their own experiences of living within this culture, and shared how oftentimes when someone is struggling, they turn to their family (rather than providers) for help. Much like Midwesterners internalizing their problems within themselves, Hispanic individuals keep their problems within the family setting. Participants noted that sharing one's own mental health struggle with family can be difficult as family members may not believe you or may not believe in mental health. One community member shared their experience of this struggle:

From personal experience in the Hispanic community, like mental illness is, like taboo, you don't really talk about it. And if you don't talk about it, it's like you either need to grow up or, like, there is not— no really good support system. And a lot of times, they don't even believe in any of the psychology or Western medicine.

Another community member spoke about the Hispanic community in a similar manner (translation in italics):

El problema que veo es que a veces siento que nuestra comunidad a veces tiene miedo de hablar... Pero venimos de una... comunidad que tiende a callar las cosas. Entonces como que traemos eso siempre de callar y no hablar, no expresar.

The problem that I see is that sometimes I feel like our community sometimes is scared to talk... But we come from a... community that tends to silence things. So we kind of always bring that silencing and not talking, not expressing.



The stigma seen throughout these different communities can make it extremely difficult to seek out help for mental health problems.

3. Lack of Providers

The participants in the stakeholder/provider focus groups were asked, “What could impede seeking mental health resources?” The participants resoundingly responded with the lack of mental health providers either in their organization or in the Sioux Falls area. Providers shared that Sioux Falls mental health resources have been suffering from poor retention and/or difficulties hiring staff, especially staff who can practice mental health services. A stakeholder from a public clinic that serves primarily low income community members described difficulty hiring staff:

And it's something that I got going on within the organization, and then I have a full-time mental health counselor position open now for three weeks with zero applicants. Now, our pay is competitive... It's just there's not that much of a pipeline out there, psychiatry, same thing.

Across all stakeholder/provider focus groups, participants recognized that they are having issues keeping up with the high demand for mental health resources. As stigma has decreased and the global pandemic left many with mental health concerns, the need for mental health services has skyrocketed. One provider described the struggle of counselors:

On behalf of counselors, I know that counselors are working, working as much as they can. They're the people in the community that honestly have some of the biggest hearts that I know. But we can't keep up with the demand.

Mental health services do not have enough staff to meet this growing demand, and to further the issue, staff retention has been difficult. Stakeholders and providers report that the resignation waves and turnover rates have made it increasingly difficult to keep social service agencies and mental health resources staffed to keep up with the demand. One of the contributing factors to high turnover is the licensure process for mental health professionals.

4. Licensure Difficulties

Many participants joked that their organization is simply a stepping stone on a mental health provider's career path, leaving their organization with a revolving door of new staff. Larger organizations that receive public funding especially suffer from such an issue, where individuals work for the organization to obtain their license but then decide to leave, saying things like, "We make a lot of jokes once people get their licenses about if they're turning in their two weeks notice along with a copy of their license. That's how that goes."


Providers suggested that the mental health licensure process in South Dakota, combined with low pay, is one contributing factor to the low staff retention and poor hiring rates. The licensure process is long and arduous with little compensation. One provider new to the field shared their experience with the process of becoming a counselor:

But when you look, this profession requires--I was an attorney before this and it was easier to become an attorney than it was to become a counselor. So it's ridiculous the amount of schooling and post schooling hours that are required to get licensed and then to sort of not be valued in that way is a little frustrating.

Many new graduates entering the field will join an organization that is willing to train them and pay for their licensure, only to leave for better compensation either in the private practice realm or the inpatient setting. This leaves the original organization vulnerable to high turnover rates, little consistency for their clients, and less experienced staff.

5. Waiting Lists

The lack of providers and high demand has created another barrier for clients: long waiting lists. Participants in the stakeholder/provider focus groups mentioned that wherever they call to make referrals for potential clients, everywhere is full. All focus groups mentioned these long waiting lists to be seen by a mental health professional. One provider shared their struggles with finding a referral, "I mean, it's hard to call



somewhere and get in within the next three months somewhere.” Another provider noted their experience with turning away a client:

We had a call from HSC last week, and they said we were the fifth practice they called for a client that was getting ready to get out and they didn't have [any], they weren't getting an appointment anywhere because they were 45 days out, but people need to be seen.

The waiting lists seem to be even longer for those who need to see a psychiatrist for medication as there is a dearth of psychiatrists specifically in the area. One stakeholder commented on lack of psychiatric care:


And so there's not enough resources to meet the needs of our community... so there's not enough therapists, and then there's not enough psychiatrists. So to see a psychiatrist, you are waiting six months for a referral from your medical doctor before you can see a psychiatrist.

Another population facing long waiting lists is youth and adolescents as there are even fewer providers who specialize in youth (see “Youth” under the “Needs” section for more information).

Stakeholders/providers noted that waitlists are problematic because it can be difficult for individuals who are struggling to reach out for help, and when they do it is discouraging to be turned away. Community members also commented on the extensive waiting lists, and several mentioned waitlists of three-plus months for agencies they have tried to contact. One community member spoke about what they have heard from others in the area:

For most people who end up going to therapy, the barriers took, like for them to go, the need to go to therapy has to be greater than the barriers to go into therapy. And for a lot of people, those barriers are really high. So that need has to be really, really big. And so for that someone to finally get to the point of pursuing it and be like, now I have to wait months, that's really disheartening.

One provider shared what they have heard from clients about this issue: “That's the number one barrier that I hear for people is ‘I recognized I was struggling, I reached out, I tried to get a therapist or psychiatrist and nobody's available.’ And so that's the big one.” Waiting lists are discouraging to new clients attempting to seek out services



for the first time and can inhibit previous clients from returning, which can be detrimental for those experiencing a mental illness.

6. Lack of Awareness


Another major barrier was the lack of awareness of mental health resources among both providers and stakeholders as well as community members. Although providers/stakeholders were able to list off several organizations that provide services, many noted that they wished they were connected with more or that they felt isolated from other providers. Some were even surprised to learn about the resources provided by other participants in their focus group session, which demonstrates the lack of awareness of what is available.

Community members had even less awareness of how to find available resources. As aforementioned, stakeholders and providers reported 211 is a great resource to locate services in the area, but no community members mentioned it as a resource they would use if they needed to find mental health resources. When asked how they would approach finding mental health services, most community members mentioned a general online search or asking their primary care provider for a referral. One community member described their search for a provider:

And I think what I was able to do, I just went online, I went through random websites and I just emailed a whole bunch of people. And then I got responses and the cheapest one that I was able to get was \$65 an hour [but it's] really hard to find a specific therapist that can help you and that's affordable.

Even then, many mentioned how complicated it was to find a provider that fits their needs.

Likewise, providers/stakeholders said they have a troublesome time navigating mental health services, which makes it even more difficult for community members to know how to navigate services. Many community members look to trusted stakeholders or general providers to guide them to services; if these individuals do not know where to find services, this makes the process more difficult. One provider




shared how they view the lack of awareness: "...the general public doesn't have an awareness of all the resources that are available. And even as a provider, I'm constantly surprised going 'I didn't know we had that in Sioux Falls.'"

Another issue brought up by stakeholders/providers is lack of awareness of mental health needs. Several participants believed that some community members fail to seek out services due to not understanding what mental health issues are and where to start looking for services. One stakeholder shared their perceptions of this problem:

I think one of the biggest [barriers] is understanding what types of services they can access for their specific need[s]. I think, in general, with mental health conditions... they [general public] may not always know what they need for their care. I think a better understanding of what care needs are and language that is helpful for people [...] making language of mental health conditions a little bit more accessible or more understandable in [...] layman's terms [...] So it's like you're writing with somebody at a third grade level. So really making it approachable.

In essence, the stakeholders and providers are describing a need for more mental health literacy. Mental health literacy encompasses the understanding of mental illness and its symptoms, knowledge of mental health resources in the community, and the knowledge of maintaining positive mental health. The knowledge of mental illness and its symptoms helps individuals know what specific behaviors are attributed to specific mental illness diagnoses. The knowledge of mental health resources has three parts to it: (1) The first integral part of the definition is to have the ability to know what facilities or clinics individuals are able to access mental health care, (2) knowing where to find information regarding facilities or clinics if they do not hold the knowledge of specific facilities or clinics themselves, (3) and having the knowledge to seek out specific modalities of therapy. The final part of mental health literacy is knowing how to maintain a positive mental health through acquired and applied knowledge. This aspect was important to highlight due to the recurring theme of mental health professionals not knowing one or all aspects of mental health literacy.



Without the recognition of mental health issues in general, individuals are less likely to seek out services. When they do, the terms and various types of services can be overwhelming to navigate on their own.


7. Cost & Insurance

Participants observed that one barrier that inhibits many from seeking help is the cost of mental health services. To corroborate their observations, researchers analyzed characteristics of mental health care providers listed in the Helpline Center's Mental Health Guide for Sioux Falls 2021. In total, the guide lists 132 providers. Based on information available in this local guide, provider services range in cost from less than \$25 per session all the way through \$250 per session. Depending on the services given, individuals who are of lower socioeconomic status are not able to afford the range of the costs. Even though some services are government funded and providers are able to lower their cost of services, participants noted that lower income clients are limited to a smaller pool of affordable providers, and may not have the range of services or quality to choose from:

But there's a lot of that that goes on, which means lower SES, pretty much across the boards where you have higher need, have less access, or less quality access... They don't have access to quality, they don't have as much consumer opportunity to decide. They don't have the breadth of available resources.

Based on the review of the Helpline Center's guide, around 24.24% of organizations offer a sliding scale fee for clients of lower socioeconomic status (SES) but even these rates can be hard to meet for some.⁸⁸ Participants noted that those who do offer sliding scale fees are often the organizations with the longest waiting lists, so it may be months before a client is seen. Cost can also be prohibitive for those who do not have health insurance or whose insurance does not cover mental health care. Those without insurance have few affordable options for services in the area, and the options they do have are often booked out for months on end.

⁸⁸ 211 Helpline Center, "2021 Mental Health Guide Sioux Falls," 2021, <https://www.helplinecenter.org/support-programs/mhguides/>.




Insured clients also encounter difficulties when seeking out services, participants explained. There is a wide variety of insurance companies, and not all providers can accept all types of insurance. In the Helpline Center's 2021 Mental Health Guide Sioux Falls, 55.30% of providers listed accept private insurance, 35.61% accept Medicaid, and 18.18% accept Medicare. This adds a layer of difficulty when looking for a provider because, as participants explained, clinics do not typically advertise which insurance companies are accepted. Further, not all insurance companies cover all mental health services, and there are often diagnosis restrictions on coverage. This can handcuff providers into giving their client a diagnosis when one is not necessary, or incorrectly diagnosing in order for insurance to cover services. One provider explained how insurance requires diagnosis for billing:

And not to mention that insurance doesn't cover all diagnoses. Right? So... when you need to explain that to a client- it's difficult too when their claim gets denied... So that's what's frustrating to me when we try to do preventative care or if it's strength based and not problem focused, and then they have to have like this diagnosis in order to get help and that doesn't make sense to me either.

Insurance coverage may also vary by modality. There are several modalities within mental health care, and one treatment option does not work for everyone. Most insurance companies only cover evidence-based therapies (EBTs) such as cognitive behavior therapy (CBT) and dialectical behavior therapy (DBT), but these types of therapy are not the best fit for everyone. Options become even more limited for clients looking for specific modalities because it may be difficult to find a provider who offers their preferred treatment modality or to afford treatment not covered by their insurance. For Medicare recipients, choices are further constrained because Medicare only reimburses for care provided by licensed clinical social workers (LCSW). As noted by a stakeholder:

I mean, one of the big barriers, that's not just South Dakota, but you know, if you have Medicare, and you are a therapist, you can only see a social worker in private practice. They don't-- Medicare does not accept any other licensure anywhere in the United States. And it's a huge issue because our population is not getting younger...



Even if insurance does cover mental health care, high deductibles can restrict clients from accessing services, which relates back to cost inhibiting treatment-seeking. One stakeholder who specializes in billing insurance explained difficulties they see day-to-day:

[...] But if your deductible is \$10,000, you're gonna have to pay out of pocket. And if we, as clinicians, submit to insurance, and it comes back that it's to your deductible, there's nothing we can do. We can't write it off, our contract says we can't, their contract with the insurance company says they can't. We have to collect to the point of sending it to collections. Because that's our contract. And so if your deductible is high, and you want it submitted to your insurance, [...] then you're responsible for the bill.

8. Basic Needs

One barrier noted among several stakeholders was meeting basic needs. Some individuals do not seek out mental health care due to a lack of basic needs being met, such as housing and food. It can be difficult to work on mental health issues when clients are worried about where their next meal is coming from or where they are going to stay that night. One counselor shared this challenge:

So barriers that I can think of are finances, lack of insurance, housing, it's pretty hard to want to talk to a counselor when you don't even have anywhere to sleep at night. Basic needs aren't being met in this community always.

Another stakeholder shared how mental health is a holistic subject and other life variables should be considered:

So many people I think wouldn't be struggling with their mental health if they could help—if they could make ends meet. If they didn't have to work three jobs, if they weren't constantly stressed. Mental health care that also looks at other social determinants of health is what I would say.

Many providers shared that their definition of mental health came from a wellbeing, or holistic point of view, which encapsulated looking at everything that could impact mental health in order to treat clients. Unmet basic needs can be a major contributing factor to mental health concerns, and basic needs cannot be addressed in a therapy session. One need in particular that was highlighted by participants was the lack of




housing. One provider described the difficulty of finding housing in Sioux Falls at the moment:

There is an incredible gap for people that need transitional housing, whether the county jail, or prison or one of the shelters, and they're [community members] not ready to sign a 12 month lease that they'll probably ruin. And then they end up ruining their rental history, for sure... there's a big gap in housing, in general, but certainly specifically to those that can't afford the general market rent... And the gap goes even further, because even if you have a voucher from Sioux Falls housing, or HUD that'll give you subsidized housing, but there aren't units available to use them.

Another provider elaborated, explaining that housing problems can contribute to mental health problems: “folks [who] can’t get into low income housing [...] that’s a mental health trauma.” Stakeholders/providers accentuated the need for transitional housing for those exiting the justice system, housing for those with a criminal record, and for those with a poor rental history. As the quote depicts, individuals who are not ready for a typical 12 month lease at market price are left with few options. According to stakeholders/providers, not meeting the basic need of housing can render mental health services useless without a stable home for clients to return to.

9. Mental Health Legitimacy

Another challenge seen throughout the focus groups was the legitimacy of mental health care. This legitimacy is twofold: community members and/or professionals not believing in mental health care and professionals doubting community members’ mental health concerns. Both stakeholders/providers and Spanish and English community members showed a lack of trust in each other, and the participants in the stakeholder/provider focus groups mentioned the lack of trust in the mental health care system. The lack of trust among community members is due to a variety of reasons such as negative experiences with mental health professionals, mental health professionals not taking into account Indigenous spiritual practices, and clients not fully believing in the work being done by mental health professionals. One provider explained the situation of some of their clients:



Or you get a person who was always forced to go to counseling because they were court ordered [...] and they see it as part of the system and not part of someone who's there to help [...] And so I've had many interactions with people who will say that I was too afraid to call and get help again, because it didn't go well last time.


As for the stakeholders/providers, they recognized the community members' concerns with mental health care, but they also greatly discussed the lack of trust in mental health practitioners. Another provider described how turnover can affect clients:

You can't come into people's life and disappear. When they've been traumatized and abandoned over and over. You help them and you walk through and then you--and I know that's just life. But that doesn't help because they've reached out taking these big risks to seek out help. And then that person disappears. Next time, you've got way more work to do to try to get that person to really buy into it.

Providers agreed that the lack of trust from community members is understandable in these situations where high turnover within mental health organizations negatively impacts the care clients receive.

Community members who had negative experiences with mental health care described instances where their needs were not being met due to a lack of competence in a particular modality, such as a gender specific competence. In the Spanish community member focus groups, the participants described instances where it is hard to receive services when there is an interpreter—for example, instances where they feel like they have to repeat themselves to the interpreter and the therapist, making it twice as hard to communicate and to make meaningful therapeutic gains. The experiences of not being able to effectively communicate with a therapist leads these individuals to reconsider participating in future therapy sessions. As for the English community members, there were individuals who discussed undesirable results and experiences of previous therapists and psychiatrists. In particular, a participant from the English community members focus group stated:

My mom took me in there with a preconceived diagnosis of what she thought I was, and they [psychiatrists] took and ran with it. There was no real like, deciding on or like asking questions to dig deeper and nothing and they just took it [and] ran with it.



The two-way road of mistrust between community members and the mental health field professionals negatively impacts clients and can delay treatment-seeking within the community.

10. Transportation

Stakeholders and providers noted that one major challenge to accessing mental health services is transportation. This challenge mainly affects those of lower SES who do not have reliable access to transportation. In the Sioux Falls area, most individuals drive their own car as the main form of transportation. For those not driving cars, stakeholders and providers described several challenges associated with the public transportation system: inconsistency, lack of stops, limited extent of system, and cost. Many participants said that the bussing system is not reliable: the bus does not arrive at stops at consistent times, causing clients to be late and taking extra time out of their day for appointments. The bus routes do not extend far into the city, leaving some areas of Sioux Falls inaccessible for those utilizing public transit.⁸⁹ There are several smaller communities surrounding Sioux Falls, but the bussing system does not extend into those communities. There are some key stops missing on the routes, including two major health facilities: Avera Behavioral Health and Falls Community Health. One stakeholder who works with houseless individuals described an instance of needing to use the bus system:

They keep eliminating routes. I had a client who either was in severe mental distress or had an appointment at Avera Behavioral. The last bus stop is 1.2 miles from Avera Behavioral. So you're asking somebody who's already in clear mental distress to ride a public transit bus, get off, and walk 1.2 miles over a busy highway to get to Avera Behavioral. That's unbelievable to me.

⁸⁹ City of Sioux Falls. (n.d.). *City of Sioux Falls Bus Routes*. <https://cityofsfgis.maps.arcgis.com/apps/MapSeries/index.html?appid=cb3dd15de0c842ab9bd18d61f8afd7c5>.



A community member commented on the lack of a bus stop at Falls Community Health:

There's also not a bus that goes directly to Falls Community Health. It actually is like, over two or three blocks over which doesn't seem like a lot. But if you're somebody who doesn't have great mobility, or it's 30 below zero, that's a long way.

Researchers mapped bus routes to these two locations and from the nearest bus stop, Avera Behavioral Health is 1.7 miles away (33 minute walk)⁹⁰ and Falls Community Health is 0.6 miles (14 minute walk).⁹¹ In addition to distance, the cost of public transportation can create barriers. The cost per ride on the bus is \$1.50, but if riders switch buses they must pay the fare again.⁹² Some agencies provide free bus passes for individuals who are in need, but this only covers one fare. If one must use the bus system regularly, the cost adds up. These difficulties with the bus system create a significant challenge for those who rely upon public transportation.

11. Childcare

One challenge associated with children that stakeholders/providers mentioned fairly often was the lack of childcare in the community and how this affects mental health services. Caregivers have a difficult time finding mental health care for their children, not to mention for themselves and the barriers they must face to secure services as discussed in other sections. One barrier to receiving services is finding childcare providers so caregivers can go to services. When stakeholders/providers mentioned childcare as a barrier, it was more often than not an offhand comment as if it was obvious that this was a barrier for caregivers, or the participants would list several barriers and pile childcare onto the end. Previous research has established

⁹⁰ Google. (n.d.). [Google Maps directions for transit from Augustana University to Avera Behavioral Health, Sioux Falls, SD]. Retrieved September 27, 2022, from <https://tinyurl.com/y63h5w79>.

⁹¹ Google. (n.d.). [Google Maps directions for transit from Augustana University to Falls Community Health, Sioux Falls, SD]. Retrieved September 27, 2022, from <https://tinyurl.com/2fz3yu6h>.

⁹² *SAM Bus Fares and Passes*. (n.d.). City of Sioux Falls. <https://www.siouxfalls.org/sam/general-info>.

that childcare is an issue in Sioux Falls as it is expensive and inaccessible for much of the community.⁹³


12. Justice-Involved

Another barrier or challenge that the stakeholders and providers noted was the overlapping judicial involvement of many individuals who are suffering a mental health crisis. Overall, the stakeholders and providers suggested individuals who are mentally ill should not receive punishment for their illness. However, they acknowledged the difficult line between what is criminal behavior and mental health crisis behavior. Further, they noted, there may be cases where individuals use mental health diagnoses to pacify, or even justify, their violent behavior. All of these aspects make it extremely difficult for the justice system to determine whether an individual is actually suffering from a mental illness or whether they are claiming so in order to receive a lesser punishment. Nevertheless, the participants who mentioned justice-involvement among individuals who also suffer from a mental health crisis noted that, often, violent behavior is not something that they can control due their possible undiagnosed mental illness. They argued these individuals need treatment, not punishment.

Other stakeholders and providers mentioned the use of detention centers as a holding place for individuals who are exhibiting extreme behaviors from an undiagnosed mental illness. Overall, they observed, the justice system has been transferred some of the mental health crisis responsibility. As one stakeholder said:

We don't get to pick our clients. When our clients come to us, they're usually in crisis, whether they have committed an offense against someone or something [...] They're already having a traumatic experience and our answer is [to] put them in a jail cell until a [Qualified Mental Health Professional] can come and do a further assessment and determine whether the hold continues, or [...] they go somewhere else for services, or if they can be released and go home.

⁹³ Olson, A. (2021). *Expensive and Inaccessible: Childcare in Sioux Falls, South Dakota*. <https://www.augie.edu/sites/default/files/documents/2022-05/Childcare%20Collaborative%20Final%20Report.pdf>.




The overlap of mental health needs and justice involvement is not restricted to adults. It affects youth, too, who may be held in juvenile detention centers or be transferred to such facilities due to their exhibition of behaviors. The stakeholders and providers mentioned the negative effects of this placement on the youth's mental health. Not only are the adults who are exhibiting extreme behaviors from an undiagnosed mental illness being transferred to detention centers, but there seems to be a mirror of the same issue among the youth, which does not help the youth's life trajectory after experiencing the juvenile detention center. One stakeholder who works in juvenile justice described it this way:

Our problem is, we're the dumping ground. We get kids that, yes, they've committed a crime—but maybe it's a chicken and an egg thing [...] they have mental health concerns that are contributing to why they're doing what they're doing [...] They've experienced a bunch of trauma in their life, they don't [always] have the support system at home [...] they don't know better [...] And they just don't know how to deal with life. And it's hard. [And]... I'm getting developmentally delayed youth that should be in a way different setting than a jail cell, but nobody [...] will take them for long-term treatment needs. Even some kids that struggle end up having major mental health concerns with us while they're awaiting court and stuff like that. There's no long-term solution for them.

When it comes to individuals who are justice-involved, these findings reflect the transfer of responsibility from an inadequate mental health care system to a justice system that was not built to take on mental health treatment. According to stakeholders and providers, not only are adults being denied the treatments that they need to help out their symptoms, but the youth are also suffering from the same issue. Both groups are suffering from a system that was not intended for them.

D. Needs

The previous section describes barriers and challenges—things that stand in the way of people's access to mental health care. This section describes needs—gaps within the mental health care system itself and opportunities to augment the services that currently exist. While discussing barriers and challenges with participants, many needs were brought up that correlated with the themes previously discussed. The sections



below reflect types of services, providers, and themes where the community is lacking regarding mental health services. The main needs gleaned from focus groups and interviews include diversity among providers, education for both providers and the public, youth and family services, medication and psychiatric services, funding, mental health provider support, and long term mental health care facilities.


1. Diversity

One of the most common themes mentioned by both stakeholders/providers and community members, as can be seen within Table 3, is diversity among mental health providers. Diversity includes but is not limited to color, race, sex, gender, age, sexual orientation, and spiritual values. Most of the participants in the stakeholder/provider focus groups were white, middle-aged women who spoke English as their primary language, which is not representative of the diversity of the Sioux Falls community. One stakeholder noted this disparity:

I was discussing with a therapist here in Sioux Falls today that she is... one of two Black providers in the city [...] But thinking about our growing diverse population, if we had more providers who spoke the language [...] for their clients, that might be beneficial. But I understand that right now, if you need to see somebody, you know, maybe you just need to see somebody, that doesn't matter.

Another provider noted a lack of representation of diverse genders and sexual orientations: "But I think that our LGBTQ2S communities, our transgender community. That is culture, yes. But to really call that out. I think health systems struggle with knowing how to treat that whole human being." Sioux Falls is a rapidly growing community with diversity rates steadily climbing, and that needs to be reflected among the provider population according to participants.

Another aspect to diversity that all focus groups commented upon is what language services are provided in. There are few organizations that provide services in a language other than English, which leaves out a significant portion of the population. Although translation services are available, having a translator in the room during a therapy session is less than ideal. Several stakeholders/providers shared that having a



translator in the room during sessions interrupts the formation of the therapeutic relationship, doubles the time needed for every session, and can be frustrating to clients when having to repeat their story to a new interpreter every session. One stakeholder described their clients' experience with interpreters:


I mean we have had [...] clients who have gone to counseling sessions, and it's a different interpreter every time. And they felt like [...] they would come back and tell us [...] I feel like I'm saying the same thing every time because it's like a new person, and then they just get frustrated and don't use the service anymore.

Stakeholders/providers and community members concurred that more multilingual providers are needed to serve the multilingual communities within Sioux Falls. In an interview with a Spanish speaking community member, they described the significant advantage of being able to effectively and efficiently communicate with doctors in English; but they are aware that others have difficulties with communication:

In my experience [...] with the doctors in the 15 plus years that I have had treatment in this community [...], I never had to use an interpreter. So, I don't have that factor of a third person in the room listening to what I had to say and conveying it to my doctor. So, I am able to communicate...and that is a big deal that I am aware a lot of people don't have, right. First we start with the stigma of I don't feel well, I don't know what is going on; everybody is like this in my family, they think that it's my fault, or whatever it is the state that you are in. And then you go to the doctor, you don't speak the language, you can't communicate--I never had that problem.

Aside from language barriers, participants addressed cultural barriers that exist between providers and clients. As aforementioned, the typical provider in the Sioux Falls area is a white, middle-aged woman who does not represent all cultures present that may be seeking mental health services. Participants noted that understanding someone's cultural values and background is essential to the therapeutic process. One stakeholder reported questions that are important to consider for providers:

Do they [clients] feel like they have representation? Do they feel like they have a voice? Do they feel like they have support? Do they feel like there's even an understanding of intersectionality and how some of the things that they might experience as, as a mom, are going to be different than what a Caucasian woman might experience as a mom or a straight woman might experience as a mom?




These questions should be at the forefront of providers' minds when starting to treat a client. Another stakeholder described the experience of the population they work with: "... as a Latina ... having somebody who can really understand something about their heritage and their background and include that into a treatment plan or a care plan." Stakeholders and providers reiterated the point that incorporating cultural practices and beliefs into treatment is necessary to truly help someone heal.

Throughout the focus groups and interviews, it was obvious that diversity was a forefront issue for the community, but there are many faces to the issue.

2. Education

The most frequently mentioned theme within needs, according to the stakeholder/provider focus groups, was education about mental health for the public and continuing education for providers. Public education often came up as a way to address the lack of awareness stakeholders and providers perceived among community members. Everyone encounters mental health issues daily, and it is important to know what problems look like and where to seek help. Several participants noted that although community members might believe that mental health training is irrelevant to most professions, in actuality, it matters. One example used by some participants was a hairdresser: this is someone who listens to clients' day-to-day life and may be the one person to whom someone feels comfortable divulging their struggles. One provider shared how information about mental health could be useful:

Mental health education: one of the things that struck me at one of the trainings I went to was educating the general public or certain occupations, like hairdressers. They [...] get a lot of suicide [and things] and [...] they don't know how to give these resources—they don't know how to handle it. But you know people that they vent to, these people they don't have the education or the resources. So that education to other people in the community is important.



This kind of training and education could potentially save many from harmful mental health issues. One provider compared mental health first aid training to CPR and triage training:


There's programs like mental health first aid [...] That was so beneficial for me to go through all that training for me to be a better mom, community member [...] So to have [...] training of Mental Health First Aid to give to the average citizen like CPR [...] Mental Health First Aid, it's the same idea of 'Okay, how do we help somebody with some quick coping skills to get through the next step?'

Stakeholders/providers agreed that basic knowledge of mental health and quick interventions to help someone in crisis would be a major benefit to the community. Besides basic education about mental health, providers and stakeholders believed that education about the process of seeking treatment would help reduce the anxiety associated with treatment-seeking. For some community members, the only exposure to mental health treatment is the media, where psychological treatment is often exaggerated and fear-provoking. One provider shared how they help community members with this:

I often say to people, when I first meet them [...] if they call and say they're not sure, I said, 'Well, come on in and let's do 15 minutes. After 15 minutes of conversation, let's see how we feel. If you're comfortable here, we'll go forward. And if you're not, go check out other people, and then assess and evaluate and make a decision.'

Education plays a vital role in the community, and participants mentioned that this can start with the youth. As reported in the "Stigma" section, stigma has lessened among the younger generations, with many younger people feeling more comfortable talking about mental health and how it affects them. Some participants have noticed that their children are learning about mental health in school, but they wished that the education was even more extensive.

Additionally, more opportunities for continuing education and professional development for providers could expand services available in the community. As discussed in the "Cost & Insurance" section, there is a lack of diversity in the types of services offered for mental health; most providers offer evidence-based therapies (EBTs), but there are few non-EBT providers and, similarly, few providers that offer




specific modalities and specialities like eating disorders and EMDR. One provider described their desire for a variety of services:

I mean, when they are reaching out for services, they will say, I'm looking for an EMDR therapist. And so just having that skill available [...] locally [...] different [from] the typical talk therapy. And that's sometimes hard for South Dakotans to kind of ride that wave of... progress and to have that niche, or... that specific modality available.

As depicted in the quote above, there is a lack of credibility for non-EBT modalities in the Sioux Falls community. Along with the lack of credibility, providers in the focus groups voiced their belief that specific modalities should be taught within the curriculum for mental health providers entering the field. Providers and stakeholders also believed that modality- and specialty-specific training should be offered locally as ongoing professional development to increase the interest and accessibility of these trainings.

3. Youth & Family Services

Participants throughout the focus groups and interviews touched on the challenges and lack of mental health services for youth (<18 years of age) in the community. They reported that there are not many providers who work specifically with children in the area, creating long waitlists and limited availability. According to one provider, "There's a shortage of therapists, and even more shortage with child therapists." This is especially apparent with child psychiatrists, as one stakeholder who works with children shared their recent experience of attempting to schedule an appointment for their client: "when we're trying to get a young person in for a psychiatric evaluation, where they need medications... We just made an appointment for a kid yesterday. And the soonest we can get him in is July" [FG took place in March]. Waitlists are similar to those discussed in the Barriers section, and may even be more exaggerated for children. One community member shared that when looking for services for their adolescent this past year [2021], waitlists were upwards of four or more weeks to see a therapist, which seemed unrealistic, especially in a crisis situation.



Many services for youth are located outside of school, and some stakeholders/providers felt that pulling a child from class to attend a counseling session can isolate them and force them to miss vital class time. One alternative is offering services within the school, and one provider shared their opinion on this option:

Talking about barriers for kids, a lot of kids don't like being pulled out of school, because I think school is so hard. And they feel stigmatized, just by being taken out of the classroom. So when the agencies are able to go to the schools, I think that's huge. I think kids really like that, because it's just like them going to another class. And then people don't ask why they're leaving.


Several stakeholders who work with children of school age agreed that this option provides the most convenient option for families who may have difficulties accessing mental health services otherwise. One community member commented on mental health services in the schools:

Now I think we need, more than ever, we need more mental health professionals to go into the schools and [...] talk with the kids [...] I think even in schools this stuff needs to be dealt with because parents aren't doing it at home and/or they don't have time, they don't realize it. Kids don't always tell their folks what's going on. You need to read about or hear about it from somebody else.

Having these services in school could alleviate the stress upon caregivers to seek out services for their children and the many steps involved.

In addition, stakeholders/providers stated there are issues with individuals under the age of 18 receiving services due to complications with caregivers, including receiving consent, transportation, and monetary support. Caregivers may not have a reliable form of transportation, which negatively impacts the child's access to services. Individuals who are under 18 years of age may rely on their caregiver for monetary support for services that caregivers cannot provide, which also limits services available to youth according to stakeholders/providers. One stakeholder recounted these limitations:

Because those kids want to be there, but the parents can't transport them because they have to work. So, I find that a lot of the people— that lower income based, it's just



you wait. And a lot of agencies will kick them out after two missed sessions. But it's not the kids' fault. The parent can't find a way to get them there.

Providers and stakeholders also shared that family involvement can be a major barrier to receiving the appropriate services for the youth. Family buy-in can be crucial to beget change in a youth; as several providers explained, what happens in the session does not make much of a difference if the home-life remains unchanged. One provider explained the necessity of family buy-in:

I think sometimes family buy-in. So we work with children, and if you can't get that family unit involved, how do we promote real change and growth? So yes, we can do 30 minute sessions in the school, but what effective changes are we making long term? We're just focusing on a sense of relief at that point. And so I think if we can't get in the homes and provide the support, that education, and that therapeutic intervention on a family system level, then we're not going to be getting anywhere.

Youth face unique challenges when it comes to mental health services including a lack of services specific to children, complications with caregivers, and missing class time.

4. Medication/Psychiatry

Another significant need that was universally mentioned by all stakeholder/provider participants was the dearth of psychiatric and psychotropic medicine care. These two go hand in hand, as described by the stakeholders/providers. When clients want or need a medicine readjustment, there tends to not be psychiatrists available to readjust the psychotropic medication, making it extremely difficult for clients to deal with their diagnoses. Stakeholders/providers and community members alike noted that many general practitioners are uncomfortable prescribing psychiatric medications and refer patients to psychiatrists. However, psychiatry is overwhelmed and unable to see patients in a timely fashion, so these referrals from general practitioners only increase the burden. In the Sioux Falls area, the waitlists to see a psychiatrist can be longer than three months according to stakeholders/providers and community members, which leaves many individuals unable to receive their necessary medications. Some community members commented that they have had to stop their medication for months at a time due to



being unable to schedule an annual appointment with their provider. One community member shared what they have heard:

One of the biggest reasons people don't have the ability to stay on their meds is because they need their one year re-up. But there's no doctors available for three months. So I can't even tell you how many people I've spoken to within the last year that went off their meds because there's no doctors available for their annual appointment.


Stopping this medication is detrimental to their progress and causes many more complications. One provider revealed what has happened when clients are unable to see their psychiatrist: "And the unspoken truth about a lot of [clients is that they take] a shortcut... by self admitting to Avera Behavioral Health because it's the fastest way to be able to see a psychiatrist and actually get your meds." This causes unnecessary hospital visits when clients just need a medication readjustment. In addition to a dearth of psychiatric care, participants explained medication access can be difficult for patients due to cost. Psychiatric medications can often be expensive, especially if an individual does not have prescription drug coverage with their insurance.

5. Funding

One major need discussed by stakeholders and providers is more funding. As will be discussed in the next section, "Mental Health Provider Support," those working in the social service field are not well compensated for their work. With the field's high turnover rate, training more professionals requires more time and financial resources. According to stakeholders/providers, funding is crucial for programs to continue and to hire high-quality staff to run them. One stakeholder described the cruciality of funding:

And then funding for sure. Because, you know, if we at least had the funding to be able to give that to people, it would be, I mean truly life saving. It's sometimes- it's a matter of life and death when it comes to mental health.

Participants noted that in general more funding is needed for organizations, but more specifically they brought up two important factors to consider with funding: restrictions and staff. With certain funding organizations have received, there are strict guidelines




regarding who is eligible to receive services and how long services may last. A provider shared their frustrations with limitations on funding:

All [funding sources] have these really nasty limits. So what's happening is these people got a little bit of hope, got eight counseling sessions, and now they're being terminated with nowhere to go. So how helpful can it be when you build a relationship only to have to end... eight sessions, eight hours with somebody and not have follow up.

Many stakeholders/providers shared their experiences of larger organizations receiving generous amounts of funding, but not implementing new programs as intended. Participants attributed this to high turnover and low staffing with no one at these organizations to implement and manage new programs as discussed in "Lack of Providers." This leaves crucial funding untouched when it could have been utilized to help many in need of services. Stakeholders/providers unanimously agreed that more funding is needed, but how it is distributed or restricted can hinder funding from being used at its full potential.

6. Mental Health Provider Support

Many mental health and social service providers are not compensated at levels commensurate with their training and education or the hard work that they do for the Sioux Falls community. One stakeholder compared the starting wage at some fast food chains as being more competitive than what a beginning counselor makes: "And I think another big gap is the, the funding from the state just is not sufficient to keep staff around in a place like that, because they're paying less than Taco John's." This disparity adds to the lack of providers in the area and does not attract new graduates, which only exacerbates provider shortages. As discussed in the section "Licensure Difficulties," the path to becoming a mental health professional is long and arduous, much like becoming a medical professional. Stakeholders and providers believed that mental health is a part of the medical field, but is not treated as such. As one provider put it: "I think it's ridiculous that it's treated as a medical field and it [compensation] just pales in comparison to other medical providers. And so I would like to see it be treated



as important as a medical doctor.” Participants noted that support for the mental health workforce looks not only like proper compensation, but more tools and resources:

But the state still kind of sees us as necessary evils. And until we embrace the necessity, and it's not just about paying people, it's about giving them resources, so that they can actually do what they need to do...

Since the pandemic and heightened case loads, providers are burnt out and need more support than ever before. One stakeholder described how burnout has affected their staff:

Staff mental health and mental well being is definitely a concern. Just concerned to see people being burnt out after two years of doing your regular job plus, now all these other things, and that constantly being able to be connected [...] And I think people did really well. Last year, I saw people like, “Hey, we're gonna make it. We're going to get through this year.” And then this year, you can just see people being so tired and burnt out and kind of done. And so, you know, your staff and in their ability to keep doing the things that they are doing is a concern.


Mental health professionals need support financially and through more resources to support their wellbeing in order to continue doing the important work they do.

7. Long Term Mental Health Care

The majority of mental health facilities in Sioux Falls are meant for short-term inpatient stays (3-7 days) or outpatient services. One type of mental health care that is missing, according to stakeholders/providers, is long term mental health care. One provider shared their views on long term care:

Because we don't have any long term care, yes, it is also a weakness. We don't have a facility where somebody can go for 30 days. Those exist all over the country. They're outrageously expensive. But they're vitally important. Because there are people who don't escape crisis in three to five days.

There are very few long term mental health facilities in the area leaving those in need to occupy hospitals in Sioux Falls or having to search in other states for solutions. This causes problems within the one psychiatric hospital in Sioux Falls where the number of



beds quickly becomes filled according to participants. Stakeholders/providers mentioned that these types of facilities can be expensive to attend, but there are already many individuals leaving the state to seek out this kind of care, so a need for this type of care exists.

V. Recommendations

Based on the numerous analyzed conversations with mental health providers, key stakeholders, and community members depicted above, researchers have several recommendations for the Sioux Falls community in order to increase accessibility of mental health services by breaking down barriers and empowering members of the community. The following section will describe six recommendations for the community. These recommendations are not exhaustive, but are ones that, based on the present findings, would be impactful and achievable.

1. Ensure accessible transportation connects clients and mental health care providers.

Transportation poses a major barrier for individuals seeking out mental health care, and the public transportation of Sioux Falls does not remedy this problem. Updates to the bus system are recommended, including adjusting or expanding routes to reach farther into the community and adding bus stops at key mental health facilities such as Avera Behavioral Health and Falls Community Health. One major complaint of the bus system by all participants was the inconsistency of route times. Unpredictable arrival times can make it impossible to make it to appointments in a timely fashion. In addition to bolstering the bus system, smaller organizations who provide rides should receive more support. One example of this is Project CAR, which provides rides to individuals who need transportation to medical appointments at no cost to the individual.⁹⁴ By bettering the bus system and assisting other organizations that provide rides, the barrier of transportation can be diminished, which could encourage more individuals to seek out mental health services.

⁹⁴ Project CAR. (n.d.). <https://projectcarsf.org/>.

2. Increase access to affordable mental health care.


One of the most inhibitive barriers discussed with participants was insurance difficulties like high deductibles and lack of coverage along with high cost of services. With the recent adoption of Medicaid expansion, insurance coverage should increase for many lower income South Dakotans. Specifically, Medicaid expansion will help individuals who currently do not qualify for Medicaid by July of 2023. Medicaid expansion is projected to help over 42,000 South Dakotans who currently make less than \$19,000 per year.⁹⁵ Expanded coverage could encourage those individuals who need mental health services, but have not sought them out due to lack of insurance and high cost of services.

Additionally, researchers recommend continued efforts to identify ways to increase access to affordable mental health care, including diverse modalities and treatment options. Achieving this recommendation will require policy change to expand insurance coverage. More immediately, stakeholders and providers could collaborate locally to identify innovative ways to deliver mental health care affordably.

3. Increase diversity and number of mental health care providers.

Lack of providers and diversity within mental health services were two of the most prominent topics discussed by participants, and one recommendation to aid these is to build a pipeline for more mental health professionals in the area. More specifically, there needs to be more professionals who are diverse in their identities, modalities provided, and language in which services are offered. At the moment, there are large groups of community members that are underserved due to a lack of providers overall, lack of diversity of services, and lack of languages other than English available. Strategically recruiting professionals in the area can target many of these

⁹⁵ *Join Our Fight to Expand Medicaid in South Dakota*, "American Cancer Society Cancer Action Network," 2022, Retrieved October 16, 2022, from <https://www.fightcancer.org/join-our-fight-expand-medicaid-south-dakota>.




issues at once while expanding the types of individuals receiving services. Current efforts to recruit professionals have been unsuccessful, which is unsurprising after hearing the stories of providers and stakeholders who describe difficulties obtaining licensure and lack of support. There must be more incentive for providers to come to the area and stay, which includes increased support as described in the final recommendation.

Stakeholders and providers could develop programs to increase and diversify the pipeline into mental health care professions. For example, they might consider developing a program similar to the Sioux Falls School District's Teacher Pathway program. This program aims to encourage local high school students to explore careers as teachers, pursue college, and enter the field. Researchers recommend a similar program where high school students are encouraged to pursue a career in mental health, either as a provider or advocate.

4. Educate community members and stakeholders/providers to increase mental health literacy.

Lack of awareness of mental health and its resources was reported as a major reason as to why many community members do not seek help when they need it. Another term for the awareness of mental health and resources is mental health literacy, which consists of knowledge of disorders and risk factors, the ability to recognize psychological distress, and awareness of how to seek mental health information. As discussed in the "Needs" section, education about mental health and its resources was recommended by stakeholders and providers in order to combat the current lack of awareness within the community. To increase the mental health literacy of the community, researchers recommend taking several different approaches to reach every population within the community:


One recommendation from researchers involves appointing community health workers or community liaisons who are recognized and trusted leaders from their portion of the community and who can educate individuals about mental health and



the various resources available in the area. Creating discussions about mental health will help not only teach the importance of mental health resources, but also serve to decrease stigma. The intent of community liaisons is to help reach those who would not otherwise seek out mental health services but may be at risk of developing a need for services such as those with low socioeconomic status, immigrants, and minority populations. Involving the community in initiatives to promote mental health is crucial to understand where they see gaps in services and how they want organizations to be involved.

Additionally, providers should increase community outreach. When conducting focus groups and interviews with community members, researchers noticed a theme: community members consistently did not know where to go to find mental health resources, especially when it came to youth. Stakeholders and providers, on the other hand, could name various resources that community members could utilize to find mental health services that fit their needs. This gap in knowledge could be filled by the previous recommendation of community liaison, but researchers also recommend organizations do more community outreach. Outreach can take on many different forms, but one area researchers recommend targeting is the youth and family population. This may mean seeking out at-risk youth and families to involve them in mental health programming that they may have not had the opportunity otherwise to participate in. Based on the feedback from stakeholders and providers, youth and family programming encounters many barriers to providing services, so making services easy to join and maintain will best suit this population. Several stakeholders who work with children and youth recommended entering the schools to provide services and educate students on the importance of mental health. Incorporating mental health into school curriculum is an easy way to reach youth who may not have sought out services.


Lack of awareness of services was not only an issue among community members but stakeholders and providers as well; many were able to name several organizations, but they could not pinpoint the services they offered. If



stakeholders/providers struggle with this, then this must be extremely difficult for community members to navigate as well. Researchers suggest creating a mental health network that describes services offered at every agency in the area, current availability, whether they offer a sliding fee scale, and what insurance types they offer. Although having the 211 Helpline Center's Mental Health Guide for Sioux Falls 2021 is helpful in the sense of listing possible organizations individuals can access, having a reimagined approach to this guide such as up to date organizations, services they provide, the current availability of such services, and having a user-friendly interface would all facilitate the process of accessing resources in the Sioux Falls community. This type of service could cut down on the frustrations of calling several clinics to be rejected for different reasons and encourage transparency. It takes courage to call even one mental health clinic when someone is struggling, let alone calling several only to be rejected or put on a waiting list for several months. An important note for this mental health service network is that it must be easily navigable for both providers and community members. Researchers recommend a separate portal for providers to update their information and a public domain for those seeking services. The ability to contact the agency from this network would provide an advantage so community members could navigate one site for all their mental health services needs. This network would also be a great place to provide educational information to community members about mental health and what different types of services cater to different needs. Although this would be an arduous project to undertake, it would drastically improve the accessibility of services in the area.

5. Provide basic needs of community members in addition to mental health care.

One of the greatest challenges that face community members who may require mental health services is meeting basic needs. As discussed in the "Basic Needs" section, providers argue that without meeting an individual's basic needs first, mental health services will not be impactful. These basic needs include housing and food




security; if an individual does not have these two needs met, therapy will be not as effective as they have greater needs at the moment. Unmet basic needs also contribute to mental health concerns as can be seen with the houseless population as discussed in the “Background Literature” section of the report. Researchers suggest the community invest more into meeting basic needs for fellow community members as it will benefit not only their immediate needs, but also lay the foundation to begin work on their mental health concerns.

6. Increase support to mental health care professionals.

Providers and stakeholders made a point to emphasize their own needs for support. Those who work in the helping professions have one of the most difficult jobs, and mental health care professionals are no exception. However, they are much less valued than other helping professions in terms of compensation and support. The lack of providers is no surprise when considering the relatively low levels of compensation for those working in the mental health field, especially in this area. More funding to support mental health professionals is essential to keep the mental health workforce here and to encourage more providers to come to the community. As the demand for mental health services has steadily increased, the number of providers has not, partly due to the lack of support they receive. It is crucial to begin valuing mental health professionals and acknowledging the hard work they do for the community. One way is to properly compensate mental health professionals that matches their educational and or experiential attainment.

Another way is to publicly recognize the hard unnoticed work that mental health professionals are doing through mental health advocacy campaigns, thank-you dinners, and bonuses, just to name a few. Mental health providers should have the opportunity to meet with each other and get to know the work of each other. This will help with getting providers connected with services that they may not yet be aware of but could prove to be beneficial for them in the future. Having such opportunities will facilitate the knowledge about resources the clients of providers that they are able to



access. The opportunity to network and have continuous contact with different providers in the community will greatly benefit the Sioux Falls community.

Overall, the mental health profession has not been properly compensated which quickly leads to burnout. In order to alleviate the burnout that providers are feeling, greater compensation and public recognition would be of benefit for the community. Along with having recurring meetings with other providers, the community would greatly benefit from an increase in support.

VI. Conclusions

Overall, mental health care in Sioux Falls faces challenges on many levels, from lack of providers creating long waitlists, to community members' lack of awareness of services, to the lack of diversity among providers and services. Insurance difficulties and high prices for services leave agencies who do provide free or sliding fee scales overwhelmed and unable to provide services in a timely fashion for those in need. Those suffering from a mental health concern face numerous barriers and challenges in order to access mental health care. At the same time, there is little to no support for the providers and stakeholders putting in long hours to try to meet the unending need for mental health services in the area.

To address some of the gaps found in the needs assessment, researchers have proposed recommendations to the community in the Sioux Falls area. There needs to be more community outreach to understand community members' perceptions of mental health resources and needs via community liaisons and an easy-to-navigate network of services. More recruitment or training of mental health professionals into the area is necessary to keep up with the growing demand and diversity of the community. Providers and stakeholders require better compensation and more funding to accomplish these goals and receive the support they need in a rigorous profession. Basic needs should be addressed such as housing, food security, and transportation to help alleviate systemic stressors that are impeding individuals with mental illnesses to receive the proper mental health care that they need.

Those who live with a mental illness already face many barriers, and the challenges to seek out and obtain mental health care should not be one. They should not have to worry about a waitlist while in crisis or whether they can afford the one provider they found who is available. Providers and stakeholders should be able to provide mental health services without worrying about their clients' basic needs like where their next meal is coming from. In addition to clients' wellbeing, providers should not be concerned with being able to provide top quality services due to feeling overwhelmed and burnt out from their workload. The mental health care system of




Sioux Falls needs more support that could benefit both providers, those in need, and the community as a whole.

Future Research

Although this needs assessment has examined the range of mental health needs of the Sioux Falls community, further research is recommended to gain an even better understanding of what mental health care needs are present within the community. This study conducted focus groups with community members, but the number of participants was small. Researchers recommend more extensive outreach to community members to better understand their perceptions of mental health needs and how mental health care can change in order to better suit their needs. The qualitative data collected for this report can help gauge community attitudes and thoughts at a deeper level and to start the conversation about mental health. In the future, researchers recommend augmenting this qualitative data by collecting quantitative data in order to better generalize results to the entire population. In particular, this could be useful to gauge interest in potential solutions to the issues presented in this report.

This study suggests that racial and ethnic differences may impact the types of needs and quality of care available to different groups in Sioux Falls. However, given the project's limited scope, researchers did not have significant findings regarding the racial demographics of individuals who have unmet mental health needs. Although a few focus groups and interviews were held with some Spanish-speaking adults, the research is limited to a majority white, middle-aged, female population. Future research—especially research inclusive of multilingual communities—should focus efforts to include systemically non-dominant groups through extensive community outreach and continuous contact with group leaders. This research project is missing valuable voices that tend to be ignored in mental health research. In future mental health needs research, there should be a more focused lens through which the



researchers can fully explore the specific lens giving strong and significant understanding of unmet mental health needs.

Appendix I (Tables)

Table 4. Demographic information of community member participants (N = 24)*

Demographic	Number of Participants (N =24)
Age	
18-29	37.50%
30-49	37.50%
50-64	12.50%
65+	12.50%
Sex	
Male	8.33%
Female	83.33%
No Response	8.33%
Gender	
Male	8.33%
Female	79.17%
Nonbinary	12.50%
Education	
<High School	8.33%
High School	16.67%
Some College	41.67%
College Degree	25.00%
More than College	8.33%
Race	
Non-Hispanic white or Caucasian	45.83%
Non-Hispanic Native American or Alaska Native	4.17%

Hispanic/Latino	50.00%
Total Household Income	
<\$10,000	25.00%
\$10,000-24,999	16.67%
\$25,000-49,000	8.33%
\$50,000-74,999	20.83%
\$75,000-99,999	4.17%
>\$100,000	20.83%
Current Living Situation	
Live alone in my own home (house, apartment, condo, trailer, etc.)	33.33%
Live in a household with other people	62.50%
Live in a residential facility where meals and household help are routinely provided by paid staff (or could be if requested)	4.17%
Live in a facility such as a nursing home that provides meals and 24-hour nursing care	0%
Temporarily staying with a relative or friend	0%
Temporarily living in a shelter or homeless	0%

* Community focus groups had 25 participants but only 24 completed a demographic survey.

Appendix II (Materials)

A – Focus Group Script - Stakeholders/Providers

Introductions

Hi, my name is ____, and I am a researcher from Augustana University. I would like to thank everyone for joining us today for this focus group concerning mental health needs in our community. I invite everyone to briefly introduce themselves.

Thank you again everyone for joining us today. We are glad to have you here.

Before we begin the discussion, we would like to go over the informed consent.


Informed Consent

We are conducting a mental health needs assessment for Sioux Falls and the surrounding metro area. I have a set of questions to ask the group, and it should take about 90 minutes.

The purpose of this discussion is to better understand available mental health resources, current client challenges, attitudes regarding mental health, overall mental health challenges, and barriers accessing mental health resources. Participation in this discussion is voluntary, and there will be no individual benefit from participating. You don't have to answer any questions you don't want to, and you are free to stop at any time.

[Read for in-person] Due to the nature of social gatherings, there is a risk of transmission of COVID-19. To lower your risk of transmission, we require you to wear a mask and space out at least six feet away from one another. There is no penalty if you do not want to participate.

The focus group will be recorded and transcribed. After it is transcribed, the original recording will be destroyed. With your permission, your name and affiliation will be included in a list of stakeholders who were consulted for this report. It will not be directly connected to any of your answers or the information you share with me. If you prefer, your identity will be kept confidential and your name will not be reported.



[Read for focus groups] I ask that participants respect the confidentiality of the discussion, but given the nature of group discussions, I cannot guarantee that other participants will keep information you share or your identity strictly confidential.

We would appreciate to hear your complete and honest opinions about the topics we will discuss today. There are no right or wrong answers to our questions. We highly encourage you to speak freely and honestly about your opinions and experiences. You can choose not to respond to a question at any time. You can also end the discussion at any time.

If one of our questions is unclear, please feel comfortable to stop us and we can ask the question in a different way. All information collected from these sessions will be stored securely and kept confidential. None of the comments you make during today's discussion will be tied to your name in any way. The discussion should take about 90 minutes [30 minutes for interviews]. For more information about this project, contact Dr. Suzanne Smith at (605) 274-5010 or suzanne.smith@augie.edu.

[For the research team]:

(In person) *Please collect signed written consent forms from each of the participants.*

(Online/Zoom) *Ask questions below and record consent using the oral consent forms. Have the participants electronically sign the consent forms by commenting their names in the chat function.*

Do you agree to participate?

- Yes
- No

May I include your name and affiliation in a list of experts?

- Yes
- No

In addition to taking notes, we would like to audio record this session. The recording will help us to summarize today's discussion concisely. Do you agree to have this interview recorded? The data from the recordings will remain confidential.

- Yes
- No

Introduction

Please tell us a little bit about your job, role, and your favorite part of your job.

Mental Health


1. How would you (or your organization) define mental health?
 - a. What comes to mind when you think about “mental health”?
 - b. What connotations are tied to mental health?
2. What goals are you and your clients working on to achieve mental health?

Resources’ Strengths

3. How are you (or your organizations) positively contributing to mental health resources?
 - a. How are you contributing to mental health resources?
 - b. How are other organizations positively contributing?
 - c. What is working right now?
4. How is the community contributing to mental health resources?

Community Mental Health Needs

5. Without disclosing identifiable information, what are common challenges for your current clients?
 - a. If you had an uptick in workload, what led them to seek you or your organizations’ services?
6. What could impede seeking mental health resources?
 - a. Accessibility?
 - i. Money?
 - ii. Transportation?
 - iii. Availability?
 - b. Language barriers?
 - c. Cultural barriers?
 - i. Stigma?
7. What challenges did COVID-19 raise in the seeking of mental health resources?
8. What other mental health challenges need to be addressed in the community as a whole?



[Instructions for research team] Move on to the Activity, using Version A, B, or C depending on the focus group/interview setting.

Activity Version A. In Person Focus Group

[Instructions for research team] From the notes that the researchers have from questions 3, 4, 5, 6, and 8, have researchers write categories down as concise or general as possible on big pieces of notecards. There should be three main general themes from the notes, “Current Strengths,” “Barriers,” and “Needs.” The participants will be told that they have 10 stickers to award for each category under a general theme. From there, the participants can distribute their 10 stickers for each topic as they see fit. Record responses.

Script for instructions:

We will now move to an activity. As you can see, we have three different themes written on the big pieces of paper: Current Strengths, Barriers, and Needs. Our researchers have taken notes from the discussion and will concisely write categories down on these pieces of paper for each general topic. You have 10 stickers to award under each general topic. Your job is to award or distribute your 10 stickers, under each topic, by the personal level of importance. It is completely up to you how you want to distribute the 10 stickers. You are free to explain why you chose to distribute the stickers the way you did only if you feel comfortable with doing so.

9. What made you decide to award the stickers the way you did?

Activity Version B. Focus Group On Zoom

[Instructions for research team] Create a poll on Poll Everywhere and share the screen to display the poll. The team will have three main topics for each poll: Current Strengths, Barriers, and Needs. For each poll, the team will concisely create responses based on the answers given from questions 3, 4, 5, 6, and 8. The participants will vote on what they think is the most important theme under each topic. Record responses.

Script for instructions:

We will now move on to an activity. Our research team has created a poll, as you can see now, the poll says “Current Strengths” and the answers consist of themes

you all have identified during our discussion earlier. We will see two other polls labeled “Barriers” and “Needs”. Your job is to vote for the most important theme. We will discuss the results afterwards.

9. What made you vote the way you did?

Activity Version C. Interview in person or Online

Script for instructions: We will now discuss the important themes that you brought up. We have three categories in which we will talk about their themes. The first category is “Current Strengths.”

9. What are 3 important current strengths in regards to mental health resources?

We will move on to the second category, which is “Barriers.”

10. What are 3 important barriers that need to be addressed to access mental health resources?

Finally, our final category to talk about is “Needs”.

11. What are 3 important needs that need to be addressed in the community in the pursuit to access mental health resources?

[All Group Types] Improving MH Needs

10. Think about your organization, how can they further improve mental health resources?

a. How would you improve mental health resources?

11. What can other organizations in SFMA do to further improve mental health resources?

a. What role does the city play in improvements?

b. What role does your organization play for improvements?

c. What role do you play for improvements?

B – Interview Script – Stakeholders/Providers

Introductions

Hi, my name is ____, and I am a researcher from Augustana University. I would like to thank everyone for joining us today for this focus group concerning mental health needs in our community. I invite everyone to briefly introduce themselves.

Thank you again everyone for joining us today. We are glad to have you here.

Before we begin the discussion, we would like to go over the informed consent.

Informed Consent

We are conducting a mental health needs assessment for Sioux Falls and the surrounding metro area. I have a set of questions to ask the group, and it should take about 30 minutes for interviews.

The purpose of this discussion is to better understand available mental health resources, current client challenges, attitudes regarding mental health, overall mental health challenges, and barriers accessing mental health resources. Participation in this discussion is voluntary, and there will be no individual benefit from participating.

The focus group will be recorded and transcribed. After it is transcribed, the original recording will be destroyed. With your permission, your name and affiliation will be included in a list of stakeholders who were consulted for this report. It will not be directly connected to any of your answers or the information you share with me. If you prefer, your identity will be kept confidential and your name will not be reported.

[For the research team]:

Do you agree to participate?

- Yes
- No

May I include your name and affiliation in a list of experts?

- Yes

No

In addition to taking notes, we would like to audio record this session. The recording will help us to summarize today's discussion concisely. Do you agree to have this interview recorded? The data from the recordings will remain confidential.

Yes

No

Introductions

Please tell us a little bit about your job, role, and your favorite part of your job.

Mental Health

1. How do you define mental health?
 - a. How would you explain mental health to someone?
 - b. What comes to mind when you hear "mental health"?
 - c. What connotations are tied to mental health

Resources Strengths

2. In your line of work, how are you positively contributing to mental health resources?
 - a. What contributions do you make to mental health resources
 - b. How are your organizations contributing?
 - c. What is working right now?
3. How is the community contributing to mental health resources?

Community Mental Health Needs

4. Without disclosing identifiable information, in your line of work, what are common challenges that many people face?
 - a. If you had an uptick in workload, what led these individuals to you or your organizations?
5. What challenges do you see, from the individuals that you have interacted with, that impedes their ability to seek out mental health resources?
 - a. Accessibility?
 - i. Money?
 - ii. Transportation?
 - iii. Availability?
 - b. Language barriers?

- c. Cultural barriers?
 - i. Stigma?
- 6. What challenges did COVID-19 raise in your line of work?
- 7. What other mental health challenges need to be addressed in the community as a whole?

Interview in person or Online

Script for instructions:

We will now discuss the important themes that you brought up. We have three categories in which we will talk about their themes. The first category is “Current Strengths.”

- 8. What are 3 important current strengths in regards to mental health resources?

We will move on to the second category, which is “Barriers.”

- 9. What are 3 important barriers that need to be addressed to access mental health resources?

Finally, our final category to talk about is “Needs”.

- 10. What are 3 important needs that need to be addressed in the community in the pursuit to access mental health resources?

Improving Mental Health Needs

- 11. Think about organization, how can they further improve to gear individuals to proper resources and care?
 - a. How would you improve mental health resources
- 12. What can other organizations in SFMA do to further improve mental health resources?
 - a. What role does the city play in improvements?
 - b. What role does your organization play for improvements?
 - c. What role do you play for improvements?

C – Focus Groups and Interview – Community Members

Introductions

Hi, my name is ____, and I am a researcher from Augustana University. I would like to thank everyone for joining us today for this focus group concerning mental health needs in our community. I invite everyone to briefly introduce themselves.

Thank you again everyone for joining us today. We are glad to have you here.

Before we begin the discussion, we would like to go over the informed consent.

Informed Consent

We are conducting a mental health needs assessment for Sioux Falls and the surrounding metro area. We have a set of questions to ask the group and it should take about 60 minutes.

The purpose of this discussion is to better understand available mental health resources, current challenges, attitudes regarding mental health, overall mental health challenges, and barriers accessing mental health resources.


Participation in this discussion is voluntary, and you will receive a \$25 Hyvee gift card upon completion. You don't have to answer any questions you don't want to, and you are free to stop at any time.

Due to the nature of social gatherings, there is a risk of transmission of COVID-19. To lower your risk of transmission, we recommend participants to follow current CDC guidelines. There is no penalty if you do not want to participate.

The focus group will be recorded and transcribed. After it is transcribed, the original recording will be destroyed. Your names will not be collected. Your identity will not be directly connected to any of your answers or the information you share with us.

I ask that participants respect the confidentiality of the discussion, but given the nature of group discussions, I cannot guarantee that other participants will keep information you share or your identity strictly confidential.

We would appreciate to hear your complete and honest opinions about the topics we will discuss today. There are no right or wrong answers to our questions. We



highly encourage you to speak freely and honestly about your opinions and experiences. You can choose not to respond to a question at any time. You can also end the discussion at any time.

If one of our questions is unclear, please feel comfortable to stop us and we can ask the question in a different way. All information collected from these sessions will be stored securely and kept confidential. None of the comments you make during today's discussion will be tied to your name in any way. The discussion should take about 60 minutes. For more information about this project, contact Dr. Suzanne Smith at (605) 274-5010 or suzanne.smith@augie.edu.

[For the research team]:

(In person) Please collect signed written consent forms from each of the participants.

Do you agree to participate?

- Yes
- No

In addition to taking notes, we would like to audio record this session. The recording will help us to summarize today's discussion concisely. Do you agree to have this interview recorded? The data from the recordings will remain confidential.

- Yes
- No

Introductions


To begin our discussion today, please tell us your name and what you enjoy doing in your free time.

Perceptions of Mental Health

1. When you hear the term "mental health" what comes to mind?
 - a. How would you explain mental health to someone?
 - b. How would other members of your community explain this term?
 - c. What do you think when you hear the term "mental illness"?
 - i. In what ways are the terms "mental illness" and "mental health" similar? How are they different?
 - d. [Go to Q4, 5, 6 pending discussion]

Mental Health literacy (4, 5, 6 dependant on question 3)

2. How familiar are you with substance abuse?
 - a. Have you, or your community, experienced instances where you or they are trying to cut back on substances?
 - i. either alcohol
 - ii. marijuana,
 - iii. other drugs?
 - b. How successful were the efforts to cut back on substances?
 - c. What resources did you, or they, seek?
 - i. How effective was the care?
 - ii. Tell me the level of satisfaction with the care you, or they, received.
 - iii. What other resources are available to you?
3. How familiar are you with Depression?
 - a. If you feel comfortable sharing, have you, your immediate family, friends, or any other acquaintance experienced depression?
 - i. How did you know you or they were experiencing depression?
 1. What are other ways that depression can manifest itself?
 - ii. What resources did you, or they, seek?
 1. How effective was the care?
 2. Tell me the level of satisfaction with the care you, or they, received.
 3. What other resources are available to you?
4. How familiar are you with Anxiety?
 - a. If you feel comfortable sharing, have you, your immediate family, friends, or any other acquaintance experienced intense anxiety (out of normal)?
 - i. How did you know you or they were experiencing anxiety?
 1. What are other ways that anxiety can manifest itself?

- 
- ii. What resources did you, or they, seek?
 1. How effective was the care?
 2. Tell me the level of satisfaction with the care you, or they, received.
 3. What other resources are available to you?

Barriers and Needs for Mental Health Access

5. What do you think are the greatest needs in your community regarding mental health?
6. What were the most challenging parts trying to access mental health resources?
 - i. COVID
 - ii. Language
 - iii. Money/insurance
 - iv. Transportation
 - v. Stigma
 - vi. Cultural
 - vii. Work place
 - a. What were the least challenging parts trying to access these resources?
7. How has the COVID-19 pandemic affected you, your immediate family, friends, and or other acquaintances' mental health?
8. What are some ways that the Sioux Falls community can better assist you, your immediate family, friends, or other acquaintances in regards to getting you connected with resources?
9. What mental health services would you like to see in Sioux Falls?
 - a. Any particular services that would be beneficial to you, your immediate family, friends, or other acquaintances?

[For the research team]:



*Please hand out surveys to participants and collect as they leave.
Hand each participant a gift card as they return the surveys.*

D – Survey – Community Member

Age? _____

What is your sex? _____

What is your gender? _____

Are you of Hispanic, Latino, or Spanish origin?

Yes

No

What is your race? (select all that apply)

Caucasian or white

Black or African American

Native American or Alaska Native

Asian

Native Hawaiian or other Pacific Islander

Multi-racial

Other: _____

What is the highest level of education you have completed?

Less than high school

High school (GED)

Some college or technical school

College degree

More than college

What is your total household income?

<\$10,000

\$10,000-\$24,999

\$25,000-\$49,999

\$50,000-\$74,999

\$75,000-\$99,999

>\$100,000

What is your current living situation?

Live alone in my own home (house, apartment, condo, trailer, etc.)

Live in a household with other people

Live in a residential facility where meals and household help are routinely provided by paid staff (or could be if requested)

Live in a facility such as a nursing home that provides meals and 24-hour nursing care

Temporarily staying with a relative or friend

Temporarily living in a shelter or homeless

Other: _____

Please return to a researcher before you leave

E – Spanish Interview and Focus Groups – Community Members

Introducciones

Hola, mi nombre es ____ y estoy representando a la Universidad de Augustana. Gracias por acompañarnos hoy para una discusión en grupo sobre necesidades de salud mental en nuestra comunidad. Invito a todos a presentarse brevemente.

Gracias otra vez por acompañarnos hoy. Estamos agradecidos que estén con nosotros.

Antes de empezar la entrevista, vamos a repasar el consentimiento informado.

Consentimiento Informado

Estamos dirigiendo una evaluación de necesidades de salud mental para la ciudad de Sioux Falls y las áreas del alrededor. Tengo algunas preguntas para la discusión y debería de durar 60 minutos.

El propósito de esta discusión es para poder entender mejor los recursos disponibles de salud mental, los desafíos actuales, actitudes sobre la salud mental, desafíos de salud mental en general, y barreras para poder acceder recursos de salud mental.

Siempre y cuando acabe la entrevista, recibirá una tarjeta de \$25 a Hyvee por su participación voluntaria en esta discusión. No tiene que responder a cualquier pregunta que le sea incómoda y tiene derecho a terminar la discusión en cualquier momento.

[Leer para entrevista en persona] Por la naturaleza de encuentros sociales, tiene un riesgo de la transmisión del virus COVID-19. Para mitigar su riesgo de transmisión, le requerimos que siga las reglas de encuentro del CDC. No hay ninguna penalidad por no querer participar en la discusión.

La discusión será grabada y transcrita. Después de que se haya transcrito, la grabación original va ser destruida. Su nombre no va a estar conectado a cualquier respuesta o información que nos comparte. Su identidad será guardada confidencialmente y su nombre no será reportado.

[Leer para discusión en grupo] Pido que los participantes respeten la confidencialidad de la discusión, pero por la naturaleza de discusiones en grupo, no

puedo garantizar que otros participantes mantendrán la información que comparte o su identidad en secreto.

Agradeceríamos escuchar sus opiniones completas y honestas sobre los temas discutidos hoy. No hay respuestas correctas o incorrectas a nuestras preguntas. Le promovemos a hablar libremente y honestamente sobre sus opiniones y experiencias. Usted puede optar por no responder a una pregunta en cualquier momento. Usted puede terminar la discusión en cualquier momento.

Si una pregunta no está tan clara para usted, puede pedir que paremos y le podemos preguntar en otra manera. Toda la información adquirida de estas sesiones van a estar seguramente guardadas y confidencialmente también. Ninguno de los comentarios que haga usted durante la discusión de hoy será relacionado a su nombre en ninguna manera. Esta discusión debería de durar más o menos 30 minutos. Para más información sobre el proyecto, entre en contacto con la Dra. Suzanne Smith al (605) 274-5010 o suzanne.smith@augie.edu.

[Para el equipo de investigación]:

Por favor coleccionan los consentimientos informados firmados de cada participante.

¿Está de acuerdo en participar en la entrevista?

- Sí
- No

Además de hacer notas, queremos grabar esta discusión. Esta grabación nos ayudará a resumir la discusión de hoy precisamente. ¿Está de acuerdo en que se grabe esta discusión? La información de las grabaciones serán confidenciales.

- Sí
- No

Para empezar la discusión, por favor díganos cuál es su nombre, donde trabaja, y que le gusta hacer en su tiempo libre.


Percepciones de Salud Mental

1. ¿Cuándo escucha la frase “salud mental” qué es lo que le viene a la mente?
 - a. ¿Cómo se lo explicarías a alguien más?

- b. ¿Cómo explicarías esta frase a otros miembros de tu comunidad?
- 2. ¿Qué es lo que se le viene a la mente cuando escucha la frase “una enfermedad mental”?
 - a. ¿En qué maneras las frases “salud mental” y “enfermedad mental” están relacionadas?
 - i. ¿Cómo son diferentes?
- 3. ¿Cuáles son las necesidades mayores en su comunidad respecto a la salud mental?
 - a. [ve a las Qs 4, 5, 6 discusión pendiente)

Educación de SM (4, 5, 6 dependiente a la 3)

- 4. ¿Qué tan familiarizado está con el abuso de sustancias?
 - a. Solo si se siente cómodo, ¿Usted, alguien de su familia inmediata, amigos, o cualquier otro conocido ha tenido experiencias donde quiso, o quisieron, tratar de limitar su consumo de sustancias?
 - i. ¿Con alcohol?
 - ii. ¿Marijuana?
 - iii. ¿Otras drogas?
 - b. ¿Qué tan exitoso fue el intento de disminuir el consumo de sustancias?
 - c. ¿Qué tipo de recursos fue usted, o fueron otros, a buscar?
 - i. ¿Qué tan eficaz fue el programa?
 - ii. Platícame sobre el nivel de satisfacción con los cuidados que usted recibió, o ellos recibieron.
 - iii. ¿Sabe de otros recursos que están disponibles para usted, o ellos?
- 5. ¿Qué tan familiarizado está con la depresión?
 - a. Solo si se siente cómodo, ¿Usted, alguien de su familia inmediata, amigos, o cualquier otro conocido ha tenido experiencias con depresión?

- 
- i. ¿Cómo supo, o supieron, que estaban con depresión?
 1. ¿Qué otras maneras se puede saber cuando una persona tiene depresión?
 - ii. ¿Qué tipo de recursos fue usted, o fueron otros, a buscar?
 1. ¿Qué tan eficaz fue el programa?
 2. Platícame sobre el nivel de satisfacción con los cuidados que usted recibió, o ellos recibieron.
 3. ¿Sabe de otros recursos que están disponibles para usted, o ellos?
6. ¿Qué tan familiarizado está con la ansiedad, o “nervios severos”?
- a. Solo si se siente cómodo, ¿Usted, alguien de su familia inmediata, amigos, o cualquier otro conocido ha tenido experiencias con ansiedad, o “nervios severos”?
 - i. ¿Cómo supo, o supieron, que estaban con ansiedad?
 1. ¿Qué otras maneras se puede saber cuando una persona tiene ansiedad?
 - ii. ¿Qué tipo de recursos fue usted, o fueron otros, a buscar?
 1. ¿Qué tan eficaz fue el programa?
 2. Platícame sobre el nivel de satisfacción con los cuidados que usted recibió, o ellos recibieron.
 3. ¿Sabe de otros recursos que están disponibles para usted, o ellos?

Barreras y Necesidades para acceder recursos de Salud Mental

7. Si usted, alguien de su familia inmediata, amigos, o otros conocidos, usaron servicios de salud mental, ¿cómo fue esa experiencia?
 - a. ¿Cuáles fueron los mayores desafíos de poder utilizar estos recursos?
 - i. El COVID?
 - ii. El lenguaje?
 - iii. Dinero/aseguranza?

- iv. Transportación?
 - v. Estigma?
 - vi. Cultura?
- b. ¿Cuáles fueron los menores desafíos de poder utilizar estos recursos?
8. Cuando estaba tratando de acceder recursos, pláticame sobre el proceso para poder recibir estos servicios.
- a. ¿Fue difícil encontrar servicios?
 - b. ¿Cuánto tiempo duró esperando para poder recibir estos servicios?
 - c. ¿Cuáles fueron algunos de los desafíos mayores cuando quiso usar estos recursos?
 - d. ¿Hubo otros desafíos que prohibieron poder usar estos servicios?
9. ¿En qué maneras la pandemia del COVID-19 afectó la salud mental de usted, su familia inmediata, amigos, y otros conocidos?
10. ¿Qué maneras puede la comunidad de Sioux Falls ayudarlos mejor a usted, su familia inmediata, amigos, y otros conocidos, para que puedan conectarse con recursos?
11. ¿Qué tipo de recursos le gustaría ver en Sioux Falls?
- a. ¿Hay un servicio en particular que pueda ser beneficioso para usted, su familia inmediata, amigos, o otros conocidos?

[Para el equipo de investigación]:

Por favor, distribuyen las encuestas a los participantes y las coleccionan cuando los participantes salen. Denle a cada participante una tarjeta de Hyvee cuando regresen con las encuestas.

F – Spanish Survey – Community Members

¿Edad? _____

¿Cual es tu sexo? _____

¿Cual es tu género? _____

¿Es usted Hispano, Latino/a/e, o de origen Española?

- Sí
 No

¿Cuál es su raza? (favor de seleccionar todas las opciones correspondientes)

- Caucásico or Blanco
 Negro o Afro-Americano
 Nativo Americano or Nativo de Alaska
 Asiatico
 Nativo Hawaiano o Nativo de la Polinesia
 Multi-racial
 Otro: _____

¿Cuál es su nivel de educación que ya ha completado?

- Menos de la preparatoria
 La preparatoria o certificación equivalente
 Un poco de colegio o escuela técnica
 Título Universitario
 Más escuela después de la universidad

¿Cuál es el ingreso total de la familia?

- Menos de \$10,000

\$10,000-\$24,999

\$25,000-\$49,999

\$50,000-\$74,999

\$75,000-\$99,999

Más de \$100,000

¿Cuál es tu situación de vivienda actualmente?

- Vivir solo/a/e in mi propia casa (casa, apartamento, condominio, casa móvil, etc.)
 Vivir con otras personas en la misma residencia
 Vivir en una instalación residencial donde las comidas y la ayuda doméstica son dadas rutinariamente por personal pagadas (o podría serlo si se solicita)
 Vivir en una institución como un asilo que provee comidas y haya cuidados de enfermería de 24 horas.
 Temporalmente viviendo con un familiar o amigo/a/ue
 Temporalmente viviendo en un albergue o indigente
 Otro: llenar

Por favor, regresa el papel a un investigador antes de salir.