

PLANNING STEPS

Step 1: Assess the Strengths and Needs of the Service System to Address the Specific Populations

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Step1: Assess the Strengths and Needs of the Service System to Address the Specific Populations - Response

CRITERION 1 Comprehensive Continuum of Care

Overview and Role of the State's Mental Health System

The Department of Public Health and Human Services (DPHHS) under the Executive Branch of Montana State Government, administers a wide spectrum of programs and projects including public assistance, Medicaid, foster care and adoption, nursing home licensing, long-term care, aging services, alcohol and drug abuse programs, mental health services, vocational rehabilitation, disability services, child support enforcement activities, and public health functions (such as communicable disease control and preservation of public health through chronic disease prevention). *The Department's mission states: Improving and protecting the health, well-being and self-reliance of all Montanans.*

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for the public mental health services for children and adults under the Divisions of Addictive and Mental Disorders and Developmental Services are described below in more detail.

Oversight of the divisions is organized into Branches:

Economic Security Services Branch: Provides direct supervision over the Human and Community Services Division, Child Support Enforcement Division, Child and Family Services Division, and the Disability Employment and Transitions Division. The branch delivers a broad range of social services to communities in Montana. The branch manager develops an organized approach to family economic security, assists with interdepartmental issues such as system development and tribal relations and develops strategies to manage scarce resources.

Medicaid and Health Services Branch: Provides direct supervision over the Senior and Long Term Care Division, **Developmental Services Division, Addictive and Mental Disorders Division**, Health Resources Division, the Medicaid Systems Support Program, and the Healthy Montana Kids Program. The branch provides medical, rehabilitative, and mental health services for Montanans through a variety of programs. The branch manager oversees and coordinates programs and activities of the branch and, as the state Medicaid Director, establishes policy for the Montana Medicaid program.

Operations Services Branch: Provides direct supervision over the Business and Financial Services Division, Quality Assurance Division, Technology Services Division, Office of Budget and Finance, and Office of Fair Hearings. The branch manager develops policy on major issues affecting operations and, as the chief operating and chief financial officer, is responsible for the department's budget, finance, technology, and oversight activities.

DPHHS Divisions that provide assistance, services and support outside of children and adult mental health services, and a brief description of their scope of authority, are listed below:

The Child and Family Services Division provides state and federally mandated protective services to children who have been or at substantial risk to be abused, neglected, or abandoned. This includes receiving and investigating reports of child abuse and neglect, working to prevent domestic violence, helping families to stay together or reunite, and finding placements in foster or adoptive homes. Many children served by this Division receive public mental health services.

The Child Support Enforcement Division provides federally mandated child support enforcement services. These include locating absent parents, establishing paternity, establishing financial and medical support orders, enforcing current and past-due child support, offering medical and spousal support, and modifying child support orders.

The Disability Employment and Transitions Division is charged to advance the employment, independence, and transitions of Montanans with disabilities. Disability Employment and Transitions offers a variety of services, ranging from employment planning to transportation coordination. Disability Employment and Transitions also works with a variety of other agencies to reduce barriers for people with disabilities so that all Montanans can be free to fulfill their potential and contribute to their communities. This work is accomplished through the following programs: Blind and Low Vision Services Division, Vocational Rehabilitation, Independent Living, Disability Determination Services, Montana Telecommunications Access Program, and ASPIRE Montana Program.

Health Resources Division (HRD) administers Medicaid primary care services, Healthy Montana Kids, Children's Health Insurance Plan, and Big Sky Rx. The purpose of the division is to improve and protect the health and safety of Montanans. The division reimburses private and public providers for a wide range of preventive, primary, and acute care services. Major Service providers include: physicians, public health departments, clinics, hospitals, dentists, pharmacies, durable medical equipment, and mental health providers

The Human and Community Services Division's mission is to support the strengths of families and communities by promoting employment and providing the assistance necessary to help families and individuals meet basic needs and work their way out of poverty. They accomplish this by providing cash assistance, employment training, food stamps, Medicaid, child care, meal reimbursement, nutrition training, energy assistance, weatherization, and other services to help families move out of poverty and toward self-support.

The Public Health and Safety Division oversees the coordination of the public health system in Montana. The Division mission is to: Improve and protect the health of Montanans by creating conditions for health living. Services range in scope from nutrition support and health education (e.g., WIC & Tobacco Use Prevention) to screening services (e.g., breast & cervical cancer screening programs for uninsured women and HIV counseling & testing services) to preventive services (e.g., immunization) and surveillance systems for infectious and chronic diseases, designed to detect and target those health threats that may impact a community.

The Senior and Long-Term Care Division manages a wide variety of programs and services guided by their missions: To advocate and promote dignity and independence for older Montanans and Montanans with disabilities. The Division administers a number of Medicaid-funded options that enable people who are aged or disabled and who have limited income and resources to remain in their homes, rather than receive services in a hospital or nursing facility. The Division operates within a cost-effective service delivery system that provides information on how participants can live healthy lives, access housing options that provide least restrictive options, and provide protective or legal services. The Division also operates and manages two Veterans' Homes for those who have served their country and spouses of veterans.

<http://dphhs.mt.gov/AboutUs.aspx>: Organizational Chart

Establishment of Mental Health System of Care

Montana provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental illness and substance abuse disorders. Available services and resources within Montana's comprehensive system of care are provided primarily with federal and state resources.

Health, Mental Health, and Rehabilitation Services

The Health Resources Division (HRD) of the Montana Department of Public Health and Human Services provides health care for low-income and disabled Montanans through Medicaid. The division provides administration, policy development, and reimbursement for the primary and acute care portions of the Medicaid program. The Health Resources Division (HRD) also manages Medicaid services for Ambulatory Surgical Centers, Freestanding Dialysis Clinics, Federally Qualified Health Centers (FQHC), Rural Health Clinics, and Critical Access Hospitals.

Medicaid Services Include:

- Primary Care
- Inpatient and Outpatient Hospital
- Prescription drugs
- Transportation
- Indian Health Service
- Durable Medical Equipment
- Dental Services

The Passport to Health is Montana's managed care program for Montana Medicaid and Healthy Montana Kids (HMK) Plus clients. With some exceptions, all services to Passport clients must be provided or approved by the Passport provider. The Passport mission is to manage the delivery of health care to Montana Medicaid clients in order to improve or maintain access and quality while minimizing use of health care resources. Approximately 70% of Montana Medicaid and HMK Plus clients are enrolled in the Passport to Health Program.

The four (4) Passport programs that encourage and support Medicaid and HM Plus clients and providers in establishing a medical home and ensuring appropriate use of services include:

- Passport to Health Primary Care Case Management: Passport provider provides primary care case management (PCCM) services. Under Passport, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a “medical home.” The medical home concept encourages a strong doctor-client relationship.
- Team Care managed-care services; Team Care is designed to educate clients to effectively access medical care. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care.
- The Nurse First Program: Supported by Team Care and provides assistance to Medicaid recipients with chronic conditions, such as diabetes, asthma, and heart conditions. Through a telephone hotline, it also helps all Medicaid clients make appropriate decisions about the level of medical care they need in any given situation.
- The Health Resources Division (HRD) also manages Medicaid services for Ambulatory Surgical Centers, Freestanding Dialysis Clinics, Federally Qualified Health Centers (FQHC), Rural Health Clinics, and Critical Access Hospitals.
- Health Improvement Program: A program for clients with chronic illnesses or risks of developing serious health conditions. The program is operated statewide through a regional network of 14 community and tribal health centers. Medicaid and HMK Plus clients eligible for the Passport program are enrolled and assigned to a health center for case management.

Magellan Medicaid Administration contracts with the Department to provide children and adult health care management services. Magellan Medicaid Administration effectively integrates advanced clinical management services, operational administration and leading systems technology to help Montana manage their healthcare programs in a way that promotes access to clinically appropriate and quality care, in a cost-effective manner. Serving Medicaid and other public sector programs in 26 states and the District of Columbia, Magellan Medicaid Administration provides a wide variety of health care management services including a variety of utilization review, quality assurance and utilization management services. Magellan Medicaid Administration is certified by the Centers for Medicare and Medicaid Services as a Quality Improvement Organization (QIO or QIO-Like) which performs utilization management and care coordination of inpatient, residential and outpatient psychiatric services for Montana Medicaid.

Employment Services and Educational Services

Addictive and Mental Disorders Division (AMDD) is now proudly providing evidence based employment to four (4) mental health centers serving youth with serious emotional disturbance and adults with severe disabling mental illness. AMDD contracts with Dartmouth University to support employment programs with technical assistance, monitoring, and training. AMDD has established Individual Placement and Supports (IPS)-Evidence Based Supported Employment as a priority for the 2016-2017 Mental Health Block Grant.

For FY 2015, 144 individuals received the opportunity to work Integrated Competitive Employment in a position of their choice through AMDD’s Individual Placement and Supports Supported Employment Program. There were 99 new Job Stats for the 144 participants,

FFY 2016-2017 Community Mental Health Block Grant (Print)

indicating good job retention for some and finding other employment that may be a better fit or increased wages for others. These individuals had not had opportunity to receive evidence based employment services prior to the IPS Program.

AMDD has an established partnership with the Montana Vocational Rehabilitation (MVR) Services Program. The partnership provides for the provision of supported employment and extended/follow-along services through community based psychiatric rehabilitation or case management. Both entities are committed to strengthening relationships and increasing the incidence of successful, meaningful employment outcomes for persons with mental illness.

The Montana Medicaid for Workers with Disabilities (MMWD) began in July, 2010, as a result of action by the 2009 Legislature. MWD allows certain current and former SSDI and SSI recipients who may not be financially eligible for Medicaid to pay affordable premiums for Medicaid coverage. Montana Department of Public Health and Human Services (DPHHS) administer the MMWD program; the MMWD will allow individuals with disabilities to participate in Medicaid, if they are employed above the income eligibility limits for Montana (monthly net household income at or below 250% of the federal poverty level). MWD resource standards are significantly higher than many other Medicaid programs - \$8000 for an individual and \$12,000 for a couple. The Project has contracted with non-profit agencies to provide benefits planning and information on Social Security Work Incentives.

Medicaid for Workers with Disabilities participants currently total 461 since implementation in July 2010. Of those, 246 or 53% have a mental health diagnosis. It is important to note that participants may be eligible for the program for years while others for a shorter period of time. A disabled individual who is working may qualify for Medicaid through the Medicaid for Workers with Disabilities (MWD) program by paying a cost share fee, based on the income, to the Department of Public Health and Human Services rather than an incurment (based on medical expenses for any given month). Workers with disabilities who are enrolled members of federally recognized tribes are exempt from the cost share fees to qualify for this program.

Housing Services

Montana Department of Public Health and Human Services (DPHHS) have an established and superior working relationship with the Department of Commerce, Housing Division. The Departments of Commerce and Public Health and Human Services have partnered since 2013 on supportive housing choices for non-elderly persons with disabilities through the HUD – Section 811 Project Rental Assistance Program. The partnership between DPHHS Addictive and Mental Disorders and Senior Long Term Care Divisions and the Department of Commerce will provide an additional 82 units in the communities of Helena, Billings, Kalispell and Missoula enrolled in a Medicaid Waiver. The 811 Project will be supported on a community level with both Divisions' regional community liaisons.

Montana's PATH Program is provided priority to Department of Commerce Shelter Plus Care Vouchers – providing a safety net for those persons considered chronically homeless. The Shelter Plus Care Program has provided opportunity to house individuals who are homeless and are diagnosed with a severe disability mental illness with approximately 35 vouchers/beds/units.

The majority of Shelter Plus Care participants do not exit the program for 2-3 years as a result of limited Section 8, Housing Choice or other HUD supported housing opportunities. Over 150 Shelter Plus Care vouchers are available through community public housing authorities.

Housing has become less and less available to individuals with mental illness. In part this is due to low FMR through HUD, increased demand for housing by economic development in the gas/oil field, and, reluctance by landlords to provide housing to persons whom they see as a rental risk. Some Regional Community Mental Health Centers operate housing developments; CMHC participate with local Housing Authorities to ensure housing opportunities for those they serve to the extent available.

Housing Services Provided by the Five Larger Community Mental Health Centers. (More detailed information on Community MH Centers may be found under Licensed Mental Health Centers)

Western Montana Mental Health Center has operated a housing development arm called the Garden City CHDO (Community Housing Development) which has developed over 100 independent housing opportunities for consumers and continues to actively maximize state and federal funds available for the construction of both permanent and short term housing solutions for persons with disabilities. WMMHC has the most comprehensive housing opportunities in the state with developed crisis and adult group home facilities in major communities in the WMMC region.

South Central Montana Regional Mental Health Center (MHC) has one (1) transitional treatment facility - a group home- that provides housing with treatment to a total of eight (8) adult consumers. SCMRMHS also owns a four-plex with four 2-bedroom units available only to MHC consumers. SCMRMHC continues to participate in State and local Continuum of Care (CoC) Projects by providing and tracking the clinical component service match of HUD Shelter Plus Care Projects. The MHC would be available to work with the CoC in development of and providing clinical services to a Safe Haven Project or other housing project(s) in our region.

Eastern Montana Mental Health Center has two group homes and 8 adult foster care beds. The Center relies primarily on case managers working with consumers to find independent and suitable housing. Eastern Montana is a very frontier area and has consistently been challenged with resource development, including housing. Housing has become even more challenging for those with severe disabling mental illness, with the migration of those seeking employment with oil companies and other industries supporting this 'boom' of sorts and holding enough financial resources to secure housing opportunities that may have been available in the past to those the Center services. AMDD and the Center are collaborating to introduce Shelter Plus Care Vouchers to this area. The Miles City Homeless Coalition will be an integral partner in the process.

The Center for Mental Health: The Center for Mental Health has a capacity of 32 beds (transitional and group) in Great Falls and 14 group home beds in Helena. The Center serves individuals with serious mental illness in need of crisis services and supervision with the goal of

preparing to live independently. Transitional beds provide support for individuals after being discharged from an inpatient treatment unit or reintegrating into the community for various reasons such as returning from a military experience. Between Great Falls, Havre and Helena there are approximately 46 beds available in the Adult program. All of these individuals in these programs have the availability of case management services, out-patient services, med management, psychiatric assessments, supported employment, crisis services, etc.

AWARE Inc. Housing Services: Since AWARE's founding in 1976, housing has been a core service for AWARE recognizing that quality, accessible, affordable, stable housing is the foundation of successful community living for persons with disabilities. The AWARE acronym stands for Anaconda Work and Residential Enterprises, and although known simply as AWARE today, meeting the housing needs of persons with disabilities remains a primary organizational mission. AWARE maintains 40 plus supportive living community living programs around the state of Montana. AWARE provides Therapeutic Group homes for children and adolescents with serious emotional disturbance in Anaconda, Billings, Bozeman, Butte, Great Falls, Helena, Kalispell, and Missoula. AWARE created the successful Intensive Community Based Rehab (ICBR) permanent community home model to serve adults with SDMI with extensive life long histories of institutionalization-AWARE maintains ICBR homes in Butte, Great Falls, and Glendive. AWARE has been Montana's leader in developing community housing for persons with dual diagnosis of SDMI/SED and developmental disabilities/intellectual disabilities. AWARE working in conjunction with John Hopkins University and other centers of quality care for persons with severe autism and other mental health, behavioral, and developmental needs has opened specialized residential programs to better serve these Montana children, youth, and adults. AWARE community services prioritize maintaining stable housing as a primary goal when working with individuals and families. AWARE supports specialized in-house housing expertise to supports its staff in meeting the housing needs of those it serves. AWARE provides the community services related for its adult clients with SDMI participating in Shelter Plus Care/Permanent Supportive Housing voucher programs with public housing providers around the state. AWARE takes an active role in encouraging personal housing planning to help achieve housing goals, and in protecting the housing rights of its clients

AWARE is a leader in housing advocacy and housing resource development for persons with disabilities in Montana. AWARE has facilitated home purchases for over 150 individuals and families with disabilities helping to develop new housing resources to overcome institutional barriers to home ownership. AWARE has played critical roles in advocating for prioritizing the housing needs of persons and families with disabilities within state and local housing programs, leading to the development of new programs and initiatives delivering millions of dollars of housing resources to better meet the housing needs of Montanans with disabilities.

Community mental health centers utilize shelter plus care vouchers that allow persons with mental illness to access housing in addition to the services available in the community. The communities of Billings, Missoula, Helena, and Butte have access to these vouchers through the public housing authorities.

Medical and Dental Services

Each community mental health provider is responsible for assessing the medical and dental needs of each client. Those persons with Medicaid are easily referred and served for their medical needs. However, dental care continues to be an ongoing problem for all persons with Medicaid. This, in part, is due to concentration of dental services in primary five (5) 'urban' areas of the State, leaving very rural and frontier areas un-and under-served. Additionally, dentists often limit the numbers of Medicaid patients they will serve because of the administrative responsibilities related to Medicaid billing.

Persons with MHSP are served through public health clinics and federally qualified clinics that provide medically necessary services for physical and dental health. Medications and limited medical care have been accessed through the federally qualified clinics and Health Care for the Homeless clinics. The Medicaid for Workers with Disabilities Program may provide some dental services for those needing dental work to secure employment.

Substance Abuse Services

Through its Chemical Dependency Bureau, AMDD assesses the need for substance use disorder treatment and prevention services throughout Montana. Services are available, statewide, through 31 state-approved programs. This includes 3 Tribal and 4 Urban Native American Programs and 3 Federally Qualified Health Care Centers. The Bureau reimburses for a full range of prevention, outpatient, residential and inpatient services.

Prevention activities address the primary prevention of alcohol, tobacco, and other drugs for all ages with the consumption focus of Binge Drinking (birth to death with an emphasis on youth) and the consequence focus of drinking and driving (birth to death with an emphasis on youth). Public treatment funding is provided for adolescents with an abuse or dependency diagnosis or adults with a dependency diagnosis and who have a family income below 200 percent of the federal poverty level. The Medicaid program funds outpatient treatment services for adolescents and adults and inpatient treatment services for adolescents who are Medicaid eligible. General and State Special Revenue funds provide reimbursement for residential and inpatient treatment services for adults.

The Bureau works closely with several state agencies to address substance use disorders in multiple settings and opportunities. Some partnerships include the Department of Transportation to address Montana's Highway Traffic Safety by providing the educational program, Prime for Life, for DUI offenders, the Office of Public Instruction by providing consistent risk and protective factor data surveys for the student populations, the Department of Revenue for Synar and alcohol compliance activities, as well as many partnerships within several Divisions within the Department of Public Health and Human Services to carry out both chemical dependency prevention and treatment activities.

Support Services

The Addictive and Mental Disorders Division has supported Mental Health Drop-In Centers for over ten years with appropriations from Recovery Grants and general fund appropriations. The Division promotes active centers with recovery focused programs. Peer-run Drop-In Centers are located in seven (7) major Montana cities: Butte, Bozeman, Billings, Missoula, Helena, Kalispell and Livingston. For the first six months of FY 2015, over 7,000 consumers were served in the Centers. Peer to Peer services have increased substantially in the last couple of years: 500 consumers were served in Peer to Peer (one on one with a peer). Other services provided in the Drop In Centers include Psycho Education, Wellness, Exercise, IMR, Twelve Step, Independent Life Skills, Spiritual, Substance Use Recovery, Smoking Cessation, and Art Therapy Groups. Montana also supports a Virtual Drop In Center which served 1,318 consumers through over 9,000 warm line and Bi-Polar support group calls.

Individuals with Disabilities Education Act (IDEA) Services

Montana's goal is for all children with disabilities to receive free appropriate public education (FAPE) in the least restrictive environment that promotes high-quality education and prepares them for employment and independent living, as evidenced by measurable, continuous progress in academic skills and continuous successful participation in school resulting in increased graduation and decreased dropout rates, inclusion in statewide assessments, and the ability to make successful school-to-adult transitions. The Individuals with Disabilities Education Act (IDEA) is the law ensuring that these services are provided to children with disabilities throughout this state and the nation. As part of its general supervision responsibilities under the IDEA, the Office of Public Instruction (OPI) uses its compliance monitoring procedure to ensure that all children with disabilities receive a free appropriate public education in accord with the Individuals with Disabilities Education Act and Montana statutes and administrative rules.

According to the 2015 Montana Child Count, 17,032 public school students were being served under IDEA on the first Monday in October. Of these, 1,213 (7.1%) were identified as Emotionally Disturbed (as defined by the IDEA and the Administrative Rules of Montana). The previous year 16,473 students were being served. Among these, 1,150 (7.0 %) were identified as Emotionally Disturbed.

Percent of Students Identified as Emotionally Disturbed					
2013-2014			2014-2015		
Child Count	ED	Percent	Child Count	ED	Percent
16473	1150	7.0	17032	1213	7.1

Data Source: Montana Child Cunt for 2014 – 2015

Child Count Criteria: Students must be ages 3-21, enrolled on the first Monday in October, have an identified disability and be in receipt of special education services as specified by an IEP.

Comprehensive School and Community Treatment (CSCT), an intense service designed for youth in immediate danger of out-of-home placement and/or exclusion from school or community, is provided in 84 Montana school districts. CSCT provides a comprehensive, planned course of outpatient treatment to children/youth with a serious emotional disturbance (SED). The CSCT Program operates through collaboration between the Department of Health & Human Services (DPHHS) and the Office of Public Instruction (OPI).

CSCT services include:

- Individual, family and group therapy
- Behavior intervention
- Crisis intervention services
- Coordination with other addictive and mental health treatment services the child receives outside the CSCT program
- Access to emergency services
- Continued treatment that includes services during non-school days consistent with the treatment plan.

Case management Services

All mental health centers in Montana provide targeted and/or intensive case management services. The majority of Mental Health Centers are non-profit agencies and are licensed under the Montana Quality Assurance Division. Community Based Rehabilitation specialists provide support, such as transportation, independent living skills training, etc., to support the brokerage and monitoring services of case managers. Mental health providers are required to submit data for at least 80% of clients receiving case management services as a minimum standard for data collection. Centers are required to collect data on employment, housing, Global Assessment of Functioning, substance use, Stage of Change, medical, dental and vision exams, probation or parole status, and chronic medical problems for all adult consumers receiving case management services. These measures are obtained at intake, quarterly, and at discharge by case managers in partnership with consumers and submitted to MHSB through the web-based Mental Health Reporting System. MHSB publishes longitudinal data annually and upon request to show trends in consumers' level of employment, housing situations, level of functioning, and improvements in substance abuse. In the future, AMDD would like to see this data as part of the client-level data used to complete the annual URS Tables and the National Outcome Measures for SAMHSA and the NASMHPD Research Institute. This data is also used by the department administrators and by providers to identify areas of improvement and areas that may need further support. Strengths based assessment and justification of the need for the support of case management must be evident in an individualized treatment plan and team review in addiction services.

Co-Occurring Disorders

Community providers for both mental health and/or substance abuse services shall provide a safe and welcoming environment. This will assure that any individual seeking services will feel accepted and respected no matter the reason for which they are seeking help. The physical,

technological, and professional environment should be sensitive to issues of compromised capacity, gender, ethnicity and multiple needs.

Community providers must adopt specific policies and practices that engage all potential clients into services. The Division policy is that all clients can be helped through timely assessment, collaboration and active referral.

All individuals presenting for services in any program will receive integrated screening to identify the presence of possible co-occurring disorders. Each program develop procedures that define how this screening will be conducted for all new client's entering either a mental health or substance related facility so that there is "no wrong door" to treatment access.

Over six percent (6.6%) of Montana's tax on the sales of alcohol is earmarked for the treatment of co-occurring disorders. This money provides mental health services within the addiction service system for those individuals with co-occurring disorders that are not covered by other indigent funding sources. Programs providing these service either have staff available with appropriate services or purchase these services through referral.

Other Activities Leading to Reduction of Hospitalization

Admission to Montana State Hospital is a judicial process, and the professional staff at the facility do not conduct a pre-admission review or exercise any decision-making authority over the medical necessity for admission. The hospital is licensed for 189 beds. AMDD contracts with First Health Services for an adult care coordinator who works closely with the hospital to ensure more successful community placements. The coordinator is familiar with the community resources across the state and works cooperatively with community providers to creatively wrap those services around persons discharged from the state hospital to ensure a successful transition to community services.

Community Liaison Officers, who are based in the community to mentor current and recently discharged patients from Montana State Hospital, assure consumers are able to get to referred services, and provide assistance in accessing needed services, supports, and resources in the community, and provide community support for meeting the recommendations of the hospital discharge plan and re-integrating into the community. (More information available under Adult Mental Health System).

Mental Health - Comprehensive Continuum of Care

The Disability Services and Addictive and Mental Disorders Divisions and associated institutions are directed by the Medicaid and Health Services Branch Director.

The Addictive and Mental Disorders Division (AMDD) is the designated State Adult Mental Health Agency for DPHHS. The mission of AMDD is to implement and improve an appropriate statewide system of prevention, treatment, care, and rehabilitation for Montanans with mental disorders or addictions to drugs or alcohol.

AMDD through the Mental Health Services Bureau is responsible for the development and management of the adult mental health system (age 18 and over). The Division provides chemical dependency and adult mental health services by contracting with providers throughout Montana. It also provides services through three inpatient facilities-the Montana State Hospital in Warm Springs, Montana Chemical Dependency Center in Butte, and Montana Mental Health Nursing Care Center in Lewistown.

AMDD has demonstrated a long-term and sustained commitment to persons with severe and disabling mental illness through a broad and evidence-based array of services. The Division is dedicated to collaboration with consumers, family members, providers, and other stakeholders and mental health advocates in the development and annual planning of public mental health services. Community collaboration and coordination is accomplished through the Local Advisory Councils and regional Service Area Authorities. More info can be found on community partners/partnerships under Community Framework – Consumer Participation.

The Disability Services Division is the designated State Children’s’ Mental Health Agency for DPHHS. Mental health services for children under 18 are administered through the Disability Services Division, Children’s Mental Health Bureau (CMHB). The CMHB was moved from the Health Resources Division in 2009 to provide a seamless transition when children age out of services provided by Children’s Mental Health and go into programs offered by Disability Services Division. The Division was restructured under the Medicaid and Health Services Branch of DPHHS. Under this Division services are now provided through two primary programs: the Developmental Disabilities Program and the Children’s Mental Health Bureau.

The Developmental Disabilities Program contracts with private, non-profit corporations to provide services across the lifespan for children and youth with serious emotional disturbance.

The **Children’s Mental Health Bureau** provides care and support to individuals under 18 years of age who have been diagnosed with serious emotional disturbance (SED). Medicaid mental health services include inpatient psychiatric, community-based services such as therapeutic foster care, and community-based outpatient. A State funded program for low-income youth with 160 percent of the federal poverty guidelines and who are not eligible for Medicaid or Healthy Montana Kids program also provides community-based outpatient psychiatric services, medication management and psychotropic drug assistance.

Separate administration and budgets don’t preclude the adult and children’s mental health systems from working together, collaborating, and ensuring quality public mental health services. Staff, administrators, parents, and consumers collaborate in meetings, services, and training in efforts to provide adequate services to those in Montana with severe and disabling mental illness and emotional disturbance.

Adult Mental Health Services

The adult mental health and substance abuse systems are administered by the Addictive and Mental Disorders Division, (AMDD). The Division consists of two Bureaus.

Through the Chemical Dependency Bureau, AMDD assesses the need for chemical dependency treatment and prevention services throughout Montana. Those services are available through contracts with 20 state-approved programs that practice a co-occurring approach to treatment. The bureau reimburses for a full range of outpatient and inpatient services, as well as education programs for DUI offenders and youth charged as a Minor in Possession (MIP).

The Chemical Dependency Bureau also organizes and funds activities designed to prevent the use of alcohol, tobacco, and other drugs by youth and the abuse of those substances by adults. People with substance abuse disorders who have family incomes below 200 percent of the federal poverty level are eligible for public funded treatment services. In addition, the Medicaid program funds outpatient and residential chemical dependency treatment for adults and adolescents who are Medicaid eligible.

The Mental Health Services Bureau is responsible for the development and oversight of the state's system for delivering and reimbursing publicly funded federal funds and state general and special revenue, adult mental health services. The Bureau ensures the availability and efficient delivery of appropriate and effective services. The Bureau also provides extensive monitoring of program implementation and operation as well as analysis and reporting of program operations, costs, and outcomes. Persons eligible for services include adult Medicaid recipients and other low-income Montanans with severe disabling mental illness.

The Mental Health Services Bureau (MHSB) provides evaluation and technical support to the local and regional planning groups, Local Advisory Councils (LAC) and regional Service Area Authorities (SAA). These groups all have membership requirements that ensure consumer and family member representation. All local planning groups are encouraged to ensure activities are conducted through a broad and inclusive representation of the community mental health system, including community mental health providers, advocates, law enforcement, judicial system, hospitals, and other medical service providers. The Bureau also facilitates and provides administrative functions for the Mental Health Oversight Advisory Council (MHOAC). The Council membership requires participation by LACs through the regional SAAs.

The Addictive and Mental Disorders Division Mental Health Services Bureau has 21 FTE to support administrative, financial, and training for mental health service provision. This includes an administrator, a bureau chief, a licensed clinician that oversees clinical program development and standards, a quality assurance manager, a mental health planner/program manager, Medicaid program manager, a community resources manager, four (4) quality assurance professionals, five (5) community program officers, , three (3) half-time and one full-time community liaison officers, and two (2) operations support staff.

Mental Health Services Bureau field staff (7.0 FTE), support the development and evaluation of community based services throughout the state. The Community Program Officers (CPOs) foster and support collaborative relationships between the Division (AMDD), the Mental Health Services Bureau and community stakeholders. These stakeholders include consumers, providers, local and tribal governments, legislators, law enforcement, Local Advisory Councils (LAC) and Service Area Authorities (SAA). Community Program Officers represent the Division and Bureau in the community by providing consultation, leadership, and direction on programs and

policies; specifically through support and attendance at Local Advisory Council meetings and events. Each CPO works to facilitate and support the planning, development, implementation, and evaluation of community mental health services; identify unmet consumer needs within the public mental health program/system; train and provide local agencies and providers information and support related to evidence-based practices, the state mental health process, state mental health programs; and, collaborate with other state/local and community agencies related to dispute resolution, collaborative mediation and consensus building. Community Program Officers serve as the point of contact for consumer health and safety concerns and also guide and provide oversight for AMDD community based grants.

Community Liaison Officers (CLOs) provide a critical component to successful community reintegration after hospitalization. CLOs provide reintegration support services to individuals who have been discharged from the Montana State Hospital, and to people who have received crisis stabilization services. There are three community liaison officers in three regions. The purpose of the community liaison position is to provide community support for patients discharged from Montana State Hospital to meet the recommendations of the hospital discharge plan and assist with successful re-integration into the community. These duties require that the CLO have expert knowledge of community and natural supports and how to effectively access them in the transition process; ability to facilitate consumer development of personal goals; and, skill to facilitate consumer involvement in community activities and supports that lead to independent living, reduced hospitalization, and recovery.

Mental Health Services Bureau Programs (Medicaid, federal and state grants)

Behavioral Health Waiver for Adults with Severe Disabling Mental Illness (HCBS SDMI Waiver). The HCBS SDMI Waiver is a 1915c home and community based services (HCBS) Waiver that allows the State to spend Medicaid on services that are not otherwise furnished under the State's Medicaid State Plan and not available to all Medicaid eligible individuals. Eligibility for the HCBS SDMI Waiver includes meeting nursing home level of care criteria. The HCBS SDMI Waiver is located in five geographical areas based on an urban core. The HCBS SDMI Waiver has grown since 2011 from 19 to twenty-four counties in 2015. Community Program Officers (CPOs) are an integral component of the implementation of the Home and Community Based Services Waiver (HCBS) for individuals with severe and disabling mental illness (SDMI). Community Program Officers work with the State's medical review agency for the referral process and nursing home level of care determination, and the waiver community case management team comprised of a mental health case manager/social worker and a registered nurse to provide community wrap around services.

The Mental Health Services Plan (MHSP) is designed to serve those individuals who do not qualify for Medicaid due to income. The MHSP program has a fixed appropriation that must be financially sustainable for the entire fiscal year. Mental health centers receive a contracted appropriation based on historical utilization. The Severe Disabling Mental Illness (SDMI) standards, qualifying diagnosis and functional impairment, are required for enrollment in MHSP. The limited pharmacy benefit of \$425 per month toward the cost of psychotropic medications is also provided. Most of the services provided have limitations.

The MHSP Program is designed to serve individuals who meet SDMI criteria and are:

- in crisis;
- PATH eligible;
- diagnosed with schizophrenia and bi-polar disorders
- young adults in transition from youth services, or
- being discharged from a state facility.

The MHSP will be reduced in Fiscal Year 2016 to support funding of the MHSP/HIFA Waiver physical and mental health benefits.

Mental Health Services Waiver - Health Insurance Flexibility and Accountability (HIFA) Waiver

This Waiver provides a physical health benefit for individuals at or below 150% of the federal poverty level, who are eligible for the Montana Mental Health Services Plan (MHSP), and not eligible for Medicare. At inception of the program in 2010, benefits were limited to specific diagnostic populations. The MHSP Waiver has expanded to include a broader group of diagnosis and number of individuals able to apply and enroll for services.

Pre-Admission Screening and Resident Review (PASRR) evaluations: AMDD oversees the PASRR process in Montana for those with mental illness being admitted to nursing facility to ensure appropriate admission.

72-Hour Crisis Stabilization Funding: program to help with costs of evaluation and stabilization for up to 72 hours for persons in crisis. Referrals are made to providers for housing placements and other recovery services.

County Matching Crisis Intervention and Jail Diversion Grant Program: This program provides a county or compendium of counties to develop a strategic plan to address crisis intervention and jail diversion. Partnerships are at the core of the program development, including tribal representatives.

The Addictive and Mental Disorders Division (AMDD) released funding for the County Matching Grant program for Crisis Intervention and Jail Diversion in July 2012. The County Matching Grant program was initiated in FY 2010 to address rural community crisis and jail diversion needs through a county or multi-county strategic plan for community-based or regional emergency services, including a commitment by the entities to collaborate and commit local funds for mental health services for crisis intervention, jail diversion, involuntary pre-commitment, and short term inpatient treatments costs. All applications must identify an in-kind local contribution. This funding, and enabling legislation, create a county matching grant program for crisis intervention, jail diversion, involuntary pre-commitment, and short-term inpatient treatment costs for individuals with mental illness. Projects or programs supported through these matching grants can reduce reliance on the Montana State Hospital for emergency and court-ordered detention and evaluation and will ultimately result in cost savings to the state.

Successful grant applicants will be those counties submitting an application with the following elements:

FFY 2016-2017 Community Mental Health Block Grant (Print)

1. A county or multi-county, strategic plan addressing crisis intervention and jail diversion. Including a plan for community or regionally based emergency or court ordered detention and examination services, as well as short term inpatient treatment.
2. A detailed proposal clearly addressing how the county and other entities will partner and commit local funds for mental health services for crisis intervention, jail diversion, involuntary pre-commitment and short term inpatient treatment costs. Counties that include tribal lands must demonstrate coordination efforts with tribal representatives both on and off reservations.

Goal 189 Program: The Goal 189 Program was established in 2007 to facilitate a more timely discharge individuals for at Montana State Hospital by creating opportunities and resources for integration back to their community and also to divert individuals from being re-admitted to Montana State Hospital.

Some creative options have included creating housing options, paying co-pays, purchasing track phones (and additional minutes), laundry expenses, groceries, setting up a home (furniture, food, etc.), supplies for working (i.e., snow shovel, winter clothing, bicycle), and other ideas, all that would reduce the time spent in, or diversion from, the Montana State Hospital. These are transitional monies only and not intended for longer term financial support. Authorizations are for 30 days at a time; however, requests can be submitted for additional intervals of 30 days at a time.

Projects for Assistance in Transition From Homelessness: See Criterion 4

Individual Placement and Supports Supported Employment Program (IPS): Addictive and Mental Disorders Division (AMDD) is providing evidence based employment to four (4) mental health centers serving youth with serious emotional disturbance and adults with severe disabling mental illness. IPS supported employment helps people with severe mental illness work at regular jobs of their choosing. Although variations of supported employment exist, IPS refers to the evidence-based practice of supported employment.

IPS practice principles include:

1. Focus on Competitive Employment
2. Eligibility Based on Client Choice – Zero Exclusion
3. Integration of Rehabilitation and Mental Health Services
4. Attention to Worker Preferences
5. Personalized Benefits Counseling
6. Rapid Job Search
7. Systematic Job Development
8. Time-Unlimited and Individualized Support

AMDD contracts with Dartmouth University to support employment programs with technical assistance, monitoring, and training. AMDD has established Individual Placement and Supports (IPS)-Evidence Based Supported Employment as a priority for the 2016-2017 Mental Health Block Grant.

FFY 2016-2017 Community Mental Health Block Grant (Print)

PACT Teams: Assertive Community Treatment (ACT) is a client-centered, recovery-oriented mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most severe disability mental illnesses, have severe symptoms and impairments, and have not benefitted from traditional outpatient programs.

Intensive Community Based Rehabilitation Group Facilities: Groups Homes focused on Rehabilitation and Recovery. Many of clients have high needs with physical impairments and some with dementia.

Short-Term Inpatient Treatment: When a civil commitment hearing has been suspended an individual may be diverted to a short-term inpatient treatment. Short-term inpatient treatment may not exceed 14 days, except pending a commitment hearing scheduled. The individual may be released before completing 14 days of treatment if determined treatment is no longer required. Eligible providers include licensed mental health centers that operate inpatient crisis stabilization programs and hospitals with an inpatient behavioral health unit.

Montana is participating in a Money Follows the Person (MFP) Demonstration Program. AMDD is collaborating with several programs in the Department, including Senior Long Term Care, Developmental Disabilities, and Children's Mental Health Programs. The MFP program is intended to reduce the use of institutionally based services and increase the use of home and community based services. The Follows the Person (MFP) grant is focused on helping individuals transition from nursing homes facilities to the community. The Program vision is to create a sustainable system that supports community options as a first choice for individuals needing long term care services. All programs were written into the operational protocol for the grant.

Peer Operated Drop In Centers: See Support Services

Montana Network of Care: This Web site is a resource for individuals, families and agencies concerned with behavioral health. It provides information about behavioral health services, laws, and related news, as well as communication tools and other features. Regardless of where you begin your search for assistance with behavioral health issues, the Network of Care helps you find what you need - it helps ensure that there is "No Wrong Door" for those who need services. <http://montana.networkofcare.org/mh/>

Network of Care for Service Members, Veterans & Their Families:
<http://montana.networkofcare.org/veterans/>

Medicaid mental health services are provided to adults with severe disabling mental illness (SDMI) through a fee for service system that includes ten (10) licensed mental health centers.

There are six community hospitals with inpatient psychiatric beds, (6 psychiatric units in state – less than 20% of beds at any point in time are used for public funded individuals) and, 24 Federally Qualified Health Centers (FQHCs), private, not-for-profit, consumer-directed health

care corporations which provide high quality, cost-effective and comprehensive primary and preventive care to medically underserved and uninsured people.

For the adult SDMI population being served by the public mental health system, the workforce development issues continue to be a challenge. AMDD continues to be optimistic about increased psychiatric workforce development through the APRN Program at Montana State University and the PharmAssist Project, a state-supported program offered through the Department of Public Health and Human Services (DPHHS) which provides Montana residents an opportunity to meet with a pharmacist for medication review and health history. Several community mental health centers utilize the skills of APRNs to ameliorate the shortage of psychiatric services in their very rural and frontier communities. The shortage of psychiatrists continues to challenge the Montana mental health system. The number of psychiatrists billing under the State of Montana Medicaid System continues to decline. For fiscal years 2013 and 2014 the number of psychiatrists billing Medicaid was 20 and 23 respectively; a 28% decline for FY 2014 from FY 2012. In FY 2012 32 psychiatrists were willing to bill the Medicaid system, a 20% drop from FY 2010. FY 2010 showed an 18% drop (49 to 40) from FY 2009. Medicaid rates most likely contribute to reluctance by psychiatrists to work under the public mental health system.

Community Framework – Consumer Participation

The Montana State Statute, *53-21-702, Mental health care system – eligibility – services – advisory council*, provides the framework for the state public mental health system. The framework begins at the local level with local advisory councils that “*report to and meet on a regular basis with the advisory council* (Mental Health Oversight and Advisory Council).

Local Advisory Councils are a coalition of community members interested in planning, evaluating and strengthening their local community mental health services. LACs are an integral element to a successful system of public mental health care. *Change begins at the local level*. It is expected that LACs consist of a broad group of stakeholders that represent the community. It is encouraged that stakeholder groups include: Consumer/family members; government and law enforcement officials; mental health service providers, mental health advocates; public health and medical providers, and citizenry that represent the local/regional culture. Each LAC is recognized through representation on the Service Area Authority Board. LACs are the foundation for recommendations to the SAA, DPHHS, MHOAC, on program issues affecting local communities. The Mental Health Services Bureau, through the Community Resources and Support Program developed a Local Advisory Council Handbook to provide guidance and support to new and established members.

Local Advisory Councils (LACs) provide input to the Mental Health Oversight Advisory Council (MHOAC) through the regional Service Area Authorities (SAA) representative on the MHOAC. There are 32 established Local Advisory Councils across the state: Central SAA has 8, serving 15 counties; Western SAA has 8, serving 13 counties; and, the Eastern SAA has 16, serving 27 counties. Due to the large geographical area of the ESAA, the use of video-conferencing is being used to reduce travel costs for the SAA membership.

The alliance of LACs and SAAs in Montana ensures the voice of communities, locally and regionally, is recognized. Local Advisory Councils and Service Area Authorities (SAA) serve as the local network to mental health strategic initiatives in Montana. Both LACs and SAA groups are expected to include representation by consumers and consumer family members. SAA executive boards are required to have 51% consumer and family member representation.

Service Area Authorities are statutorily defined for the purpose of collaboration with the Department for the planning and oversight of mental health services within a service area. Each Service Area Authority has incorporated, adopted by-laws, and an appointed board of directors. Service Area Authorities in collaboration with Local Advisory Councils, including provider and advocacy networks work on a strategic plan that addresses the unique needs of their geographic region and population.

All three SAAs are incorporated and registered with the Secretary of State. Each Service Area Authority appoints a regional Board to provide leadership. Regional SAA Boards meet monthly to collaborate with the Mental Health Services Bureau in planning and oversight of mental health system structure and services. Each SAA holds an annual meeting to elect board members and network. Any person may become a member of the Service Area Congress if they reside within the service area and submit a membership form. Congress members have the exclusive right to elect the SAA Board. Executive Committees of the three SAAs meet quarterly to collaborate on statewide mental health planning, providing a collective vision.

The Mental Health Services Bureau continues to provide the financial and technical support to sustain the SAA system.

Service Area Authorities provide guidance to the MHSB directly and through the MHOAC for service development and planning.

Each Service Area Authority is represented on the Mental Health and Oversight Advisory Council (MHOAC) through Local Advisory Council membership. The MHOAC is the body responsible under federal statute to *“monitor, review, and evaluate the adequacy of mental health services within the State.”*

The Addictive and Mental Disorders and Health Resources Divisions, and their respective mental health service bureaus are represented on the Montana Mental Health Oversight and Advisory Council (MHOAC). Together, with the assistance of the MHOAC Block Grant Committee, the Council and Divisions develop and implement the Community Mental Health Services Block Grant and adult and children’s state mental health state plans.

Service Provision – Available Services

Because of the frontier nature of Montana, our entire mental health service plan is essentially a plan for delivery of services in rural and frontier settings. “Frontier” designation is determined through a weighted matrix of population density, distance in miles to a service/market center and travel time in minutes. Over 800 of the country's 3190 counties have been designated as frontier by the Frontier Education Center in consultation with State Offices of Rural Health. Most

frontier land is located in Alaska, the Great Plains and the West. Montana ranks number three (3) out of 19 states that account for about 95% of the land designated as frontier. When comparing the Top Ten Frontier States by Population and Area, Montana ranks 6th in Largest Frontier Population and, as noted above, 3rd in Largest Frontier Area. (Footnote: National Center for Frontier Communities). The entire plan addresses the manner in which mental health services will be provided to individuals residing in rural/frontier areas.

Although concentrating services in the most populated areas would be the most efficient strategy for delivery, Montana has maintained an effort to provide consumers a choice of mental health services in every county in the State. This accessibility provides for, at a minimum, identification of serious mental health problems, referral to more specialized services in larger communities, and supportive therapy and case management.

Description of Service Providers – Adult

State Operated Service Providers

Montana State Hospital (MSH) is the only state operated inpatient psychiatric hospital. Montana State Hospital, an inpatient psychiatric treatment hospital under the Addictive and Mental Disorders Division, serves persons suffering with serious and disabling mental illness who have been committed by courts for evaluation or treatment. The hospital aspires to provide individualized, holistic, evidence-based, and integrated health services with the goal of helping people recover their mental health and return to their life in the community. The hospital receives oversight and guidance from licensing boards, advisory boards, certification boards, mental health advocates, and a Resident Council made up of current clients. The hospital has adopted treatment approaches and models including: recovery model; integrated care model; trauma-informed care; person-first model; co-occurring model; relapse-prevention model; supported-employment model; and the peer-support model. The hospital provides multidisciplinary evaluation, psychiatric treatment, psychological treatment, mental health counseling, psycho-education, recreational therapy, vocational therapy, occupational therapy, peer support, and other treatments as indicated. Four on-campus group homes are available to help those who have stabilized achieve more confidence in their recovery and independence before re-entering the community. The hospital collaborates with its community providers in an attempt to provide a seamless, coordinated, and continuous mental health service to the citizens of Montana.

Patient treatment at MSH is organized around five primary clinical pathways, called “Pathways to Recovery.” The purpose of the pathways is to provide meaningful, coordinated treatment for each individual in order to promote recovery and independence to the fullest extent possible. All Pathways address co-occurring substance abuse problems concurrently with other treatment provided.

Primary Pathways:

Coping Skills: designed for individuals whose primary problem is maladaptive coping behavior; including suicidal and self-injurious behaviors, eating disorders, problems with anger, and

problems in interpersonal relationships. Learning and practicing more effective coping and communications strategies provide the focus for treatment in this pathway.

Co-Occurring Disorders: designed to provide programmatic, stage-based, integrated treatment of individuals with co-occurring mental illness and substance abuse disorders. Addictive pattern behaviors, such as problem gambling or sexual behavior is also addressed. Groups and therapeutic activities are designed to address mental illnesses and addictive behaviors concurrently with a recovery perspective.

Social and Independent Living: designed for individuals who have been identified as having functional deficits in their Independent Living Skills and social functioning. These deficits in functioning are significantly affecting their ability to manage their mental illness and adaptation to successful community placement. Groups and therapeutic activities are designed to provide learning and practice experiences to improve these areas of functioning as well as to promote healthy patterns of living and improve quality of life.

Adaptive Living Skills: designed to enhance the physical, mental and psychosocial well being of individuals who have long-term psychiatric disabilities and/or significant physical limitations. Individuals considered for this pathway include those who psychosis or cognitive limitations are such that they interfere with daily functioning. Significant physical impairments may be present as well. Groups and therapeutic activities are highly individualized and designed to provide a daily schedule that promotes physical, cognitive, emotional and social health; and, promote each individual's self-respect and quality of life by providing activities that allow for self-expression, personal responsibility and choice.

Management of Legal Issues: designed for people who have misdemeanor or felony charges pending and in various stages of adjudication. MSH provides care, treatment and stabilization to help people cope with stress related to legal issues. Personal responsibility and recognition of the perspective of victims receive appropriate emphasis.

The Addictive and Mental Disorders Division in partnership with MSH has an active Resident's Council. The Resident's Council remains active and collaborates consistently w/NAMI and Montana Peer Network. Express concerns to Legislators and Governor's Office and have met w/the Governor's Office at least once in the past year. The Council advocates for Peer Support expansion/certification. The Wellness Recovery Action Plan (WRAP) program is in use at MSH and is co-lead by two peer specialists who are employed by MSH. MSH has also implemented procedures to greatly reduce the use of restraint and seclusion procedures. MSH has provided many staff members with training in trauma informed care.

For FY 2015 Montana State Hospital had an average daily census of 216. MSH admitted 691 individuals during FY 2015 and discharged 658. Over the past several years Montana State Hospital discharges have been increasing at a slightly slower rate than admissions and consequently the average daily census is growing. As more patients are admitted each year and slightly fewer leave, the average daily census grows. A possible explanation for the disparity between discharge and admission rates is that many admissions to the state hospital have not been to the hospital before and are not receiving community mental health services at the time of

admission. The hospital is therefore serving largely a newly diagnosed or unserved population of seriously mentally ill people. Finding community services for this population at discharge is a major challenge for Montana’s current mental health system.

The hospital is certified for participation in the federal Medicare and Medicaid programs.

	<i>FY 2012</i>	<i>FY 2013</i>	<i>FY 2014</i>	<i>FY 2015</i>
<i>Admissions</i>	739	606	625	691
<i>Discharges</i>	714	598	606	658
<i>Median Length Stay</i>	33	41	37	48

Median Length of Stay: Increased 45% from FY 12 to FY 15
 Increased 17% from FY 13 to FY 15
 Increased 30% from FY 14 to FY 15

Montana Nursing Care Center (NCC) The Montana Mental Health Nursing Care Center is a licensed residential facility for the long term care and treatment of persons who have mental disorder and who require a level of care not available in the community, but who cannot benefit from the intensive psychiatric treatment available at Montana State Hospital. The Nursing Care Center is dedicated to deliver care with courtesy, efficiency, and respect. The Nursing Care Center is committed to provide high-quality resident care in a safe environment using the least restrictive methods that meet residents’ physical and emotional needs. The average age for residents is 65 years. The average daily census for fiscal year 2015 was 92.3. In 2012 NCC entered into an agreement with the Montana Dept. of Corrections to provide long term care services in a secure environment to 25 inmates from Montana State Prison.

Montana Chemical Dependency Center (MCDC) is administered by the Department of Public Health & Human Services within the Addictive & Mental Disorders Division and is the single state administered in-patient addictions, co-occurring addictions and psychiatric disorders treatment facility.

MCDC models its treatment methods from on-going research into the neurobiology of addiction and related treatment regimens that have transformed the delivery of service. Detoxification services are provided on a standalone basis; provided as needed to individuals who are entering treatment. Treatment is individualized with no defined number of days required or mandatory discharges. An average length of stay is 35 days for individuals. Significant to the evolution of treatment at MCDC is the recognition and implementation of integrated treatment for persons with co-occurring addiction and psychiatric disorders. As with other States co-occurring disorders are the expectation not the exception – 75% – 80% of patients suffer from co-occurring disorders. Medication in treatment is now a significant factor in stabilizing and treating individuals with co-occurring disorders at MCDC allowing individuals to more effectively participate in their treatment. MCDC utilizes an interdisciplinary treatment team consisting of physicians, nurses, mental health therapists, addiction counselors and treatment aides. MCDC continues to develop treatment by implementing best practice models such as dialectical behavioral therapy, parenting and trauma related services.

Referrals into MCDC come from the entire state of Montana from community and reservation based programs. Individuals must be referred by a Montana Licensed Addiction Counselor (LAC) and meet the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for this level of care which is in-patient medically monitored treatment. MCDC serves both male and female adult (18 years of age or older) patients in a non-secure, 24 hour, seven day a week, residential environment. This facility serves approximately 600 patients per year.

MCDC is dually licensed by the State of Montana as a chemical dependency treatment facility as well as a health care facility. MCDC is a 48 bed facility with 40 designated for treatment and 8 for detox. Funding for the facility is appropriated by the state legislature with funding being from state special revenue alcohol tax as well as federal block grant with a current annual budget of \$ 4.5 million.

Community Operated Services

Montana's community-based mental health services are provided by a variety of local agencies including licensed mental health centers, independent private practitioners, and short-term psychiatric inpatient units in community hospitals. The community psychiatric inpatient units are located in Kalispell, Missoula, Billings, Helena, Glendive, and Great Falls.

Montana currently has twelve (12) licensed mental health centers that may provide community-based services in fifty-five of fifty-six counties, and approximately 35,000 individuals determined eligible for Medicaid or state supported mental health services. The four regional community mental health centers provide the greatest portion of high-end services for the public mental health system.

Licensed Mental Health Centers

AWARE Inc. (Statewide): AWARE Inc., is a non-profit, licensed mental health center serving children, adolescents, adults, and families providing services across the state of Montana. AWARE delivers quality community-based services to persons with challenging mental, emotional, behavioral and in some cases, physical needs who would otherwise be served in a more restrictive setting. AWARE operates statewide with over 1200 employees with services provided in over 60 facilities in communities in all regions of the state of Montana. AWARE maintains major regional service offices in Anaconda, Billings, Bozeman, Butte, Deer Lodge, Dillon, Glasgow, Glendive, Great Falls, Helena, Kalispell, Miles City, Missoula, and Red Lodge. AWARE administratively supports its statewide network of services with centralized administrative offices in Anaconda, MT. AWARE's services are nationally accredited as exemplary through the Council for Accreditation of Rehabilitation Facilities(CARF).

AWARE provides a full array of community based mental health services to children, adolescents, adults, and families across the state of Montana including Psychiatric Services, Outpatient Therapy, Adult Intensive Case Management, Child and Adolescent Intensive Case management, Child and Adolescent Day Treatment, Comprehensive School and Community Treatment Programs, Mental Health Group Homes, Therapeutic Child and Youth Group Homes,

Intensive Community Based Rehab and Support (ICBR)Homes, early intervention Early Head Start and Head Start mental health services, Child Victim Advocacy Support, and Psych Rehab and Support services. AWARE maintains the largest community network of psychiatrists across the state and provides additional psychiatric access to underserved regions of the state including Montana's isolated Indian Reservations through its statewide tele-psychiatry network.

AWARE is also a qualified provider of residential, work/day, case management and transportation services for adults and children with developmental disabilities (including autism spectrum disorders). AWARE is the only organization in the state that has achieved this unique status as both a licensed mental health center and a qualified provider of services for individuals and families with developmental disabilities. This dual expertise makes AWARE uniquely qualified to provide effective support to children , youth , and adults with complex challenging needs related to Dual Diagnosis, the co-existence of the symptoms of both intellectual or developmental disabilities and mental health problems. AWARE is also a qualified provider of Early Head Start (EHS) services helping it develop specialized mental health programs to serve the needs of not only children and families in its programs but also through unique program partnerships with Head Start (HS) providers in various communities across Montana.

AWARE has a proud history of developing innovative programs for persons who otherwise would be served in more restrictive institutional settings, or even be sent out of state. AWARE has taken the lead on numerous projects related to the downsizing of state institutions when asked to partner by the state of Montana. AWARE works to identify the best evidenced based best practices and to deliver and apply those service models here in Montana to open up community living for all.

Billings Community Crisis Center serves as a single point of access for people with mental illness and co-occurring mental illness/substance abuse disorders, based on “no wrong door” philosophy, in the Billings area. The Mission of the Center is: *“The Community Crisis Center will provide assessment and referral services to people in crisis who need access to integrated mental health, chemical dependency, and social services.”* The Center is a licensed outpatient facility designed to provide crisis intervention services for a period under 24-hours.

Expected community outcomes for the Billings Community Crisis Center include: decreased utilization of acute level of care and emergency departments for outpatient crisis mental health care; decreased suicide rate in Yellowstone County; increase effective use of county and state tax dollars to meet increasing needs of co-occurring population; decreased healthcare spending for co-occurring population; reliable diversion of those with mental illness from local jail facilities; increased community linkages; and, telehealth opportunities to meet regional aspect of need and resource utilization.

Montana Community Services, Inc. provides intensive mental health services to children and adults; as well as assisted living services to senior citizens and other individual who require supervision and have not been successful in other community placements. Montana Community Services, Inc. is a licensed mental health center that works collaboratively with South Central Montana Regional Mental Health Center and other private practitioners to provide necessary services. MTCS provides intensive community based rehabilitative services to adults with significant mental illness who have lived in higher levels of care, primarily the Montana Mental

Health and Nursing Care Center and the Warm Springs State Hospital. MTCS also provides intensive therapeutic services to primarily young children who are seriously emotionally disturbed, ages 4 to 15, and require an intensive intervention which may enable them to move to a less restrictive setting. Montana Community Services, Inc. works closely with physicians, other agencies, schools and families involved to provide quality services. The company also operates the Autumn Care Center which also provides services to individuals who are senior citizens, people who are private pay, as well as individuals enrolled in the SED waiver, and the Home and Community Based Waiver.

The Center for Mental Health (Regional) is a community mental health center that was established in 1974. The Center employs over 250 staff to serve a thirteen county area in North central Montana, with services provided in 18 facilities. The population of the Center's service area is 215,426. The two largest communities in the region are Great Falls (population 56,215) and Helena (population 27,885). The administrative offices are located in Great Falls. The Center provides an array of mental health and co-occurring services to more than 3900 individuals, over 700 of which are children, ranging from inpatient care at Benefis Healthcare to in-home services and supports across the region.

The Center is in transition to a recovery-oriented service model that recognizes the need to work together with people with mental illness and with other community partners to improve people's lives and to increase their participation in the community. The Center piloted the first certified Peer Support program in Montana and has maintained a contract with the Vocational Rehabilitation to create a model for statewide peer employment training.

The Center contracts with Benefis Healthcare in Great Falls to provide over 90% of the inpatient psychiatric and chemical dependency physician services in its Behavioral Health unit. In addition, the Center contracts for the psychiatric management of individuals in the Benefis Skilled Nursing facility. Center physicians also provide the medical direction of these units. The Center maintains a supportive relationship with St. Peter's Behavioral Inpatient Services Program in Helena.

The Center has established a veteran-specific array of treatment services. To facilitate this service array, the Center has created a Military Affairs Division which coordinates access to services for veterans and their families, as well as facilitates improved services and supports to active-duty members of the military and their families. The Center is committed to provide training for its clinical staff to meet the treatment needs of this population.

The Center has implemented an electronic medical record (EMR) that is supported by a regional management information system using high-speed internet connections with all offices in the region. This system has the ability to transmit electronic billing, client service information and medical records in a secure encrypted environment. The Center is a member of the REACH telemedicine network, with the capacity to link directly with hospitals in the Northern Montana Hospital Association, to link with other telemedicine networks through the Montana Telemedicine Network, and to link worldwide through other existing networks.

The Center has entered into partnerships with several other governmental and private nonprofit agencies in recent years. This includes contractual relationships with the Vocational Rehabilitation, Child and Family Services, and Law enforcement; jail evaluations and diversion services. Since 2000, the Center has provided space and support to the Voices of Hope, a certified suicide intervention and information and referral center.

The Center has had a long-term partnership with Great Falls Public Schools; The Mental Health Center provides Comprehensive School and Community Treatment (CSCT) Teams in 14 schools. The Center is a member of the Cascade County Early Childhood Coalition, which includes over 20 community agencies which focus on the mental health needs of youth under the age of seven and their families. The coalition is coordinating prevention and early intervention services, including preschool behavioral health screenings, and service coordination.

Eastern Montana Community Mental Health Center is a regional community mental health center that serves seventeen (17) counties in the eastern-most part of the state. This is a huge land area (48,588 square miles) with a population density of less than two (2) people per square mile. This service area, which is larger than many states (service area is larger than the state of Pennsylvania), is bordered by Canada on the north, North and South Dakota on the east, and Wyoming on the south. The Center's service area includes two large Native American reservations, the Fort Peck Reservation to the north, headquartered in Poplar; and the Northern Cheyenne Reservation to the south, headquartered in Lame Deer. The Native American population comprises approximately seven (7) percent of the total population of this service area and 13% of the Center's caseload.

EMCMHC offers some level of services in all 17 counties, although some communities are served on a part-time basis by staff traveling from offices in other counties. Targeted case management for adults is available throughout the entire service delivery area. Day treatment services for adults with severe mental illness are provided in Miles City, Glendive, and Sidney. Adult residential programs, (an adult group home, adult foster care and a level 3 chemical dependency recovery home), are located in Miles City. Services provided throughout the region are: medication management; outpatient psychotherapy services; community rehabilitation and support; emergency services; education and consultation. EMCMHC has a state approved chemical dependency program in 12 of its 17 counties and has co-located Mental Health and Chemical Dependency staff in all of its joint locations. Eastern Montana uses the Telemedicine Network extensively to provide services to rural areas. The Telemedicine Network makes psychiatric care available to all citizens of Eastern Montana and is being used for education and group sessions. The Network presently serves Ekalaka, Miles City, Glendive, Sidney, Culbertson, Colstrip, Baker, Glasgow, Plentywood, Scobey, Terry, Wolf Point, Malta, Forsyth, and Poplar. The Telemedicine Network is used four (4) nights per week to provide chemical dependency treatment groups region wide. Support groups (AA and NA) are held in EMCMHC teleconferencing facilities. EMCMHC has contractual relationships with the VA and the US Probation Service.

South Central Montana Regional Mental Health Center provides comprehensive services in an eleven-county region in south-central Montana. Their administrative offices are located in Billings with six (6) satellite offices providing services to adjacent counties.

SCMRMHC provides outpatient services through facilities in Hardin, Columbus, Big Timber, Roundup, Red Lodge and Lewiston as well as at 6 locations in Billings. The continuum of care includes psychosocial rehabilitation, residential treatment, vocational, outreach to the homeless mentally ill, PACT, targeted case management, day treatment substance abuse treatment, drop-in center for the homeless, and a wide variety of outpatient services. Liaisons and support staff offer the largest, most comprehensive adult outpatient mental health and addiction services and treatment in South Central Montana. The eleven counties served by the MHC have an approximate population of 201,421 and covers an area of 25,625 square miles, slightly larger than the entire state of West Virginia.

The Mental Health Center provides comprehensive services in Billings including psychiatry, psychotherapy, community recovery center, adult residential services, program for assertive community treatment (PACT), targeted case management, an outreach to the homeless program (PATH), and drop-in services. In partnership with the Department of Veterans Affairs, the Center provides services to Veterans who have served in Iraq, Afghanistan, and other conflicts overseas. Two major community resources are the Billings Clinic, which has the state's largest private psychiatric unit for short-term inpatient acute care and Riverstone Health Care which provides primary care services as well as medication management.

The Mental Health Center is a founding partner (along with St. Vincent's Healthcare; Billings Clinic; and Yellowstone City-County Health Department) of the Community Crisis Center in Billings. The Community Crisis Center provides outpatient assessment and referral and helps divert unnecessary presentations at area emergency rooms. The Mental Health Center provides case management services to the Community Crisis Center and PATH outreach services on-site.

The Mental Health Center provides licensed mental health providers for the purpose of evaluation for the Home and Community Based Waiver for individuals with severe disabling mental illness (HCBS - SDMI).

Western Montana Community Mental Health Center (2014): a regional mental health center that serves fifteen counties in western and southwestern Montana. The area is the most populated region of the state with a density of more than ten people per square mile. WMMHC has worked to provide a comprehensive service system in Missoula, Butte, Kalispell, Hamilton and Bozeman. Each of these communities has outpatient psychotherapy, day treatment, targeted case management, psychiatric services, mobile crisis and crisis residential services. Missoula, Butte and Kalispell have PACT programs. Kalispell Regional Hospital and St. Patrick Hospital (Missoula) each have inpatient psychiatric units; and Butte operates a local secure emergency detention facility, the first in the State of Montana. WMMHC provides outpatient therapy and case management services in the other ten counties in the region. WMMHC also provides medication clinics to outlying communities by psychiatrists and APRNs who travel from Missoula, Bozeman, and Kalispell.

WMMHC continues to offer services to youth including outpatient therapy, psychiatric services, case management, comprehensive school and community treatment, family based services, therapeutic group home services and therapeutic foster care.

Peer Support Programs continue to be developed throughout the WMMHC system. Bozeman and Livingston have been operating Drop-In Centers since 2008, with Superior and Plains opening new Drop-In Centers in 2010. The Superior DIC specifically targets those consumers with co-occurring disorders, providing specialized peer group activities for this population. Other new drop-in activities include an 8,000 square foot community garden in Superior, peer led recovery groups in Plains and Superior, jail and ER diversion, IMR groups and community outreach throughout the region. In Missoula, the Adult Services program has rented a small outbuilding very near the campus, where peers are supporting one another in the making of art and soon, the raising of chickens. These services are peer run and offer temporary safety and basic supports for people experiencing mental illness. Peer Programs are essential components for individuals working towards recovery and offer a number of different services in different combinations including information, support, skill building, social networking, advocacy, inspiration and empowerment. WMMHC currently employs a significant number of peers throughout the organization. The agency supports continued education for peers and offers models of support such as WRAP, IMR and Peer Leadership trainings.

The network of mental health centers under the western umbrella serves over 9,800 individuals annually. The center employs over 760 employees throughout all its counties and affiliates. The center also operates a substance abuse affiliate, Western Montana Addiction Services with services in Missoula, Ravalli, Lake and Mineral counties. The center has operated a housing development arm called the Garden City CHDO, which has developed over 100 independent housing opportunities for consumers and continues to actively maximize state and federal funds available for the construction of both permanent and short term housing solutions for persons with disabilities.

WMMHC-Bozeman recently completed a campus, which includes an expanded crisis facility (with secure bed capacity), a new drop in center facility, a four unit independent living complex, as well as a new adult service center for Gallatin County. Additionally, WMMHC also expanded substance abuse services by opening Tri-County Addiction Services that provides chemical dependency services to Deer Lodge, Granite and Powell counties. In January 2009, a consortium of the two hospitals (St. Luke and St Joseph), Lake County and the WMMHC created a full time emergency capacity for Lake County. This program has been very well received by the community and especially by both hospitals involved. On-going collaborative efforts with St. Joseph Hospital have led to an agreement to make nearly three acres of land adjacent to the hospital available for a new WMMHC campus in Polson. The new campus is planned to expand services to include a crisis residential facility and group home beds. Just recently, an agreement was negotiated between WMMHC Butte and WMMHC Bozeman to provide services to the outlying area of Madison County for crisis response services. An agreement has also been reached with Marcus Daly Hospital in Hamilton to donate land for the purpose of building a secure crisis facility similar to the secure programs already operating in Butte and Bozeman.

Other collaborative efforts in Superior have led to a \$4,000 grant from the People's Law Center, and a \$5000 Child Care Partnership grant, which is being used to provide services using the Oasis Family Support Program, a family parenting, support, and psycho educational program for families with children aged 0-6 years. The Superior office was also the recipient of the 2010

Missoula Job Service Employer's Council Employer of Choice Award. In Lake County (Polson and Ronan) the office collaborates with the Tribe's Suicide Oversight Committee. Staff members do periodic educational presentations to County and Tribal providers, participate in planning and implementing suicide prevention/intervention programs. The Lake County office of WMMHC participates in County, Tribal, and public schools' health fairs, as well as health fairs put on by private businesses, such as Jore Electronics. Staff provides training in suicide prevention to the County jail, and other interested parties as requested. Staff members are core team members of Ronan School Districts Healthy Schools/Safe Students Program, which helps in identifying activities and training to meet the goals of this program. Staff members are also on the Board of the SKC Social Work Program, and provide presentations on working with SED/SDMI individuals in selected Social Work classes.

As mentioned, the Sanders County Office received recovery grant funding from the State of Montana to open a peer run Drop-In Center in Plains. The team has begun individual and group IMR programming in Thompson Falls, Plains and Hot Springs after receiving training in the model. Staff from the Mental Health Center, local law enforcement, the County Commissioners, Clark Fork Valley Hospital, and local clinicians in private practice are continuing to meet and plan a coordinated crisis response program for the County.

The Lincoln County office in Libby participates regularly in the annual community health fair and provides public education and prevention through articles in the local newspaper, with a consumer question format. The office is moving forward with peer support and direction by adapting the day treatment program into more of a peer drop in center.

In 2008, Butte developed a model consumer employment program (Workers Now), which offers employment opportunities to more than 75 persons monthly. To date, Workers Now in Butte has placed 36 consumers into permanent community job placements; served 10 homeless persons; coordinated and linked several consumers into the mental health system; and have hired 5 peers to work in the Workers Now Program offering support and mentoring. This program is now being implemented in Missoula and will continue to work as a vehicle for people with mental illness to move forward in the process of recovery. Additionally, Bozeman will be submitting a grant to assist with potential supportive services for the Gallatin County area. In Missoula, a therapeutic group home program was redesigned to receive direct discharges from the Montana State Hospital of persons with co-occurring illnesses who require a sober living arrangement to assist in their recovery. The WMMHC has worked extensively with AMDD to reduce recidivism at MSH through creative use of Plan 189 and use of the 72-hour crisis diversion funding. In partnership with the Department of Veterans Affairs the Center provided services to 880 veterans in the past year who have served in Iraq, Afghanistan, and other conflicts overseas.

Staff receives training in trauma treatment offered by the VA and other outside programs. Staff is offering treatment based on Najavitz's Seeking Safety model, as well as CBT and other evidence based therapeutic approaches.

As all behavioral health systems move toward Health Care Reform, WMMHC looks for innovative ways to work with local community stakeholders. Increasingly, WMMHC offices are partnering with other local agencies such as substance abuse providers and community health

clinics in an effort to provide more efficient and more complete care to the consumers of these services.

Winds of Change Mental Health Center provides strength-based, recovery oriented, co-occurring services for adults with severe and disabling mental illnesses and also works with consumers involved in the judicial and correctional systems. A team approach is utilized to provide all services. Winds of Change provides the following services: Case Management, Community Based Psychiatric and Rehabilitation Services, in-home crisis stabilization for mental health issues with CBPRS, out-patient therapy, psychiatric medication management, IMR, DBT Skills Group, Therapy, and Phone Coaching, three (3) Group Homes, Employment Program, Job Coaching, and a 24 Hour Crisis Line for Winds of Change consumers. Crisis intervention is provided by phone and face-to-face. Services are available throughout Missoula County.

Winds of Change developed a pilot project called Montana Intensive Treatment Teams (MITT) early in their development. These teams consist of a Case Manager, two community-based rehabilitation and support staff and a part time Peer Support Specialist. The goal is to utilize existing resources or build on natural supports in the individual's community without having to use a full team of mental health professionals available in each community all of the time. Winds of Change have developed MITTs specializing in Jail Diversion, the needs of the Adult Group Home clients, and parents involved with Department of Child and Family Services.

Sunburst Mental Health Services is licensed to provide outpatient mental health services to adults and children in Kalispell, Eureka, Libby, Polson and St. Ignatius (northwest Montana). Services include providing Clinical Assessments and Therapy, Medication Evaluations and Medication Management, Service Coordination (case management) and Community Support (CBPRS). Sunburst has a crisis line to help meet needs after typical working hours. Sunburst hosts a Drop In Center in Kalispell to meet the needs of community members wanting/needing a "safe space", access to resources and referral along with a variety of groups. Sunburst provides a range of groups in various locations. These include Dialectical Behavioral Therapy Groups, Recovery Cafe (art focused "safe space"), Boy's Groups, Girls Groups, Tween groups, Participant Advisory Board, Art groups and Writing Groups. Sunburst Mental Health Services staff include: Medical Director/Psychiatrist, Psychiatric Mental Health Nurse Practitioners (2), Certified Family Nurse Practitioner, Licensed Clinical Social Workers (4), and other supporting master's and bachelor's level staff.

Blackfeet Family Wellness Center is a Licensed Mental Health Center operated by the Blackfeet Tribe and located in Browning Montana. The Center provides mental health and substance abuse services.

3 Rivers Mental Health Solutions is a licensed Mental Health Center providing services in Missoula, Montana and the Bitterroot Valley. Center staff are focused on individuals' independence, choice, and dignity. 3 Rivers Mental Health Center offers a wide range of mental health support services. All services are deeply rooted in a commitment to client service. 3 Rivers staff works with clients, client's family, friends, and support systems to help clients maintain and improve their quality of life.

3 River's Mission is: *To support independence by improving the quality of life of the clients we serve.* 3 Rivers Mental Health Center is founded upon a fundamental belief that the lives and experiences of people with mental illness are just as valid as those of people without mental illness. Our staff works tirelessly to therapeutically meet our clients where they are at in their lives, without preconceived expectations, or any desire to control and to help those people develop their own life's goals and work to realize those goals.

The Center provides Adult Case Management; Medication Management; Out Patient Therapy; Mental Health Assessments and Diagnosis; Representative Payee Services; Support with Activities of Daily Living; support and advocacy for people with mental illness; an Intensive Community Based Service program which includes face to face medication reminders and medication prompts; a work program and many mental health groups.

Mountain Home Montana's mission is "To provide a safe, loving home where young mothers can discover their strengths and their children can experience the joys of childhood." Mountain Home serves pregnant and/or parenting mothers ages 16-24 offering transitional housing and mental health services. Services include targeted case management, therapy, community based therapeutic supports, access to basic needs, parenting programs, life skills classes, Mountain Mamma's Drop in Center, and Supported Employment. At any stage in their journey to independence, we arm young mothers with the resources they need to provide safe, stable, and nurturing homes for their children.

CRITERION 2:

Mental Health System Data Epidemiology

The National Association of State Mental Health Directors Research Institute provides Montana with standardized formula for determining the service penetration rate nationwide. Applying data from the SFY 2014 Uniform Reporting System (URS), we can determine that Montana provided services to 22,900 adults; a penetration rate of 22.4 per 1,000 of the adult population (Medicaid and Mental Health Services Plan). This is down somewhat from the percent (%) for rate of penetration in the past.

The 2015 Montana Legislature passed SB 405, an Act creating the Montana Health and Economic Livelihood Partnership Act (HELP). The Governor signed the HELP Act into law April, 2015. The purpose of the act was to expand health care coverage to additional individuals, improve access to health care services, and control health care costs, once federal approval is in place. The HELP Act extends health care coverage through Medicaid to adults between the ages of 19-64 who earn incomes less than about \$16,000/year for an individual or \$30,135/year for a family of three. Montana has drafted a Waiver for public review and released a formal state request for proposal for a third party administration contract. The Waiver is required because the HELP Act includes provisions of premiums, copays, and employment.

Based on the current national economic conditions, recent application for expansion of Medicaid in Montana, and lack of other strategies for predicting numbers served, we project the 2016-2017 utilization to increase.

Over the last five (5) or more years, Montana's yearly utilization of services has been fairly stable; however, it is expected that Medicaid Expansion could increase utilization by 10%.

Montana officials report 15 percent of Montanans lack health insurance, down from 20 percent two years ago. Preliminary statistics show the state saw a net increase of more than 23,000 people with health insurance as of May 2015. Approximately 195,000 Montanans lacked health insurance in 2013 before the final changes required by the Affordable Care Act went into effect. The number of individuals lacking health insurance is down to about 151,000 Montanans.
(Montana Insurance Commissioner Monica Lindeen)

Medicaid Expansion will change the number of those using the Montana Health Exchange allowing those below 138% of federal poverty level to consider Medicaid coverage.

Definition of Severe Disabling Mental Illness (SDMI)

This definition of severe disabling mental illness is based on diagnosis, duration of illness, and level of functioning. The criteria used by Montana are as follows:

"Severe disabling mental illness" means with respect to a person who is 18 or more years of age that the person meets the requirements of (7)(a), (b), (c) or (d). The person must also meet the requirements of (7)(e). The person:

- (a)) has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at Montana State Hospital (Warm Springs campus) at least once;
- (b) has recurrent thoughts of death, recurrent suicidal ideation, or a suicide attempt, or a specific plan for committing suicide;
- (c)) has a DSM-IV-TR diagnosis of:
 - (i) schizophrenic disorder (295);
 - (ii) other psychotic disorder (293.81, 293.82, 295.40, 295.70, 297.1, 297.3, 298.9);
 - (iii) mood disorder (293.83, 296.22., 296.24, 296.32, 296.33, 296.40, 296.42,, 296.43, 296.44, 296.52, 296.53, 296.54., 296.62, 296.63, 296.64, 296.7, 296.80, 296.89);
 - (iv) amnestic disorder (294.0, 294.8);
 - (v) disorder due to a general medical condition (293.01, 310.1);
 - (vi) pervasive developmental disorder not otherwise specified (299.80) when not accompanied by mental retardation;
 - (vii) anxiety disorder (300.01, 300.21, 300.3); or
 - (viii) posttraumatic stress disorder (309.81);
- (d) has a DSM-IV-TR diagnosis of personality disorder (301.00, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, or 301.90) which causes the person to be unable to work competitively on a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency for a period of at least six months or is obviously predictable to continue for a period of at least six months; and
- (e)) has ongoing functioning difficulties because of the mental illness for a period of at least six months or for an obviously predictable period over six months, as indicated by at least two of the following:
 - (i) a medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;
 - (ii) the person is unable to work in a full-time competitive situation because of mental illness;
 - (iii) the person has been determined to be disabled due to mental illness by the social security administration; or
 - (iv) the person maintains a living arrangement only with ongoing supervision, is homeless, or is at imminent risk of homelessness due to mental illness; or
 - (v) the person has had or will predictably have repeated episodes of decompensation.
- (f) has ongoing functioning difficulties because of the mental illness for a period of at least six months or for an obviously predictable period over six months, as indicated by at

least two of the following:

- (i) a medical professional with prescriptive authority has determined that medication is necessary to control the symptoms of mental illness;
- (ii) the person is unable to work in a full-time competitive situation because of mental illness;
- (iii) the person has been determined to be disabled due to mental illness by the Social Security Administration;
- (iv) the person maintains a living arrangement only with ongoing supervision, is homeless or is at imminent risk of homelessness due to mental illness;
or
- (v) the person has had or will predictably have repeated episodes of decompensation. An episode of decompensation includes increased symptoms of psychosis, self-injury, suicidal or homicidal intent or psychiatric hospitalization.

National Outcome Measures (NOMS) and Client Level Data are available from the AMDD Quality Assurance Manager; these include MHSP and Medicaid. Client Level Data, through a Uniform Reporting System (URS Tables) format, is provided to SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ) in collaboration with the National Research Institute (NRI).

CRITERION4: Targeted Services to Rural and Homeless Populations

Targeted Services to Rural Populations

For planning mental health services, Montana is an entirely rural state and its mental health system is a rural/frontier mental health system. The extent to which this mental health system serves Montana's huge geographic area is impressive. The public mental health system provides professional mental health services in counties with as few as 1.66 people per square mile (Beaverhead County), and part-time professional mental health services in 26 counties with as few as 0.27 people per square mile (Garfield County).

Because of the frontier nature of Montana, our entire mental health service plan is essentially a plan for delivery of services in rural and frontier settings. "Frontier" designation is determined through a weighted matrix of population density, distance in miles to a service/market center and travel time in minutes. Over 800 of the country's 3190 counties have been designated as frontier by the Frontier Education Center in consultation with State Offices of Rural Health. Most frontier land is located in Alaska, the Great Plains and the West. Montana ranks number three (3) out of 19 states that account for about 95% of the land designated as frontier. When comparing the Top Ten Frontier States by Population and Area, Montana ranks 6th in Largest Frontier Population and, as noted above, third in Largest Frontier Area. (National Center for Frontier Communities). The entire plan addresses the manner in which mental health services will be provided to individuals residing in rural/frontier areas.

Concentrating services in larger areas may be the most efficient strategy for delivery; however, Montana has maintained an effort to provide consumers a choice of mental health services in every county in the State primarily through the community mental health centers. This accessibility provides for, at a minimum, identification of serious mental health problems, referral to more specialized services in larger communities, and supportive therapy and case management.

Services to Those Who Are Homeless

The Projects for Assistance in Transition from Homelessness (PATH) programs supports SAMHSA's Strategic Initiatives; specifically Recovery Support. Three major mental health centers concentrate service delivery in the areas of: Outreach, Screening and Diagnostic Treatment, Community Mental Health, Case Management, Referral for Primary Health Services, Job Training, Education, and relevant Housing services. Enrolled individuals will all be provided the opportunity to transition to community mental health center services as soon as eligible and the PATH program can ensure service stability for the individual.

The PATH program is critical to provide the outreach necessary for those experiencing severe and persistent mental illness and homelessness to access the mainstream public mental health system and accompanying community mental health services.

The Stepping Stones To Recovery SSI/SSDI Outreach, Access And Recovery (SOAR) Initiative is part of the contractual requirements under PATH.

As part of the SOAR Initiative, several partners have come together to develop a leadership group that meets monthly to discuss on-going community development, challenges, successes, and statewide processes. The SOAR Leadership group consists of the State PATH Lead, the State Disability Determination Services Administrator, the Continuum of Care (CoC) State Coordinator, Montana State Hospital Enrollment Coordinator, SOAR TA representatives, and Missoula County Mental Health Center staff.

The Statewide Leadership and Missoula County Teams have developed Action Plans to promote and develop community SOAR Teams in the state. Missoula's Action Plan includes working with the Missoula County Detention Center to facilitate successful discharge and reentry into the community, to reduce recidivism and promote recovery.

Montana is using the SOAR Online Training to coordinate SOAR trainings statewide to community mental health center case managers and other organizations serving persons who are homeless or at risk of homelessness. All PATH case managers/liaisons are required to complete the SOAR Online Training.

Housing services are an integral component of the PATH program and critical to recovery for persons with severe disabling mental illness or co-occurring disorder. The Montana PATH Program works closely with the Department of Commerce Shelter Plus staff in the areas of reporting for match requirements and housing grant opportunities. All FY 2012 PATH sites were provided access to State funded Shelter Plus vouchers through the State Department of Commerce Supportive Housing Program. Montana's PATH Program is provided priority to Department of Commerce Shelter Plus Care Vouchers – providing a safety net for those persons considered chronically homeless. The communities of Billings, Missoula, Helena, and Butte have access to these vouchers through the Department of Commerce, Housing Division and public housing authorities across the state. The Shelter Plus Care Program has provided opportunity to house individuals who are homeless and are diagnosed with a severe disability mental illness with 35 vouchers/beds/units.

An agreement with Missoula Housing Authority and the Department of Commerce opened up additional housing opportunities in the Missoula area, a high cost, and limited housing option area. Of the 38 individuals served in FY 2015, statewide: 79% were male; 36% between the ages of 45-64 (male & female); 97% of Non-Hispanic/Non-Latino Race, and 95% of white ethnicity.

Targeted Services to Order Adults

Nationally, the "SHIP" (State Health Insurance Assistance Program) is an advocacy group whose primary mission is to educate and advocate for, Medicare beneficiaries and their families. The Montana SHIP, housed in the DPHHS Senior & Long Term Care Division, has long enjoyed collaborations with the Addictive and Mental Disorders Division (AMDD) of the Montana Department of Public Health & Human Services.

SHIP counselors frequently work with beneficiaries with varying levels and types of mental illness. As advocates for seniors, as well as adults with disabilities, SHIP counselors are often in the position of assisting individuals whose independence rests, to some extent, on their ability to cope with everyday situations and challenges. The partnership with SHIP and AMDD is providing counselors some basic mental health training and technical support. As the senior population grows, MT SHIP counselors report they are increasingly consulting with mentally ill beneficiaries, thus our partnerships with AMDD are increasingly important. In addition to staff training, AMDD staff have presented at the Annual Governors Conference on Aging.

CRITERION 5: Management Systems

Financial Resources, Staffing and Training

The Addictive and Mental Disorders Division Mental Health Services Bureau has 21 FTE to support administrative, financial, and training for mental health service provision. This includes an administrator, a bureau chief, a licensed clinician that oversees clinical program development and standards, a quality assurance manager, a mental health planner/program manager, Medicaid program manager, a community resources manager, four (4) quality assurance professionals, five (5) community program officers, , three (3) half-time and one full-time community liaison officers, and two (2) operations support staff. The SFY 2015 budget for the Division was \$143,702,402.

Training: Montana has incorporated strengths based and recovery oriented services and training in their mental health system. Because Montana has a significant Native American population all of our training events offered to mental health centers include urban Indian and reservation based programs.

Regional Community Mental Health Centers have developed Crisis Response Teams (CRT); dedicated clinicians whose job is to respond to crisis calls in the community, at the local emergency room, or in the detention center. Teams are operational in Kalispell, Missoula, Butte, Helena, and Bozeman/Livingston. Each of the local mental health agencies and chemical dependency programs train first responders in mental health crisis. Many of the emergency rooms contact either the CRT or trained CIT officers when a person in a mental health crisis presents.

Montana continues to cultivate a long-standing partnership with Departments of Corrections and Justice Team to ensure first-responders and emergency health services providers are trained through the nationally recognized Crisis Intervention (CIT) model. The 40-hour training is held over the course of a week and includes courses on personality disorders, psychotropic medications and side effects, post-traumatic stress disorder, traumatic brain injury, suicide assessment, and children's issues. Participants also spend a day visiting the Montana State Hospital to visit with patients. A Mental Illness Intervention Field Guide is provided to all basic programs to effectively respond to persons exhibiting mental health concerns once trained and working in their communities.

The Behavioral Health Specialist with AMDD has met regularly with CIT coordinators from around Montana to make sure curriculum was consistent statewide for several years and also to create a CIT umbrella organization. In 2013 a nonprofit CIT Montana was born and an executive director appointed in January 2015. The position will solidify the long-standing work of leaders from Corrections, Mental Health and Justice Systems.

The 2015 Montana Legislature voted to continue and expand funding for the Addictive and Mental Disorders Division (AMDD) County Matching Grant program for Crisis Intervention and Jail Diversion; the program was first approved by the 2009 Legislature. The County Matching Grant program was first implemented in FY 2010 to address rural community crisis and jail

diversion needs through a county or multi-county strategic plan for community-based or regional emergency services, including a commitment by the entities to collaborate and commit local funds for mental health services for crisis intervention, jail diversion, involuntary pre-commitment, and short term inpatient treatments costs.

A local investment/county match is required for these funds. The match rate is determined based upon utilization rates at Montana State Hospital during FY2014.

FY 2016 Grant Applicants will respond to the following application elements:

1. A county or multi-county, strategic plan addressing crisis intervention and jail diversion that clearly identifies how requested funds will expand or enhance an existing project.
2. A county or multi-county strategic plan for community or regionally based emergency or court ordered detention and examination services, as well as short term inpatient treatment.
3. A detailed proposal clearly addressing how the county and other entities will partner and commit local funds for mental health services for crisis intervention, jail diversion, involuntary pre-commitment and short-term inpatient treatment costs. Counties that include tribal lands must demonstrate coordination efforts with tribal representatives both on and off reservations.
4. A detailed budget identifying cash and in-kind local contribution amounts.

Block Grant Designation

The Montana Community Mental Health Block Grant will be designated for the following Priority Areas for 2016-2017 MH Block Grant Dollars Allocation

1. Mental Health/Recovery Services for individuals with severe disabling mental illness who are uninsured or underinsured that meet MHSP criteria.
2. Community Support (Rehabilitative) Evidence Based Individual Placement and Supports (Supported) Employment Services.
3. Implement a Transitions project to create a model for treatment plan coordination for transition age youth including those experiencing First Episode Psychosis.

Children's Mental Health

Overview of Children's Mental Health Bureau:

CMHB is part of the Developmental Services Division (DSD). The DSD assists Montanans with disabilities and children with emotional disturbances to live, work, and participate in their communities. The Division contracts for institutional care, residential services, home based services to youth and families, case management, and a variety of employment related services.

The Division is organized into 3 major programs:

- Children's Mental Health Bureau (CMHB)
- Developmental Disabilities Program (DDP)
- Montana Developmental Center (MDC)

The CMHB supports Montana youth and families in accessing effective mental health care to meet their needs and managed and funded mental health services for over 14,500 youth enrolled in Montana Medicaid in SFY 2014. CMHB provides leadership through the provision of quality reviews, which may include retrospective reviews, service reviews, quality audit reviews, and inspections of care. CMHB promotes both efficiency and quality mental health care for children.

The CMHB is organized into a Central Office with 18 staff to include management, program, clinical, and administrative staff. CMHB also has Regional Offices in Billings and Missoula that are comprised of 3 regional staff. The Central Office provides statewide utilization management of mental health services for youth under age 18 (or until 19 if still in secondary school), along with policy development, rule writing, training and technical assistance for providers, technical support for provider payment and processing, and federal reporting and compliance.

Regional staff assists child and family teams to access resources, approve youth enrollment into non-Medicaid services, as well as monitor provider compliance with state and federal regulations. Regional staff also helps develop and support community-based alternatives for youth with Serious Emotional Disturbance (SED) at risk of placement out of their communities and provides oversight of discharge planning for youth with SED with complex needs returning from PRTFs.

Children's System of Care (SOC) Planning Committee

The **Children's SOC Planning Committee** was established by statute in 1993 ([52-2-301](#), [52-2-303](#), [52-2-304 MCA](#)) to develop an integrated service system for children under age 18 who are seriously emotionally disturbed (SED), at risk for placement in an out-of-home setting, and needing the assistance of more than one state agency. The statute was updated in 2001 to further describe a children's System of Care and to define the duties of the planning committee.

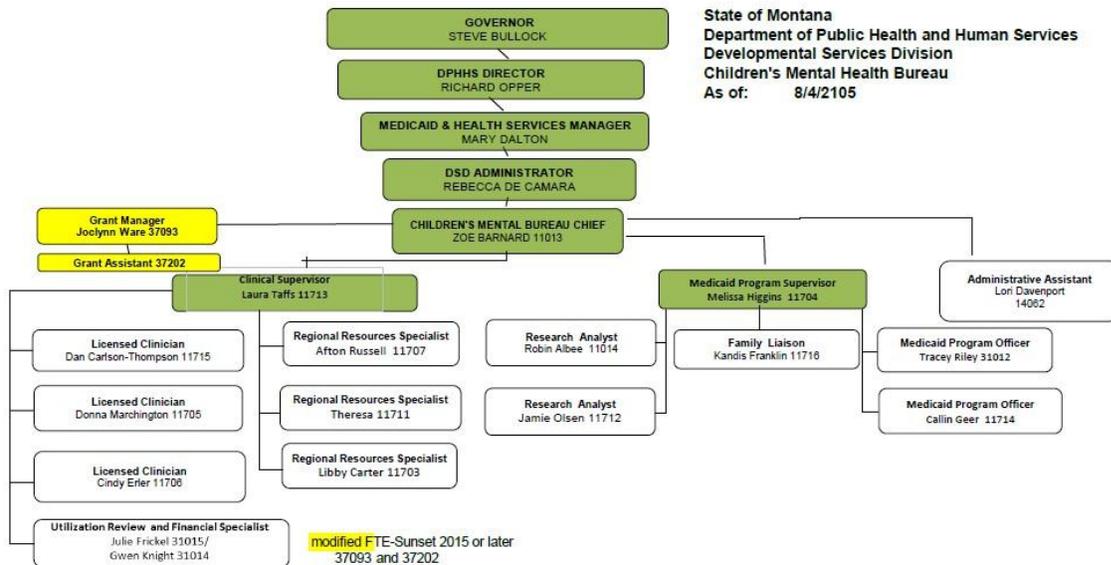
The **Children's SOC Planning Committee** is made up of approximately 30 members who represent family members of youth, Native Americans, advocacy groups, and mental health

providers that serve young people and community members. The Director of Department of Public Health and Human Services (DPHHS) appoints the members.

The work of CMHB with the SOC Planning Committees is guided by the following values:

- Family and youth participation at all levels of the children’s system of care from policy planning to individual care planning.
- Cultural sensitivity in service design and delivery.
- A strengths-based focus on the family and youth as drivers of treatment and recovery.
- Respectful partnership with communities, including the tribes, to design and develop the system of care.
- Partnership with providers to increase use of evidenced-based and promising practices to serve youth with SED and their families.
- An integrated focus on both mental health and chemical dependency treatment needs of youth with co-occurring disorders.

Below is the Children’s Mental Health Bureau organizational chart.



Criterion 1 Comprehensive Community Based Mental Health Service System

Child Available Services:

CSCT (Comprehensive School and Community Treatment)

Comprehensive School and Community Treatment is a comprehensive planned course of community mental health outpatient treatment that includes therapeutic interventions and supportive services provided in a public school based environment in office and treatment space provided by the school. Services are focused on improving the youth's functional level by facilitating the development of skills related to exhibiting appropriate behaviors in the school and community settings. These youth typically require support through cueing or modeling of appropriate behavioral and life skills to utilize and apply learned skills in normalized school and community settings.

Comprehensive School and Community Treatment includes:

Individual, Group and Family Therapy
Skill Building and Integration

Therapeutic Group Home (TGH)

Therapeutic Group Homes provide behavioral intervention and life skills development in a structured group home environment for youth who cannot be served in a less intensive level of care due to safety concerns or functional impairments that result from serious emotional disturbance.

TGH services are appropriate for youth requiring a higher intensity of specific therapeutic services than are available through traditional outpatient service, and which clearly exceed the capabilities of immediate family, relatives, friends, or other community systems.

The purpose of this service is to provide for the maximum reduction of the symptoms of the SED of the youth, to restore the best possible functional level of the youth, to reverse or change maladaptive patterns of behavior, and to encourage personal growth and development. A combination of supportive interactions, cognitive therapy, interactive psychotherapy, behavior modification techniques and therapeutic interventions are used to induce therapeutic change for youth in therapeutic group homes.

This level of treatment intervention includes a consideration of the safety and security needs of the youth, the degree of self-care skills demonstrated by the youth, and the likelihood of the youth to benefit from a community integrated program. Room and board costs in a therapeutic group home are not covered by Montana Medicaid.

Extraordinary Needs Aide Service (ENA)

ENA services are provided for youth in a TGH who exhibit extreme behaviors that cannot be managed by the TGH staffing requirements and who do not require services in a higher level of care. These services may be requested if the youth has extreme behaviors that are current, severe, and consist of documented incidents that are symptoms of the SED of the youth.

Home Support Services (HSS)

Home Support Services are in-home family support services for youth with serious emotional disturbance exhibiting symptoms that are of a persistent nature requiring in-home behavioral intervention. Services are focused on the reduction of behaviors that interfere with the youth's ability to function in the family and community and facilitation of the development of skills needed by the youth and family to prevent or minimize the need for more restrictive levels of care. The provider is available by phone or in-person to assist the youth and family during crises. Home Support Services include functional assessment of the youth and family system, crisis planning and response, and behavioral coaching and training for the youth and family.

Therapeutic Foster Care (TFC)

Therapeutic Foster Care Services are in-home therapeutic and family support services for youth living in a licensed therapeutic foster home environment. Services are focused on the reduction of behaviors that interfere with the youth's ability to function in the family and/or home community and facilitation of the development of skills needed by the youth and family to prevent or minimize the need for more restrictive levels of care and to support permanency or return to the legal guardian. The provider is available by phone or in-person to assist the youth and foster family during crises.

Therapeutic Foster Care Services include functional assessment of the youth and family system, crisis planning and response, and behavioral coaching and training for the youth, foster and natural family.

Therapeutic Foster Care Permanency (TFOC-P)

Therapeutic Foster Care-Permanency Services are an intensive level of treatment for youth in a permanent therapeutic foster family placement. As with Home Support Services and Therapeutic Foster Care, services are focused on the reduction of behaviors that interfere with the youth's ability to function in the family and facilitation of the development of skills needed by the youth and family to prevent or minimize the need for more restrictive levels of care. With this service, the parent(s) receive specialized behavioral training by a licensed mental health professional.

Targeted Youth Case Management Services (TCM)

"Targeted Case management" means the process of planning and coordinating care and services to meet individual needs of a youth and to assist the youth in obtaining necessary medical, social, nutritional, educational, and other services. Case management provides coordination among agencies and providers in the planning and delivery of services.

Case management includes assessment, case plan development, monitoring, and service coordination.

Day Treatment

Youth Day Treatment services are a set of mental health services provided in a specialized classroom setting that is not co-located in a public school. The educational component of the program is not paid for by Medicaid and must be provided through full collaboration with a public school district.

A licensed therapist provides services at no more than a ratio of one to twelve members. The services are focused on building skills for adaptive school and community functioning and reducing symptoms and behaviors that interfere with a youth's ability to participate in their education at a public school, to minimize need for more restrictive levels of care and to support return to a public school setting as soon as possible. Day Treatment includes, individual, family, and group therapy; social and life skills training; and therapeutic recreation services.

1915i

On January 1, 2013 a new State Plan option under Medicaid, the 1915i, was approved which allows the state the flexibility to offer Home And Community Based Services (HCBS) usually available only in waivers, along with the option to waive comparability, although services must be offered statewide. This is a community based alternative to Psychiatric Residential Treatment Facilities. This also allows states to offer a new optional eligibility category for full Medicaid benefits to a group of youth who will be receiving HCBS.

Respite:

Respite is available concurrently with HSS and TFC unless prior approved by the Bureau. The payment source is state general funds managed by CMHB. When the funds are exhausted, respite becomes unavailable until the start of the next SFY. CMHB is considering an alternative method of managing the respite funds to address this issue and to give families more choice in the way they use respite.

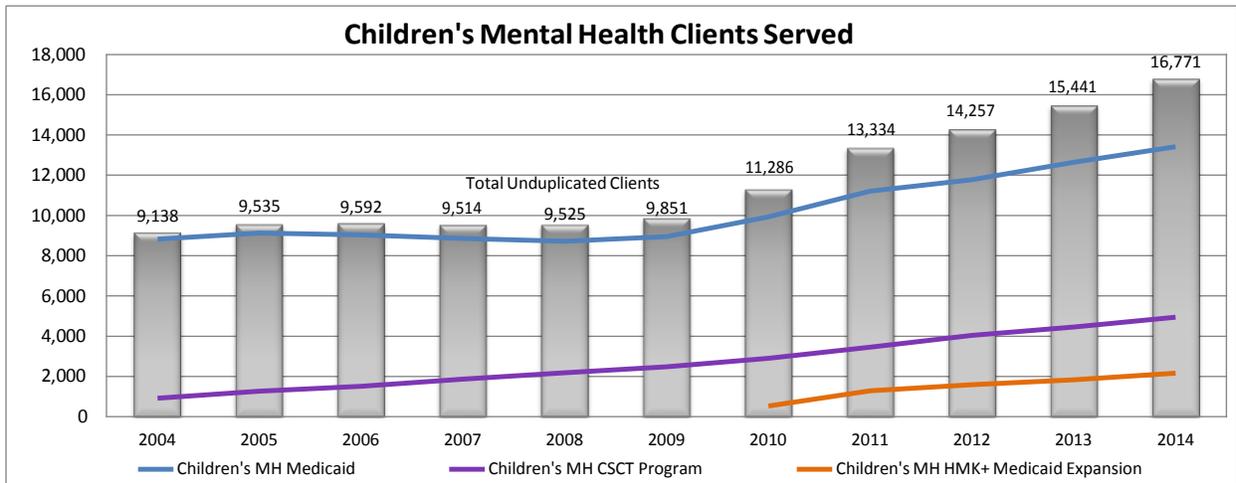
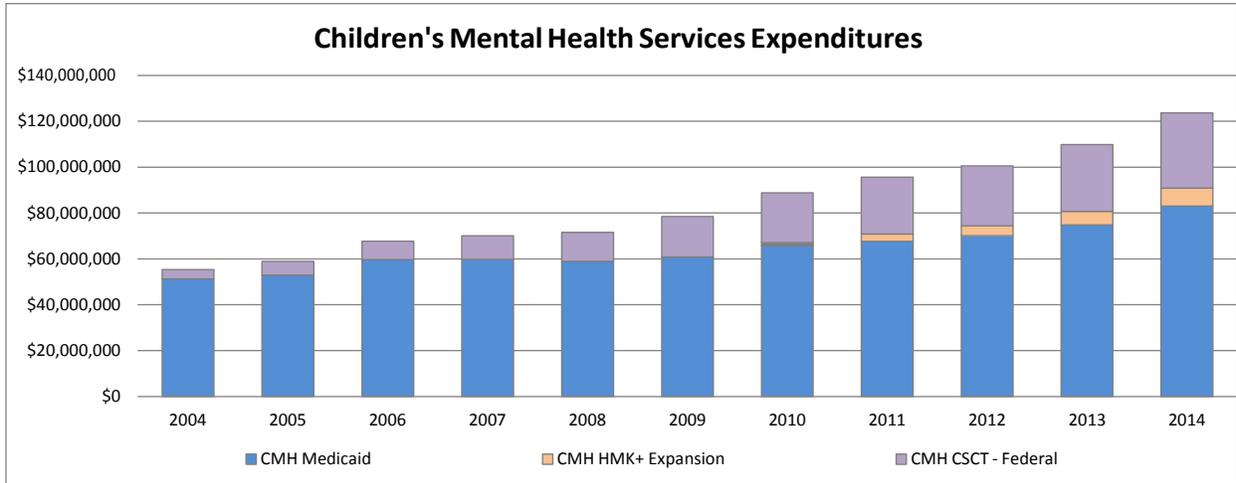
Community Based Psychiatric Rehabilitation and Support Services (CBPRS) are available through licensed mental health centers. See the "Rehabilitation Services" section for additional details about this service.

Service Trends and Growth

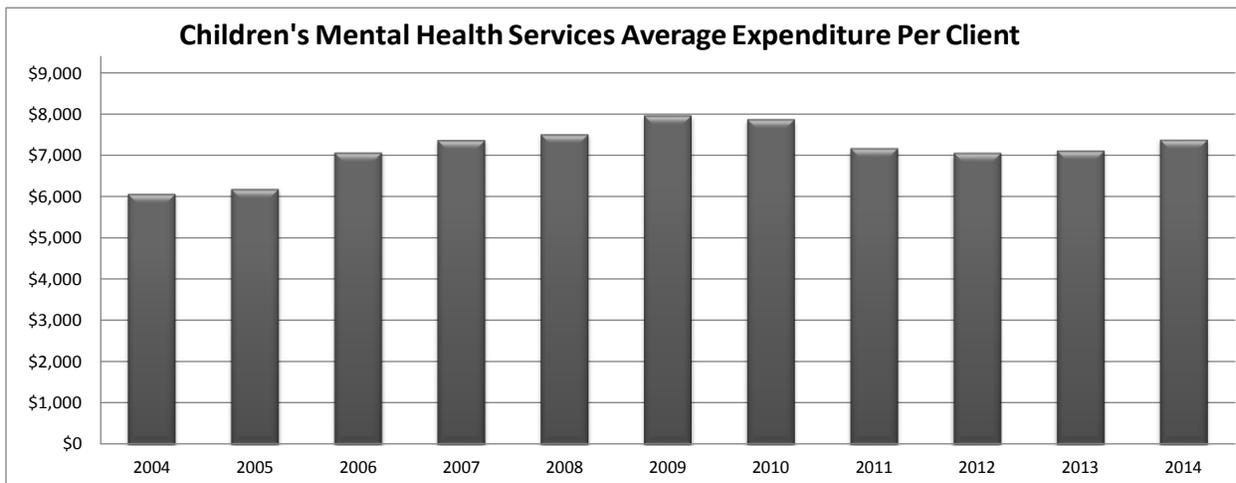
The bar chart shows the basic funding levels for CMHB services since 2004. As the chart illustrates; the blue section shows the Federal FMAP-able Medicaid services, the tan represents the CHIP funded Medicaid expansion clients (that began with the Healthy MT Kids initiative), and the light and dark purple represents the CSCT program.

Services that have grown the most include community based services such as CSCT, TCM, and HSS/TFC/TFC-P. This growth has not resulted in a decreased cost of out of home placement.

Out of home placements continue to increase as well.



**Note that children can be in more than one group during the year, but the total client figure is unduplicated.*



MEDICAID MENTAL HEALTH YOUTH
SFY 2014 To-Date and Projected SFY 2015 Expenditures by Provider Type

Service Expenditure	Actual as of 7/22/2015 SFY2014	Estimated with Current Growth Rates SFY2015	Estimated Growth Rates SFY14 to SFY15
* Comprehensive School & Community Treatment (CSCT)	\$ 32,786,134	\$ 34,043,603	3.8%
* THERAPEUTIC GROUP HOME (PT61)	\$ 19,459,770	\$ 21,584,035	10.9%
* PSYCHIATRIC RES TREATMENT FAC (PT38)	\$ 18,205,559	\$ 20,445,563	12.3%
* HOME SUPPORT SERVICES / THERAP FOSTER CARE (PT64)	\$ 14,136,447	\$ 11,692,954	-17.3%
* MENTAL HEALTH CENTER (PT59)	\$ 7,609,918	\$ 7,200,810	-5.4%
* CASE MANAGEMENT - MENTAL HEALTH (PT60)	\$ 7,176,618	\$ 8,413,337	17.2%
* LICENSED PROFESSIONL COUNSELOR (PT58)	\$ 5,423,373	\$ 6,388,221	17.8%
* HOSPITAL - INPATIENT (PT01)	\$ 5,248,265	\$ 4,638,681	-11.6%
* SOCIAL WORKER (PT42)	\$ 2,760,758	\$ 3,192,036	15.6%
* DIRECT CARE WAGE (CMHB) - <i>Not a Service Type</i>	\$ 2,726,456	\$ 2,726,456	0.0%
* PSYCHIATRIST (PT65)	\$ 1,978,378	\$ 2,321,028	17.3%
* HOSPITAL - OUTPATIENT (PT02)	\$ 1,489,716	\$ 1,702,332	14.3%
* PHYSICIAN (PT27)	\$ 1,071,583	\$ 1,299,883	21.3%
* MID-LEVEL PRACTITIONER (PT44)	\$ 960,310	\$ 1,383,433	44.1%
* PSYCHOLOGIST (PT17)	\$ 745,859	\$ 769,873	3.2%
* FEDERALLY QUAL HEALTH CENTER (PT56)	\$ 542,206	\$ 651,805	20.2%
* HOME & COMM BASED SERVICES (PT28)	\$ 493,049	\$ 103,540	-79.0%
* RURAL HEALTH CLINIC (PT55)	\$ 322,006	\$ 333,853	3.7%
* RESPITE (PT59)	\$ 204,320	\$ 236,037	15.5%
* CRITICAL ACCESS HOSPITAL (PT74)	\$ 172,543	\$ 167,794	-2.8%
* PERSONAL CARE AGENCY (PT12)	\$ 148,924	\$ 49,859	-66.5%
* LABORATORY (PT40)	\$ 47,627	\$ 144,652	203.7%
* INDEP DIAG TESTING FACILITY (PT72)	\$ 369	\$ 369	0.0%
Total Children's Medicaid Mental Health and CSCT	\$ 123,710,187	\$ 129,490,153	4.7%

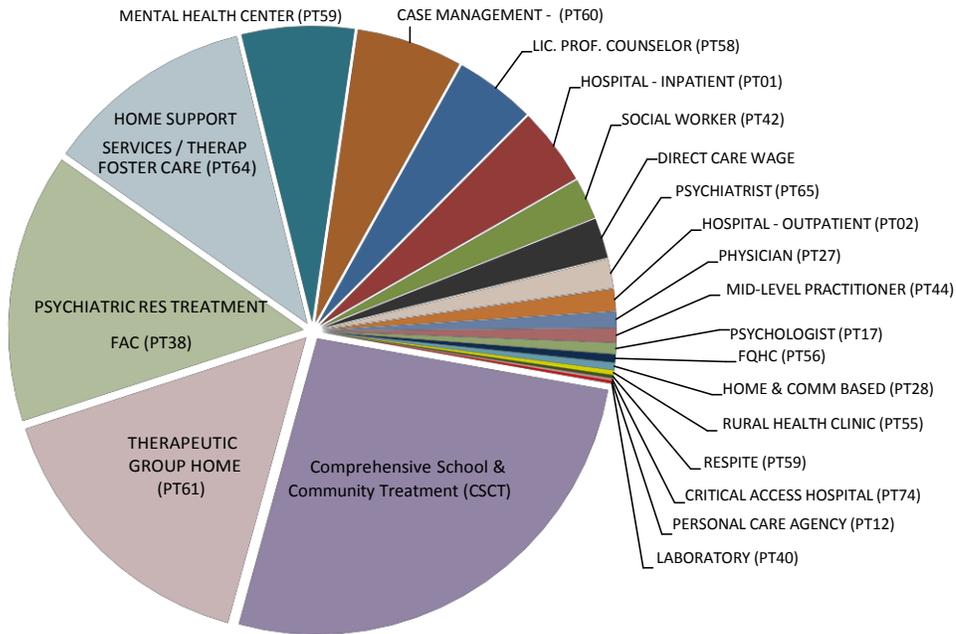
† Expenditures through July 22, 2015 based on Date of Service. Includes CHIP funded HMK+ Medicaid Expansion.

** CSCT is matched with School funds. The CSCT amounts shown represent the Federal match portion only. The FMAP % is approximately 66% / 34%: the school match amount that is not shown totals \$16.7 million.

*** SFY2015 is an approximation based on partial claims information and current growth percentages since providers have 365 days to bill.

MEDICAID MENTAL HEALTH YOUTH

SFY 2014 To-Date Expenditures by Provider Type based on Dates of Service



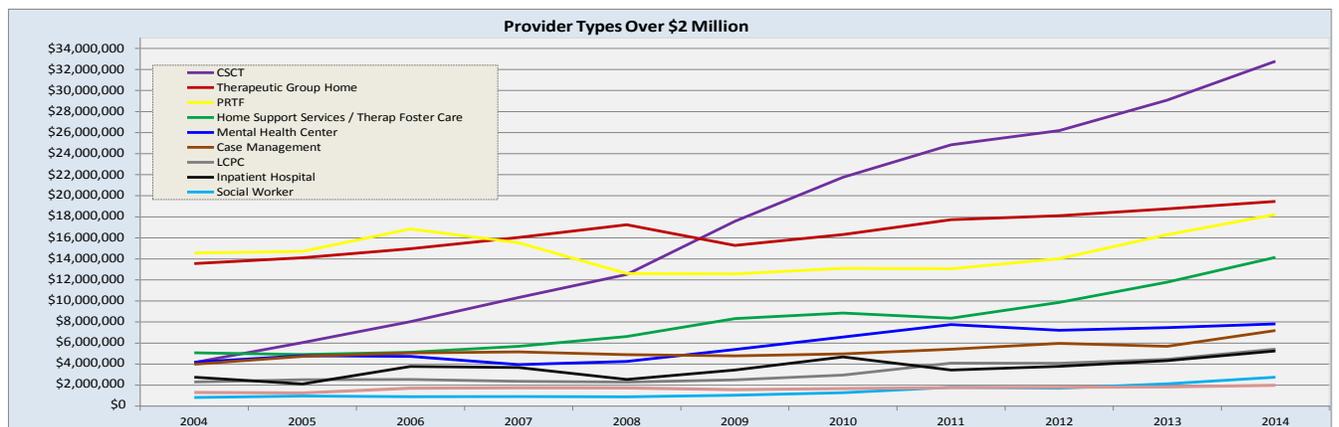
Service Expenditure	# Served	Expenditures	
* Comprehensive School & Community Treatment (CSCT)	4,957	\$ 32,786,134	26.5%
* THERAPEUTIC GROUP HOME (PT61)	655	\$ 19,459,770	15.7%
* PSYCHIATRIC RES TREATMENT FAC (PT38)	549	\$ 18,205,559	14.7%
* HOME SUPPORT SERVICES / THERAP FOSTER CARE (PT64)	1,881	\$ 14,136,447	11.4%
* MENTAL HEALTH CENTER (PT59)	2,467	\$ 7,609,918	6.2%
* CASE MANAGEMENT - MENTAL HEALTH (PT60)	3,977	\$ 7,176,618	5.8%
* LICENSED PROFESSIONL COUNSELOR (PT58)	6,286	\$ 5,423,373	4.4%
* HOSPITAL - INPATIENT (PT01)	750	\$ 5,248,265	4.2%
* SOCIAL WORKER (PT42)	3,606	\$ 2,760,758	2.2%
* DIRECT CARE WAGE (CMHB) - <i>Not a Service Type</i>		\$ 2,726,456	2.2%
* PSYCHIATRIST (PT65)	2,965	\$ 1,978,378	1.6%
* HOSPITAL - OUTPATIENT (PT02)	2,801	\$ 1,489,716	1.2%
* PHYSICIAN (PT27)	4,942	\$ 1,071,583	0.9%
* MID-LEVEL PRACTITIONER (PT44)	2,472	\$ 960,310	0.8%
* PSYCHOLOGIST (PT17)	1,309	\$ 745,859	0.6%
* FEDERALLY QUAL HEALTH CENTER (PT56)	864	\$ 542,206	0.4%
* HOME & COMM BASED SERVICES (PT28)	54	\$ 493,049	0.4%
* RURAL HEALTH CLINIC (PT55)	822	\$ 322,006	0.3%
* RESPIRE (PT59)	341	\$ 204,320	0.2%
* CRITICAL ACCESS HOSPITAL (PT74)	480	\$ 172,543	0.1%
* PERSONAL CARE AGENCY (PT12)	29	\$ 148,924	0.1%
* LABORATORY (PT40)	249	\$ 47,627	0.0%
* INDEP DIAG TESTING FACILITY (PT72)	1	\$ 369	0.0%
Total Children's Medicaid Mental Health and CSCT	16,771	\$ 123,710,187	100%

† Expenditures through July 22, 2015 based on Date of Service. Includes CHIP funded HMK+ Medicaid Expansion.

** CSCT is matched with School funds. The CSCT amounts shown represent the Federal match portion only. The FMAP % is approximately 66% / 34%: the school match amount that is not shown totals \$16.7 million.

Children's Mental Health Expenditures by Provider Type											
Provider Treating Type	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
CSCT	\$4,140,815	\$6,030,806	\$8,028,661	\$10,323,573	\$12,512,586	\$17,561,972	\$21,762,269	\$24,850,926	\$26,202,735	\$29,094,802	\$32,786,134
Therapeutic Group Home	\$13,551,603	\$14,110,905	\$14,967,222	\$16,027,134	\$17,247,287	\$15,289,309	\$16,310,595	\$17,723,508	\$18,094,214	\$18,748,707	\$19,459,770
PRTF	\$14,568,950	\$14,711,177	\$16,840,641	\$15,528,989	\$12,606,454	\$12,579,093	\$13,104,532	\$13,049,098	\$14,028,650	\$16,288,728	\$18,205,559
Home Support Services / Therap Foster	\$5,075,063	\$4,916,096	\$5,109,435	\$5,690,792	\$6,627,562	\$8,330,505	\$8,850,738	\$8,358,497	\$9,862,449	\$11,779,163	\$14,136,447
Mental Health Center	\$4,176,112	\$4,794,804	\$4,738,961	\$3,943,267	\$4,254,318	\$5,382,191	\$6,571,411	\$7,745,729	\$7,203,215	\$7,453,443	\$7,814,238
Case Management	\$3,992,292	\$4,741,081	\$5,056,952	\$5,159,114	\$4,899,089	\$4,778,461	\$4,963,773	\$5,406,199	\$5,961,472	\$5,679,045	\$7,176,618
LCPC	\$2,307,142	\$2,513,443	\$2,540,166	\$2,362,837	\$2,293,913	\$2,490,649	\$2,944,868	\$4,093,234	\$4,080,396	\$4,455,719	\$5,423,373
Inpatient Hospital	\$2,760,707	\$2,111,385	\$3,773,945	\$3,665,589	\$2,533,643	\$3,428,027	\$4,679,563	\$3,431,294	\$3,777,509	\$4,317,978	\$5,248,265
Social Worker	\$822,185	\$954,801	\$902,161	\$913,138	\$877,064	\$1,035,002	\$1,280,950	\$1,785,846	\$1,703,107	\$2,131,876	\$2,760,758
Direct Care Wage	\$0	\$0	\$965,433	\$1,549,526	\$2,498,186	\$2,177,088	\$2,798,118	\$2,798,118	\$2,758,983	\$2,726,456	\$2,726,456
Psychiatrist	\$1,310,976	\$1,251,838	\$1,702,201	\$1,743,787	\$1,735,839	\$1,573,711	\$1,664,888	\$1,755,096	\$1,793,274	\$1,829,217	\$1,978,378
Outpatient Hospital	\$1,401,642	\$1,437,400	\$1,568,071	\$1,502,023	\$1,494,632	\$1,612,263	\$1,486,327	\$1,472,739	\$1,348,861	\$1,392,108	\$1,489,716
Physician	\$359,375	\$384,256	\$409,578	\$399,979	\$464,157	\$565,579	\$716,910	\$837,539	\$863,960	\$898,936	\$1,071,583
Mid-Level Practitioner	\$178,730	\$179,866	\$230,904	\$213,778	\$305,035	\$275,997	\$347,977	\$452,049	\$511,763	\$691,459	\$960,310
Psychologist	\$401,516	\$425,703	\$496,205	\$628,511	\$644,489	\$719,087	\$532,766	\$659,429	\$686,920	\$655,098	\$745,859
Federally Qual Health Center	\$97,466	\$103,471	\$156,375	\$195,000	\$240,302	\$231,502	\$257,902	\$292,702	\$289,140	\$361,167	\$542,206
Home & Comm Based Services	\$0	\$0	\$0	\$0	\$697	\$134,276	\$200,613	\$431,997	\$824,243	\$674,935	\$493,049
Rural Health Clinic	\$91,152	\$90,648	\$119,983	\$120,818	\$105,937	\$99,165	\$149,214	\$233,255	\$289,613	\$278,282	\$322,006
Critical Access Hospital	\$0	\$0	\$0	\$0	\$2,667	\$62,731	\$93,255	\$119,778	\$126,966	\$168,287	\$172,543
Personal Care Agency	\$132,422	\$149,956	\$153,787	\$127,904	\$108,653	\$91,896	\$109,148	\$132,060	\$178,560	\$183,775	\$148,924
Miscellaneous	\$6,462	\$4,528	\$8,718	\$6,411	\$13,660	\$21,943	\$26,568	\$13,345	\$8,817	\$13,881	\$47,996
Total Children's MH	\$55,374,611	\$58,912,164	\$67,769,400	\$70,102,171	\$71,466,169	\$78,440,446	\$88,852,384	\$95,642,438	\$100,594,848	\$109,823,062	\$123,710,187

* Includes CHIP funded HMK+ Medicaid Expansion. Expenditures through July 22, 2015 based on Date of Service. Providers have 365 days to bill.



Out of State Admission Trends

Psychiatric Residential Treatment Facility (PRTF) Census Snap Shot at End of Each Month												
PRTF Longitudinal Trends Fiscal Year 2015												
Placements as of:	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
2015												
Total In-State	113	95	112	112	111	113	115	128	134	135	137	133
Total Out-of-State	47	45	44	40	41	46	47	48	56	54	52	49
Total Placements	160	140	166	162	162	169	182	177	190	189	189	182
% Out of State Placements	29%	32%	26%	25%	27%	29%	29%	28%	29%	29%	28%	27%
PRTF Longitudinal Trends Fiscal Year 2014												
Placements as of:	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
2014												
Total In-State	97	85	105	110	117	118	116	123	122	119	125	125
Total Out-of-State	39	34	35	41	43	45	43	47	48	51	55	53
Total Placements	138	120	140	161	160	163	169	170	170	170	181	178
% Out of State Placements	29%	28%	25%	27%	27%	28%	27%	28%	28%	30%	30%	30%

The total volume of out of state admissions decreased from state fiscal year 2014 to 2015.

Health, Mental Health, and Rehabilitation Services

Health

Healthy Montana Kids Plus

Montana's Medicaid program for children is called Healthy Montana Kids Plus or HMK Plus. Through the Medicaid program, the Bureau manages the following services for children who are SED:

- Inpatient psychiatric services provided in hospital settings or residential treatment facilities; outpatient partial hospitalization programs
- Community-based services, such as home support services, therapeutic foster care and therapeutic group homes (not including room and board expenses);
- Mental health center community-based outpatient services, including individual, group and family therapy; psychotropic medication management; Assessment; Case Management; Youth Day Treatment; Community-Based Psychiatric Rehabilitation And Support Services (CBPRS); and Comprehensive School And Community Treatment (CSCT); and
- Services provided by mental health professionals, including licensed psychologists, licensed social workers, and licensed certified professional counselors, advanced practicing RN's and licensed psychiatrists or medical doctors.

Funding for children's public health services is available through children's Medicaid (HMK+) and (HMK). Free or sliding scale health services also are available through county Health

Departments, community health centers, Indian Health Services facilities on reservations and urban Indian center clinics. DPHHS manages public health services for children through the Developmental Services Division, Human & Community Services Division and the Public Health and Safety Division. Bureaus within those Divisions that deal with health needs of children include the Children's Mental Health Bureau, Maternal and Child Health Bureau and the Early Childhood Services Bureau, among others. Some examples of health services available in addition to medical and dental services covered by Medicaid or HMK include: Women, Infants, and Children (WIC), the Medicaid Nurse First Helpline, Immunizations, and Early Periodic Screening Diagnosis and Treatment (EPSDT).

Montana's Healthy Montana Kids also funds some children's mental health services for covered youth with SED via the HMK Basic Mental Health Plan that includes pharmacy, inpatient services, therapeutic group home, and outpatient psychotherapy. The HMK Extended Mental Health Plan includes additional services once limits are met on the Basic Mental Health Plan (for outpatient therapy and therapeutic group home) and also includes therapeutic family care, day treatment, respite care and community-based psychiatric rehabilitative treatment and support (CBPRS). The HMK Basic and Extended Mental Health Plans are managed by HMK program staff in the Health Resources Division.

Early Childhood Services Bureau

CMHB works in collaboration and support of Early Childhood Programs. The mission of the Early Childhood Services Bureau is to improve the quality, affordability and accessibility of child care in Montana, with focused efforts on coordinated systems to best meet the needs of young children, their families, and the professionals who work on behalf of young children and families.

The Early Childhood Services Bureau, housed in the Human and Community Services Division, is encouraging early childhood programs to implement the Pyramid Model to Promote Social and Emotional Competence developed at the Center on the Social and Emotional Foundations for Early Learning (CSEFEL). The bureau offered focused training for providers as well as a general training. Some Head Start and Early Head Start programs now have CSCT or contracted mental health consultation services.

Mental Health

There are four Acute Psychiatric Hospitals that serve youth in need of emergency psychiatric hospitalization: Shodair Hospital in Helena, Billings Deaconess Hospital in Billings, St. Patrick's Hospital in Missoula, and Pathways Treatment Center in Kalispell.

Youth in need of Psychiatric Residential Treatment Facility (PRTF) are first referred to the three in-state PRTFs: Acadia in Butte, Shodair in Helena, and Yellowstone Boys and Girls Ranch in Billings. When youth in need of PRTF level of care cannot be served in-state, referrals are made to out of state PRTFs certified by CMS and enrolled as Montana Medicaid providers.

There are 24 mental health centers licensed in the State. Many of these mental health centers provide children's mental health services.

There are four "community" mental health centers which include:

Center for Mental Health is based in Great Falls. The center serves 13 counties in north central Montana. Service area includes Helena, the state capital, as well as rural counties. Services for youth include: youth case management, day treatment, and therapeutic group care, CSCT, outpatient therapy, medication management, and crisis intervention. This center also offers DBT groups for adolescents. A telemedicine network is available. The region includes 3 Indian reservations: Blackfoot, Fort Belknap, and Rocky Boy.

Eastern Montana Community Mental Health Center is based in Miles City. The center serves 17 rural counties in eastern Montana. Services for youth include: outpatient therapy, medication management and crisis intervention. A telemedicine network is available. The region includes two Indian reservations: Fort Peck and Northern Cheyenne.

South Central Regional Mental Health Center is based in Billings. The center provides services in a 12-county region in south-central Montana. Services for youth include: CSCT, therapeutic group care, outpatient therapy, medication management and crisis intervention. This region includes the Crow reservation.

Western Montana Community Mental Health Center is based in Missoula. The center serves 15 counties in western Montana. Services for youth include: youth case management, day treatment, CSCT in 18 schools, therapeutic group care, medication management, outpatient therapy, some additional support services and some chemical dependency services. This region includes the Flathead Reservation.

All of the regional mental health centers have satellite offices in multiple communities in the regions they serve. Several of the additional mental health centers described below also have multiple satellite offices or CSCT service sites.

Montana has 12 additional licensed mental health centers that serve youth:

Alta Care/Acadia, headquartered in Butte, provides CSCT services across the state. It is the largest provider of CSCT providers.

A.W.A.R.E., Inc., headquartered in Anaconda, provides youth case management, day treatment, CSCT across the state, as well as therapeutic group care, therapeutic family care, medication management, and outpatient therapy. This agency also provides multiple services for DD children and adults.

Bitterroot Valley Education Cooperative, headquartered in Stevensville, provides CSCT.

The Community Crisis Center in Billings provides outpatient crisis response geared to adults, but acts as a resource for youth crises.

Full Circle Counseling Solutions in Missoula provides therapeutic family and foster care, outpatient therapy services, some additional support services and CSCT.

Intermountain, headquartered in Helena, provides therapeutic group care, therapeutic foster and family care, youth case management, day treatment, CSCT and medication management. Intermountain offers some services in Great Falls and Kalispell.

Montana Community Services in Billings provides therapeutic group care.

New Day, Inc. in Billings provides youth case management, therapeutic group care and day treatment. This agency also provides youth case management services on the Crow reservation and has a focus on providing services to Native American youth.

Kalispell Regional Behavioral Health, headquartered in Kalispell, provides youth partial hospitalization. It also provides CSCT in the Kalispell area.

Sunburst Mental Health Services, in Polson, provides youth case management and outpatient therapy services.

Yellowstone Boys and Girls Ranch, headquartered in Billings, provides youth case management, day treatment, therapeutic group care, therapeutic foster and family care, IPS supported employment and CSCT.

Youth Dynamics, Inc., headquartered in Billings, provides youth case management, day treatment, therapeutic group care and therapeutic foster and family care in several communities.

Private providers (psychiatrists, psychologists, LCSWs, LCPCs, LMFTs, physicians and APRNs) also offer mental health services for Medicaid and Healthy Montanan Kids (HMK) eligible youth. Billings Clinic Behavioral Health psychiatrists assist with provision of psychiatric consultation for youth in rural eastern Montana. The extensive telemedicine network reduces some of the necessity for families to travel to Billings for their child's medication management.

For children from birth to 3, free screening for developmental disabilities, including autism, is available through the Developmental Disabilities Program. IDEA Part C funds this service. A child with developmental disabilities who is found eligible may also receive services to address the disability.

Rehabilitation Services

Community-based psychiatric rehabilitation and support (CBPRS) means additional one-to-one, face-to-face, intensive short-term behavior management, and stabilization services in home, school, or community settings. They are for youth receiving mental health center services but failing to progress and at risk of out of home or residential placement; or for youth under six at risk of removal from their current setting. The purpose of CBPRS services is to “reduce disability” and “restore function.”

Employment Services

Youth approaching age 18 may be referred to Vocational Rehabilitation Services for assistance with employment. For youth with IEPs who are 16 and older, a transition plan is required and usually addresses preparation for employment. Supported employment services for adults with DD or SDMI may be available after age 18 if the youth is eligible. Addictive and Mental Disorders Division is implementing three evidence based Individual Placement and Supports employment programs in Billings and Missoula, Montana. (More information is available under Adult Services).

Housing Services

Most youth with SED live with their families. Youth whose needs cannot be managed in their families may be placed in Psychiatric Residential Treatment Facilities (PRTFs) or community group homes, but those levels of care are not intended to be permanent placements.

High needs SED youth who also are eligible for services from developmental disabilities may be screened in to a children's DD group home, which is a long term placement. This is dependent on availability of funding for the youth through the DD program, availability of a slot in a children's group home, the priority of the child's need compared to others on the referral list and an assessment of whether the child is a good fit for that group home's current milieu.

Youth who are turning 18 who cannot return to a family home and who are eligible for services from the developmental disabilities program or the adult mental health system are referred to adult case managers in those systems so that access to appropriate housing or supported living services can be sought for them.

The Foster Care Independence Program, through Chaffee funding, offers housing assistance to youth aging out of the foster care system. Public housing is available in many larger communities, but often there is a waiting list.

Great Falls, Missoula, Helena and Billings have homeless shelters for families and youth, but many shelters only accept adults. Some churches provide shelter and food for homeless families.

Educational Services- Comprehensive School and Community Treatment (CSCT)

For students with SED, Comprehensive School and Community Treatment programs in the schools provide mental health support in classrooms, 1:1 behavioral aides, and individual, group and family therapy. There are approximately 300 schools offering CSCT services. CSCT is offered in many rural and reservation schools as well as in more populated communities. CSCT is available for all ages - from Early Head Start through high school. Youth do not have to qualify for special education services to receive CSCT. CSCT programs can bill Medicaid, private insurance or offer a private pay sliding fee scale option.

The Montana Behavioral Initiative (MBI), sponsored by the Office of Public Instruction, offers training and supports to schools at all grade levels who choose to become an “MBI school”. MBI promotes a positive school culture of mutual respect, the use of positive behavioral supports with all students and targeted interventions to assist students with more intensive needs. MBI offers a Summer Institute yearly to provide training. Since 2009 the Institute has offered mental health tracks. The Montana Behavioral Initiative (MBI) Summer Institute, sponsored by the state Office of Public Instruction (OPI) provides training to teachers and other school staff. A mental health track was offered for the first time in 2009 and has continued each year since. A parent involvement track was added in 2010. The Summer Institute now includes a youth and parent panel and digital stories by youth with SED. The Children’s Mental Health Bureau’s Regional staff has participated in the planning committee for each year’s Summer Institute, and the Family Liaison Officer has organized and participated in the parent and youth panel. The digital stories were created by youth.

The Early Childhood Services Bureau is making training and coaching in supporting the social and emotional development of young children available to providers of early childhood services (such as Head Start, preschools, and daycares). They are using the **Center on the Social and Emotional Foundations for Early Learning (CSEFEL)** model.

Juvenile Justice

The Regional staff work as the liaisons to the Juvenile Justice system to ensure efforts are not only collaborative, but smooth when transitioning a youth in need of SED placements from the Juvenile Justice system to a more appropriate setting.

Substance Abuse and Co-Occurring

The Addictive and Mental Disabilities Division (AMDD) maintains contracts with chemical dependency programs across the state for state-funded chemical dependency services. Children’s Mental Health Bureau does not manage any funding for substance abuse services for youth.

There are two providers of inpatient chemical dependency treatment for Medicaid eligible youth, Rimrock in Billings and Teen Recovery in Missoula. Outpatient services are available in several communities, but the providers often have a waiting list.

Although co-occurring disorders are presumed to be common with older youth, most providers of public children’s mental health services (PRTFs, group homes, and clinicians) are not trained to provide integrated services for youth with co-occurring disorders.

CMHB obtained a SAMHSA grant to address Co-Occurring substance problems for youth that began September 30, 2012 and will end September 29, 2015. The goals of the Montana Co-occurring Building Project are:

1. Establish a learning laboratory by collaborating with local community based mental health treatment providers (sites) interested in delivering Integrated Co-occurring Treatment (ICT)
2. Improve outcomes for youth who receive ICT.
3. Increase the number of professionals trained & licensed to provide co-occurring treatment, recovery/support to MT youth.
4. Increase funding sources for ICT, and increase the number of youth who receive ICT.

Outcomes for Youth and Families:

1. At least 30 youth served per year, per site, once fully operational.
2. Show a *decrease in use* of alcohol and/illegal drugs by 40% compared to intake data (GAIN assessment).
3. Show a *25% increase in school functioning* compared to intake data (CANS & the GAIN assessments).
4. Show a *25% decrease in mental health symptoms* compared to intake (CANS).
5. Show a *25% decrease in criminal and violent behavior* compared to intake (GAIN).
6. Will maintain placement in home (bio/kinship/foster) during treatment period and for at least six months following intake.
7. By Year 3, the number of youth who received ICT will have increased by 50% compared to the number of youth in Year 1.

The Montana State Youth Treatment-Implementation Project will address the critical need for providing evidence based care to transitional age youth with substance use and co-occurring disorders in our state by improving the infrastructure for and access to treatment for the population of focus in our state. The project will fund four provider sites, three in central and eastern Montana where access to services is extremely limited, to implement the evidence based practice Interactive Journaling, which is well suited for use with the population of focus and with Native American clients. The four provider sites will also implement a Behavioral Health Home model throughout the course of the project to provide more comprehensive care to the transitional aged youth being served. A minimum of 365 youth in the population of focus will be treated under the Interactive Journaling model over the course of the project period. In addition, grant funds will be used to improve the infrastructure related to serving co-occurring and substance abusing youth in Montana, including bolstering work force development for professionals, addressing policy and funding barriers and better engaging youth and caregivers in designing systems and implementing evidence based care. By the end of the project, the State of Montana will submit a Behavioral Health Home State Plan Amendment to CMS to create sustainable system for reimbursement of comprehensive treatment for substance use and co-occurring disorders.

Co-occurring Treatment Services:

- 2 sites are currently trained to provide ICT services and another site is being added.
- Intensive, home-based method of delivering services.
- 12 to 24 weeks; 24/7 on call services.
- ICT Therapists are master's level professionals; dually licensed or eligible for dual licensure.

Wraparound facilitators assist families with service planning and coordination at intake and discharge.

In order to be successful with the Grant, Children's Mental Health Bureau has partnerships with, youth and family, addictions and mental health disorders division, center for innovative practice, Western Montana Addiction Services, Intermountain, and the local planning councils.

Medical and Dental Services

Youth with SED may access medical and dental services if eligible for Medicaid (HMK+) or (HMK). County Health Departments and Community Health Centers also provide some medical and dental services for low-income residents. Finding a dentist who will accept Medicaid is difficult in some communities. Medicaid recipients can access medical advice through the Nurse First help line.

Support Services

Family and Communication Liaison:

CMHB's Family and Communication Liaison officer coordinates System of Care Committee (SOC) participation in advising multi-agency grants where the SOC is listed as the advisory entity. Work in general involves understanding enough about the purpose of the Committee (oversee the development of the statewide system of care effort where grants cross agency lines in the care of high-risk children; study and report on the progress made in developing a system of care, ensure input from communities and from families/children in the development of the system of care, etc.) to explain the grants to the Committee, write letters of support explaining the advantages of grant activities and the position of the Bureau, review information about youth mental health activities from across the country and select appropriate information for the Committee, bring to the Committee the family viewpoint from interactions at advocacy meetings, etc. In addition, acts as a liaison between various advocacy and community groups involved with high-risk children and the Committee and Bureau, providing assistance to families/youth in navigating the system of care, and providing liaison insight and recommendations to Bureau programs.

Youth Move:

Although the SAMHSA Systems of Care (SOC) grant managed by CMHB ended in September 2010, some aspects have continued. These include, active parent and youth support groups, families and youth participating in their own care planning and a Montana Youth Move chapter. This chapter has increased family and provider awareness of what wraparound facilitation can offer, as well as how natural and community supports can strengthen a youth and family's functioning.

Individuals with Disabilities Education Act (IDEA) Services:

Many students with SED qualify for special education services and have IEPs that provide for individualized supports to help them participate in their education. For students 16 and older, the IEP must include plans to assist the youth with transition from school to adulthood. Frequently the transition plans include referral to vocational rehabilitation services, employment services, adult mental health services or other post-secondary education and training programs. The Office of Public Instruction monitors compliance of Montana schools with the requirements of IDEA.

Activities to Reduce Hospitalization:

Regional staff work diligently with youth case managers, other state agency staff, providers and families to strengthen community and family capacity to care for high needs youth in their family and community and to manage crises without hospitalization or placement into PRTFs.

In 2012 CMHB was awarded \$850,000 from the MMHST to fund a statewide RFP process to support communities in the development of local youth crisis diversion programs. This funding is supporting the development of community programs to enhance the healthy connection between youth crisis diversion facilities and the therapeutic and natural supports the family is already utilizing. Responders are required to develop a program(s) to support crisis diversion that allows the youth to remain in their home community. Funds would be used to augment existing community resources and supports, as well as to promote locally developed, creative, research based solutions that divert youth in crisis.

The 2015 Legislature appropriated \$1.2 million to expand the crisis diversion program and the state will be awarding between 5 and 8 grants.

This community based, youth crisis diversion model is designed to accomplish the following outcomes:

1. Enhance the community's ability to develop a safe place for the youth to reside until they are able to return home safely;
2. Support the youth in staying in or close to their community, close to their family, professional, and natural supports;
3. Facilitate effective crisis planning if needed;
4. Support activities and interventions identified in the crisis plan that might not otherwise

be available through existing state and local supports.

5. Improve communication and increase reunification efforts with family and significant caregivers;
6. Allow Law Enforcement options and offer support to a family without removing youth from their family and community for significant amounts of time;
7. Reduce long-term, higher cost care.

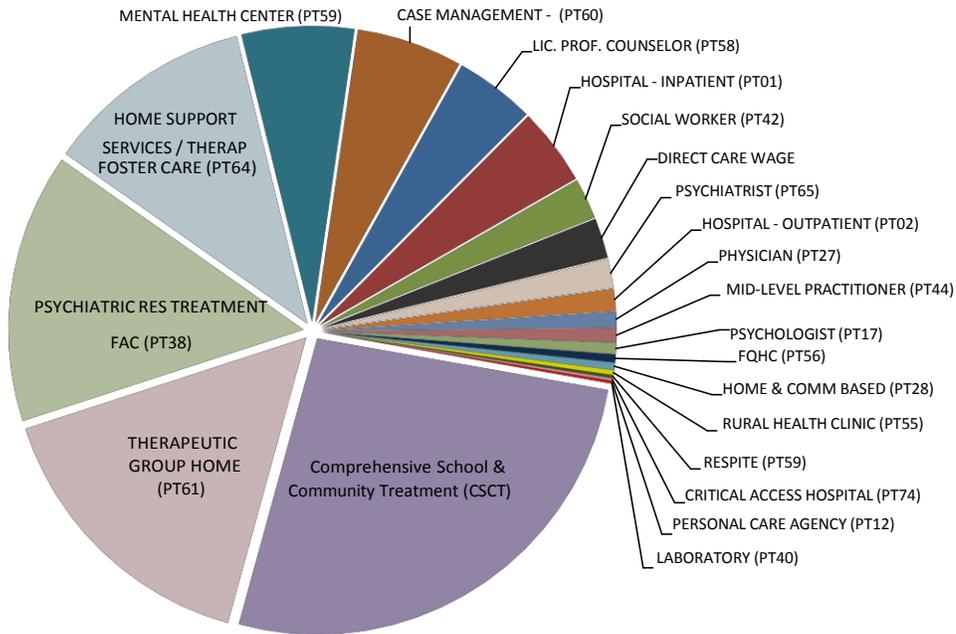
Criterion 2 Mental Health System Data Epidemiology

Children's Mental Health Bureau Expenditures:

CMHB is funded almost entirely with federal Medicaid funds and associated matching state funds at the FMAP. The following chart shows state fiscal year 2014 expenditures by provider type.

MEDICAID MENTAL HEALTH YOUTH

SFY 2014 To-Date Expenditures by Provider Type based on Dates of Service



Service Expenditure	# Served	Expenditures	
* Comprehensive School & Community Treatment (CSCT)	4,957	\$ 32,786,134	26.5%
* THERAPEUTIC GROUP HOME (PT61)	655	\$ 19,459,770	15.7%
* PSYCHIATRIC RES TREATMENT FAC (PT38)	549	\$ 18,205,559	14.7%
* HOME SUPPORT SERVICES / THERAP FOSTER CARE (PT64)	1,881	\$ 14,136,447	11.4%
* MENTAL HEALTH CENTER (PT59)	2,467	\$ 7,609,918	6.2%
* CASE MANAGEMENT - MENTAL HEALTH (PT60)	3,977	\$ 7,176,618	5.8%
* LICENSED PROFESSIONAL COUNSELOR (PT58)	6,286	\$ 5,423,373	4.4%
* HOSPITAL - INPATIENT (PT01)	750	\$ 5,248,265	4.2%
* SOCIAL WORKER (PT42)	3,606	\$ 2,760,758	2.2%
* DIRECT CARE WAGE (CMHB) - Not a Service Type		\$ 2,726,456	2.2%
* PSYCHIATRIST (PT65)	2,965	\$ 1,978,378	1.6%
* HOSPITAL - OUTPATIENT (PT02)	2,801	\$ 1,489,716	1.2%
* PHYSICIAN (PT27)	4,942	\$ 1,071,583	0.9%
* MID-LEVEL PRACTITIONER (PT44)	2,472	\$ 960,310	0.8%
* PSYCHOLOGIST (PT17)	1,309	\$ 745,859	0.6%
* FEDERALLY QUAL HEALTH CENTER (PT56)	864	\$ 542,206	0.4%
* HOME & COMM BASED SERVICES (PT28)	54	\$ 493,049	0.4%
* RURAL HEALTH CLINIC (PT55)	822	\$ 322,006	0.3%
* RESPIRE (PT59)	341	\$ 204,320	0.2%
* CRITICAL ACCESS HOSPITAL (PT74)	480	\$ 172,543	0.1%
* PERSONAL CARE AGENCY (PT12)	29	\$ 148,924	0.1%
* LABORATORY (PT40)	249	\$ 47,627	0.0%
* INDEP DIAG TESTING FACILITY (PT72)	1	\$ 369	0.0%
Total Children's Medicaid Mental Health and CSCT	16,771	\$ 123,710,187	100%

† Expenditures through July 22, 2015 based on Date of Service. Includes CHIP funded HMK+ Medicaid Expansion.

** CSCT is matched with School funds. The CSCT amounts shown represent the Federal match portion only. The FMAP % is approximately 66% / 34%: the school match amount that is not shown totals \$16.7 million.

Child-Estimate of Prevalence

According to information provided by the National Association of State Mental Health Program Directors Research Institute’s State Data Infrastructure Coordinating Center (NRI/SDICC) for CMHS, 2010 population of children in Montana aged 6-17 was 148,908. The penetration rate for Montana children aged 6-17 with SED is 90.1 children/1,000 population or approximately 10% penetration. These estimates include children with Level of Functioning Scores of up to 60.

Montana’s definition of Serious Emotional Disturbance is:

SED Definition:

FOR CHILDREN AGE 6 – 17

Must meet <i>one</i> of the following within the last 12 months as diagnosed by licensed mental health professional (must be moderate/severe):					
i.	Childhood schizophrenia (295.10, 295.20, 295.30, 295.60, 295.90)			xi.	Dysthymic disorder (300.4)
ii.	Oppositional defiant disorder (313.81)			xii.	Cyclothymic disorder (301.13)
iii.	Autistic disorder (299.00)			xiii.	Generalized anxiety disorder (300.02)
iv.	Pervasive development disorder NOS (299.80)			xiv.	Posttraumatic stress disorder (chronic) (309.81)
v.	Asperger’s disorder (299.80)			xv.	Dissociative identity disorder (300.14)
vi.	Separation anxiety disorder (309.21)			xvi.	Sexual and gender identity disorder (302.2, 302.3, 302.4, 302.6, 302.82, 302.83, 302.84, 302.85, 302.89)
vii.	Reactive attachment disorder of infancy or early childhood (313.89)			xvii.	Anorexia nervosa (severe) (307.1)
viii.	Schizoaffective disorder (295.70)			xviii.	Bulimia nervosa (severe) (307.51)
ix.	Mood disorder (296.0x, 296.2x, 296.3x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89)			xix.	Intermittent explosive disorder (312.34)
x.	Obsessive-compulsive disorder (300.3)			xx.	Attention deficit/hyperactivity disorder (314.00, 314.01, 314.9) when accompanied by at least one of the

					diagnoses listed above
AND (Must meet <i>one</i> of the following):					
		As a result of the diagnosis determined above, must consistently and persistently demonstrate behavioral abnormality in <i>two or more</i> of the following for a period of at least <i>six months</i> that cannot be attributed to intellectual, sensory or health factors:			
	i.	Has failed to establish or maintain developmental and culturally appropriate relationships with adult caregivers or authority figures			
	ii.	Has failed to demonstrate or maintain developmentally and culturally appropriate peer relationships			
	iii.	Has failed to demonstrate a developmentally appropriate range and expression of emotion or mood			
	iv.	Has displayed disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic or recreation setting			
	v.	Has displayed behavior that is seriously detrimental to the youth's growth development, safety or welfare, or to the safety or welfare of others			
	vi.	Has displayed behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment			

FOR CHILDREN AGE 0 – 5

Must exhibit <i>one or more</i> of the following for at least <i>six months</i> (or is predicted to continue for at least 6 months) which cannot be attributed to intellectual, sensory or health factors and results in substantial impairment in functioning:		
i.	Atypical, disruptive or dangerous behavior which is aggressive or self-injurious	
ii.	Atypical emotional response which interfere with the child's functioning, such as an inability to communicate emotional needs and to tolerate normal frustrations	
iii.	Atypical thinking patterns which, considering age and developmental expectations, are bizarre, violent or hypersexual	
iv.	Lack of positive interests in adults and peers or a failure to initiate or respond to most social interaction	
v.	Indiscriminate sociability (e.g., excessive familiarity with strangers) that results in a risk of personal safety of the child	
vi.	Inappropriate and extreme fearfulness or other distress which does not respond to comfort by caregivers	

The CMHB has an open rule where they are proposing new SED criteria. The new rule will be effective Oct.1, 2015; the new criteria is located in the proposed manual located on the CMHB website.

Criterion 3 Children's Services

Child Available Services under Overview of Services will provide a more detailed picture of CMHB comprehensive system of care. Below is the Matrix of Children's Services and other supporting partners.

**State Wide Children's Mental Health Services and Resources
Paid through MT Medicaid-June 2013**

<u>MEDICAID SERVICES AVAILABLE</u>	Where service is available	Who is eligible
Acute inpatient- psychiatric hospital	Missoula, Kalispell , Billings, Helena	A Medicaid eligible youth under the age of 18 (unless in secondary school), who meets diagnostic and functional guidelines.
Partial Hospitalization Program (PHP) active treatment program that offers therapeutically intense coordinated structured clinical services to youth.	Billings, Kalispell, Missoula	A Medicaid eligible youth with SED who meets medical necessity criteria for this level of care
Psychiatric Residential Treatment Facility (PRTF)- a secure 24 hour facility with psychiatric supervision. This also includes a 14 day assessment admission paid at a higher rate.	Helena , Billings, Butte There are also numerous out-of-state facilities.	A Medicaid eligible youth with SED who meets medical necessity criteria for this level of care
MH Therapeutic Group Homes (TGH), Extraordinary Needs Aid (ENA)	Anaconda, Billings, Boulder, Bozeman, Butte, Great Falls, Helena, Kalispell, Lewistown, Missoula, Available for a youth in a therapeutic group home who needs short term 1:1 aide to remain in placement	A Medicaid eligible youth with SED who meets medical necessity criteria for TGH level of care.
Targeted Youth Case Management (TYCM)	Available through Licensed Mental Health Centers across the State.	A Medicaid eligible youth with SED who meets medical necessity criteria for this level of care.
Home Support Services or Therapeutic Foster Care (TFC; TFOC)	Various locations; available from some child placing agencies.	A Medicaid eligible youth who meets admission criteria.
<u>MEDICAID SERVICES AVAILABLE</u>	Where service is available	Who is eligible
Comprehensive School & Community Treatment (CSCT)	In approx. 300 School districts across the state	A Medicaid eligible youth with SED who meets medical necessity criteria for this level of care.

Outpatient children's mental health services (therapy, Day Tx, medication monitoring;. Community based psychiatric rehab and support aide (CBPRS);	Available from a licensed mental health center in various locations in the state; Outpatient therapy also available from licensed mental health professionals throughout the state; Medication management available from licensed prescribers.	A Medicaid eligible youth under the age of 18 (unless in secondary school), who meets diagnostic and functional guidelines.
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Trainings		
SOAR - SSI / SSDI Outreach, Access and Recovery	State-wide trainings available.	Those individuals needing assistance in the SSI/SSDI application process.
Crisis Intervention Team - CIT	State-wide trainings available.	Law enforcement / 1st responders.
Family to Family/ In Your Own Voice/NAMI Basics trainings	State-wide trainings available.	Anyone
Recovery International	MSH, Butte, Missoula	Anyone
Mental Health Advocacy Organizations		
Child Abuse Neglect Hotline	1-866-820-5437	
Disability Rights Montana	1-800-245-4743	
Board of Visitors	1-800-332-2272	
Mental Health Ombudsman	1-888-444-9669	
Mental Health America of MT	1-406-587-7774	
NAMI MT	1-406-443-7871	
Montana Youth Move	1-406-256-7783	
Parent's Let's Unite For Kids (PLUK)	1-800-222-7585	
Federation of Families	1-877-376-4850	
NON-MEDICAID SERVICES		
Supplemental Services Plan (SSP)	Where available	Who is eligible
Respite Services	State Wide- General Fund \$ through Licensed Mental Health Centers that are also child placing agencies	Eligible families with income under 185% of Federal Poverty Level. Duration is limited to no more than 4 calendar months per FFY. A Medicaid eligible youth under the age of 18, who meets diagnostic and functional guidelines.

Vocational Rehabilitation	State Wide	Individuals with Disabilities
Supported Employment Programs	Butte, 2 in Missoula	A Medicaid eligible youth transitioning to adult services.
Crisis Response Team - CRT	WMMHC -Kalispell, Missoula, Butte, Bozeman CMH - Helena	Any youth in a psychiatric crisis.
Network of Care	http://montana.networkofcare.org/mh/home/index.cfm	Information for consumers, families, providers, and other interested persons.
Mental Health Warm Line (MMHA)	Telephonic	Anyone
Suicide Hot Line	Telephonic	Anyone
Montana 211 for community resources	Telephonic and web www.montana211.org	Anyone

For more detailed information on services visit:

Children's Mental Health Bureau web site: <http://dphhs.mt.gov/dsd/CMB.aspx>

Providers refer to the CMHB Medicaid Services Provider Manual:
<http://dphhs.mt.gov/dsd/CMB/Manuals>

For Medicaid Claims questions please call ACS Provider Relations at 406-449-7693.

Children's Mental Health Bureau
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406-444-4545 FAX 406-444-5913

Bureau Chief: Zoe Barnard, zbarnard@mt.gov, 444-1290

Administrative Assistant: Lori Davenport, ldavenport@mt.gov, 444-5978

Family and Communication Liaison: Kandis Franklin, kfranklin@mt.gov, 444-6018

CANS

Research Analyst, Robin Albee, ralbee@mt.gov, 444-2727

Research Analyst, Jamie Olsen, jgainesolsen@mt.gov, 444-7392

South Central and Eastern Regions:

Regional Resource Specialist: Libby Carter, ecarter@mt.gov, 254-7028 (Tel) 254-7305 (Fax)
Big Horn, Fergus, Phillips, Stillwater, Carbon, Garfield, Powder River, Sweet Grass, Carter,
Golden Valley, Prairie, Treasure, Custer, Judith Basin, Richland, Valley, Daniels, McCone,
Roosevelt, Wheatland, Dawson, Musselshell, Rosebud, Wibaux, Fallon, Petroleum, Sheridan,
Yellowstone

Southwestern and North Central Regions:

Regional Resource Specialist: Theresa Holm, tholm2@mt.gov, 444-2958 (Tel) 444-6864 (Fax)
Beaverhead, Gallatin, Madison, Broadwater, Jefferson, Meagher, Deer Lodge, Lewis & Clark,
Silver Bow, Park, Blaine, Glacier, Pondera, Cascade, Hill, Teton, Choteau, Liberty, Toole

Western Region:

Regional Resource Specialist: Afton Russell, ARussell@mt.gov, 329-1330 (Tel) 329-1332 (Fax)
Granite, Powell, Mineral, Ravalli, Missoula, Lake, Flathead, Lincoln

Medicaid Program Supervisor: Melissa Higgins, mhiggins@mt.gov 444-1535

Medicaid Program Officer: Callin Geer, cgeer2@mt.gov, 444-5913, CSCT, Day Treatment,
Home Support Services/Therapeutic Foster Care/Therapeutic Foster Care permanency,
Community Based Psychiatric Rehabilitation and Support (CBPRS), Targeted Case Management
and Mental Health Centers

Medicaid Program Officer: Tracey Riley, TRiley@mt.gov, 444-7064, Hospital, Partial Hospital,
Psychiatric Residential Treatment Facility, Therapeutic Group Home, Extraordinary Needs Aid
(ENA) and Outpatient.

Clinical Supervisor: Laura Taffs, ltaffs@mt.gov, 444-3814

Licensed Clinician: Dan Carlson-Thompson, dcarlson-thompson@mt.gov, 444-1460

Licensed Clinician: Donna Marchington, dmarchington@mt.gov, 454-6083

Licensed Clinician: Cynthia Erler, cerler@mt.gov, 329-1594

Financial Specialist: Julie Frickel, jfrickel@mt.gov, 444-3819

Utilization Review: Gwen Knight, gknight@mt.gov, 444-1822

Criterion 4 Targeted Services to Rural and Homeless Populations

CSCT programs are providing access to mental health services through the schools in many rural communities. Some of these include: Eureka, Troy, Trout Creek, Florence, Sheridan, Dillon, Havre, Stevensville, Choteau, Boulder, Ennis, Fort Benton, Miles City, Glendive and Sidney. CSCT programs in the schools are providing access to mental health services to Native American youth with SED on and near the reservations. Communities served include: Ronan, Polson, Cut Bank, Rocky Boy, Harlem, Lodge Pole, Frazer, Wolf Point, Poplar, and Lame Deer.

CSCT programs also are providing access to mental health services to young children in some elementary schools, Head Start and Early Head Start Programs. In Great Falls CSCT is available in Title IX and IDEA preschool classrooms.

Schools of Promise

CMHB has a working partnership with The Montana Schools of Promise – School Improvement Grants Initiative is a partnership between schools, communities and the Office of Public Instruction to improve Montana’s most struggling schools. In communities across Montana, parents, families and caregivers share the hope that their children will graduate from high school and be prepared to go on to college or enter the workforce. Montana Schools of Promise was established in 2009 under the leadership of State Superintendent Denise Juneau to significantly improve the educational experience and outcomes for students attending SIG eligible schools. OPI hired 22 employees in this unprecedented effort. CMHB and the Schools of Promise worked together to bring the wraparound process to Title I Schools across rural Montana on the reservations.

Emergency Health Services

Montana’s policy is to serve high-risk children with multi-agency service needs, either in their homes or in the least restrictive and most appropriate setting for their needs, in order to preserve the unity and welfare of the family whenever possible per Montana Code Annotated (MCA) 52-2-301(2) and Montana Code Annotated 53-2-201. The System of Care (SOC) Statutory Committee is working with CMHB to support a model to serve youth and families with the least restrictive home and community services.

Youth in need of emergency psychiatric hospitalization may access Acute Inpatient services at Shodair Hospital in Helena, Billings Deaconess Hospital Pathways Treatment Center in Kalispel, or St. Patrick’s Hospital in Missoula.

Youth in need of psychiatric residential treatment are first referred to the three in-state PRTFs: Acadia in Butte, Shodair in Helena, and Yellowstone Boys and Girls Ranch in Billings. When youth in need of PRTF level of care cannot be served in-state, referrals are made to out of state PRTFs certified by CMS and enrolled as Montana Medicaid providers.

Crisis Diversion Grants:

An identified gap in community based mental health services was identified as Youth Crisis Diversion Programs (YCDP) across the state. When in crisis, a family's options are limited when they or their child is struggling, behaviors are escalating and everyone needs a break, but the youth does not require or meet medical necessity for Acute or Psychiatric Residential level of care.

CMHB was appropriated \$1,200,000 from the 2015 Legislature to fund a statewide RFP process to support communities in the development of local youth crisis diversion programs. This funding would support the development of community programs to enhance the healthy connection between youth crisis diversion facilities and the therapeutic and natural supports the family is already utilizing. Responders would be required to develop a program(s) to support crisis diversion that would allow the youth to remain in his/her home community. Funds would be used to augment existing community resources and supports, as well as promoting locally developed, creative, research based solutions that divert youth in crisis. These funds would not be available for planning purposes, but for the actual development of a local, youth crisis diversion program.

This community based, youth crisis diversion model is designed to accomplish the following outcomes:

- a) Enhance the community's ability to develop a safe place for the youth to reside until they are able to return home safely;
- b) Support the youth in staying in or close to their community, close to their family, professional, and natural supports;
- c) Facilitate effective crisis planning if needed;
- d) Support activities and interventions identified in the crisis plan that might not otherwise be available through existing state and local supports.
- e) Improve communication and increase reunification efforts with family and significant caregivers;
- f) Allowing Law Enforcement options and offer support to a family without removing youth from their family and community for significant amounts of time;
- g) Reduce long-term, higher cost care;

Criterion 5 Management Systems

Children's Mental Health Bureau (CMHB) is organized into a Central Office with 18 management, program, clinical, and administrative staff. CMHB also has three Regional Offices with 4 program staff. The Central Office provides statewide utilization management of mental health services for youth under age 18 (or until 19 if still in secondary school), along with policy development and rule writing, training and technical assistance for providers, technical support for provider payment and processing, and federal reporting and compliance.

Regional staff assists child and family teams to access resources, enroll youth into home and community services and approve those cost plans, as well as monitor provider compliance with state and federal regulations. Regional staff also helps develop and support community-based alternatives for youth with SED at risk of placement out of their communities and provide oversight of discharge planning for youth with SED with complex needs returning from PRTFs.

As Montana is diverse both in need and population, three (3) of the regional support specialists, in addition to the above duties are responsible for the Supplemental Services Program (SSP) that uses TANF Maintenance of Effort funds, SOCA (state funded System of Care Account) funding requests and requests for room and board. SSP and SOCA are sources of flexible funds for services needed by eligible SED youth that are not available from any other source. All Regional staff promote youth and family stabilization/reunification efforts, through the wraparound process, using family driven and community based values and practices.

CMHB continues to meet with providers and provider groups, to include the Montana Children's Initiative and in-state Psychiatric Residential Treatment Facilities (PRTF) programs, to discuss strategies to improve practice and processes. PRTF providers participated in the development of the Discharge Plan Review Form, which is now required with all PRTF continued stay requests. This information will help everyone better understand the reasons for residential placements.

Local Advisory Councils across Montana provide a venue for rural/frontier communities to conduct community mental health planning and development. Children's Mental Health Bureau regional staff and their constituents are encouraged to participate in Local Advisory Councils and advance the voice of parents, youth and other family members in rural/frontier communities. More information on Local Advisory Councils is available under the Adult Community Framework – Consumer Participation section.

Planning Steps

Step 2: Identify the Unmet Service Needs and Critical Gaps Within the Current System

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use

indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

Step 2: Identify the Unmet Service Needs and Critical Gaps Within the Current System Response

Pharmacy and Prescriber Services

Montana's Mental Health Services Plan (MHSP) provides a broad range of services for persons who are un/under insured. Approximately 5,764.00 individuals of all ages were provided services under the MHSP Program for SFY 2015.

Montana was approved for a waiver that would fund physical health and mental health benefits for those that met eligibility for the Mental Health Services Plan. As a result of the approval of the MHSP/HIFA Waiver, many of the individuals qualified under MHSP in the past, will now be provided services under the MHSP/HIFA Waiver (reducing the allocation for the MHSP).

Case management and other services will be provided through contract to licensed mental health centers. Pharmacy and Prescriber Services will continue to be a fee-for- service under the MHSP Program and provided to all those individuals at 150% of poverty and 18 years of age and older. Montana plans to continue to support the unmet service need for prescriber and pharmacy services with Community MH Block Grant dollars under the 2016-2017 Block Grant Application.

Individual Placement and Supports (Supported Employment)

Addictive and Mental Disorders Division (AMDD) is now providing evidence based employment to four (4) mental health centers serving youth with serious emotional disturbance and adults with severe disabling mental illness. IPS supported employment helps people with severe mental illness work at regular jobs of their choosing. Although variations of supported employment exist, IPS refers to the evidence-based practice of supported employment.

For FY 2015, 144 individuals received the opportunity to work Integrated Competitive Employment in a position of their choice through AMDD's Individual Placement and Supports Supported Employment Program. There were 99 new Job Stats for the 144 participants, indicating good job retention for some and finding other employment that may be a better fit or increased wages for others. These individuals had not had opportunity to receive evidence based employment services prior to the IPS Program.

Data from Vocational Rehabilitation confirms that Supported Employment Services are valuable and effective for persons with a primary mental health diagnosis; particularly in comparison to the overall effectiveness of vocational rehabilitation services for all clients served and those with a mental health diagnosis. For FFY 2014 7,755 individuals were served through Montana Vocational Rehabilitation. Of those 7,755 individuals, 4,416 noted a primary mental health diagnosis on their VR application for services – approximately 57%.

For FFY 2014, twenty-one percent (21%) of those clients receiving VR Supported Employment Services with a MH diagnosis were successfully employed. In comparison, of all clients receiving VR services, an average of 10% were successfully employed during the federal fiscal year. Note: Those receiving VR Supported Employment are included in total of clients receiving VR services.

It is clear employment for those individuals with severe mental health issues is an unmet need when considering the number of Montana VR clients with a primary or secondary mental health diagnosis – 4,416 and 3,164 respectively. Considerable work is left to be done before a reasonable penetration rate for employment services is achieved.

Youth Transitions Services including First Episode Psychosis Development

The Mental Health Oversight Advisory Council (MHOAC) included Youth Transitions Services as a service priority in their Strategic Planning process for over four (5) years. Youth Transitions Services were identified as an unmet service need and critical gap through Council discussions with the Addictive and Mental Disorders and Disability Services Division, Children's Mental Health Bureau, stakeholders outside of state government, and, historical research related to past initiatives to address the issue. Supporting data, unfortunately, is not available through state programs. This is due in part to the fact that children's and adult mental health programs are not integrated; do not have a common language; and no requirements for data collection on youth transitions currently exist. The system for serving youth who are at high risk of needing adult mental health services when they turn 18 is diversified, decentralized and composed of a number of major and minor federal and state funding sources.

Each year Montana conducts a MHSIP consumer satisfaction survey for adults, families of children and teens. In FY 2014 we began preparation for a demonstration project directed toward transitional services for teens and young adults. We decided to develop a survey for teens that would give us a baseline of life skills and unmet needs. The Montana Life Transition Survey For Teens and Young Adults was disseminated electronically and the response rate was too low to produce valid results. In FY 2015 the teen survey was sent out again – this time through regular mail with an option to complete an electronic version. The response rate significantly improved and comments on the surveys indicate a genuine interest from teens and their families in having access to transitional services. One thousand (1,000) surveys were sent out and with some still coming in we have a 15% response rate, enough to offer some useful information. Survey results can be shared when a report is completed. (Copy attached).

As part of the Transitions FEP service development, the Center for Children & Families disseminated a survey to assess community perceptions of unmet needs related to transitions and first episode psychosis services.

YOUTH TRANSITIONAL PROGRAM SURVEY RESULTS

Over 500 surveys sent out; 102 responded.

Responses were received from persons in ten (10) communities. The majority were from Billings. Other communities included Missoula, Lewistown, Laurel, Broadview, Red Lodge, Joliet, Fromberg, Roberts, and Helena.

Question #1. How do you rate availability of transitioning services for youth aging out of substitute care in your community? (Not available, scarcely available, moderately available, very available, not sure)

Housing, Transportation, Independent Life Skills Training, and Caregiver Support ranked as not available.

Education, Employment Therapy, and Mental Health Services were ranked as moderately available.

Crisis Support ranked between scarcely and moderately available.

Twenty (20) respondents added comments. The comments primarily emphasized the lack of housing and transportation. Additional comments included a lack of services and long wait lists for the available independent living services and a lack of collaboration between providers and state government (specifically mentioned lack of collaboration between CMHB and AMDD).

Question #2. What do you identify as barriers for youth making a successful transition into adulthood? (Not a barrier, minimal barrier, moderate barrier, substantial barrier, not sure)

All responses stated moderate barriers existed for all choices with self-esteem and dropping out of transitional programs ranked higher than substance use and mental health conditions, supportive positive influence, early pregnancy and living wage employment. Transportation and access to adult services and physical health conditions had a slightly lower rating than the others.

Nine (9) respondents added comments. Comments included the following: SED child doesn't always equal SDMI adult, hard to navigate through changes from 17 to 18, lack of services, little experience with modeled healthy behaviors (take themselves off meds and cease therapy), and a requirement for professionals to provide intensive services on a daily basis with lack of support.

Question #3. What do you identify as barriers in your community for youth leaving substitute care? (Not a barrier, minimal barrier, moderate barrier, substantial barrier, not sure)

All indicated a moderate barrier with funding and affordable housing ranking highest, followed by housing capacity, trauma-focused therapy, available resources, transportation, outreach and youth awareness, and lack of jobs.

Six (6) respondents added comments focused on ineffective or lacking transitional services.

Question #4. Do you feel that the community is impacted by any negative effects that are associated with youth who transition poorly into adulthood? (Not at all, slightly, moderately, substantially, not sure)

All responses indicated a moderate negative impact. The ranking went from emergency room visits and use of public assistance, followed by violence, lost wages, incarceration and homelessness.

Nine (9) respondents added comments that centered on the need to do better to break the cycle and all public health issues are negatively impacted.

Question #5. What do you feel are helpful aspects for youth who are aging out of substitute care? (Not helpful, a little helpful, moderately helpful, significantly helpful, not sure)

All were seen as moderately helpful with at least one supportive adult, a strong social network and being held accountable by a supportive person ranking highest. Living skills programs ranked next, followed by peer groups, recreational opportunities, substance abuse education and spirituality.

Six(6) respondents commented stating support from friends, family and the community were very important as were transitional housing, and life skills training.

Question # 6. Does your community currently have any programs that are specific to youth with mental illness who are transitioning into adulthood from substitute care? (No, yes limited, yes extensive, not sure, other)

Limited services received the most responses, followed by not sure, no, and one response was extensive services were available and one response was other.

Twelve (12) respondents commented. Comments included needing access to transportation for the services, limited programs and limited awareness, youth wanting to experience life outside of the system, and concern about connecting between child and adult systems.

Question #7. Does your community currently have any outreach focused on connecting with youth transitioning into adulthood from substitute care? (No, yes, not sure, other)

Most respondents (60) were not sure, twenty (20) indicated yes, fourteen (14) reported no and seven (7) reported other.

Twenty-five (25) commented about their response. Several wrote the specific services that were available including Chafee, HRDC, Voc. Rehab., DD Services, The Center for Children and Families, YBGR, Tumbleweed, MT Youth Transitions. Many indicated difficulty with access due to lack of collaboration between state providers and state programs and difficulty with the adult world and the child world working together.

Question # 8. (narrative responses) What do you feel would help youth transition into adult services in your community?

There were sixty-six (66) responses to this question. The majority stated there was a need for supportive services, followed by independent life skills training, housing, funding and collaboration between systems.

Question # 9. How frequently do you have contact with young people who may be experiencing possible psychosis?

Seventy-five responded to this question. Most reported very limited contact with these youth. There were nine (9) who reported no contact, ten (10) who reported weekly contact and (6) who reported daily contact. The majority of respondents reported their community was not well equipped to handle this population and that there was a lack of qualified providers even in the communities where services were available. Funding was also cited as an issue.

Planning Steps

Quality and Data Collection Readiness

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's **NBHOE**. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable. SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

Response:

The Mental Health Reporting System (MHRS) application collects data at the client level per provider through one of the application screens. The application also collects client level claims data from other source systems; Medicaid Management Information System (MMIS), Management Information and Cost Reimbursement System (MICRS) and arrest records from Department of Justice. The data reported is client level using none PII unique identifiers. Aggregated totals of clients using demographic data, mental health diagnostic data and substance abuse data are used extensively for a large federal report.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

Response:

The state's current data collection and reporting system is specific to mental health and substance use.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

Response:

We are currently capable of collecting client level data on adult new criminal charges while in treatment. We are unable to retrieve housing status, including homelessness until further notice from our administration.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Response:

The State will require detailed technical assistance from SAMHSA to establish a cost estimate on a data system rebuild, and federal or state legislation to require the school systems to submit new data as well as all primary care providers in the state. Private fee-for service providers would require new Medicaid mandates and possibly additional incentive to add staff from out of state (due to workforce shortages in Montana) to collect client level measures, including extensive client surveys and additional treatment costs.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Table 2 State Agency Planned Expenditures

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Transition Age Youth including those experiencing FEP
Priority Type:
Population(s): SMI, SED

Goal of the priority area:

Continue to establish a system of identification, referral, and screening to address the needs of youth age 15-24 with early serious mental illness and those experiencing first episode psychotic disorders.

Objective:

Contract with the Center for Children and Families to engage appropriate stakeholders, assess current capacity to identify youth experiencing first episode psychosis, research protocol for a system of identification, referral, and screening for youth experiencing first episode psychosis; and determine what would be needed to fully implement the RAISE or other evidence based model to serve high-risk youth.

Strategies to attain the objective:

Engage Appropriate Stakeholders
 Assess Current Capacity to Identify Youth Experiencing FEP
 Determine What Would Be Needed to Fully Implement the RAiSE or other Evidence Based Model for Youth

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Development of planning infrastructure to serve youth with serious emotional disturbance, including psychotic disorders through stakeholders.
Baseline Measurement: Policy and Procedure to Implement and Replicate
First-year target/outcome measurement: Policy and Procedure Manual for Process
Second-year target/outcome measurement: Replicate, Assess and Modify as Needed

Data Source:

Manuals
 Flow Charts
 Logic Models
 Meeting Minutes
 Stakeholder Surveys
 Outcome Data
 Evaluation Plan

Description of Data:

See Above

Data issues/caveats that affect outcome measures::

Will be determined from process and outcome data
 Lack of psychiatric support could impact outcomes

Indicator #: 2
Indicator: Conduct Fidelity of Components Implemented for LEAD Program
Baseline Measurement: Fidelity Tools

First-year target/outcome measurement: Complete 1st Review in December 2015 and June 2016

Second-year target/outcome measurement: Complete 2nd Review December 2016 and June 2017

Data Source:

Fidelity Tools: Navigate - Family Education Program, IRT, IPS/SE, Trauma Focused CBT

Description of Data:

Scores on Fidelity - will review areas for improvement.

Data issues/caveats that affect outcome measures:

Indicator #: 3

Indicator: Serve Eligible Youth

Baseline Measurement: 6

First-year target/outcome measurement: 20

Second-year target/outcome measurement: 40

Data Source:

Client List

Description of Data:

Demographics
Services Delivered
Outcomes of Services

Data issues/caveats that affect outcome measures:

Potential lack of engagement from youth and families/referral sources

Priority #: 2

Priority Area: Evidence Based Services to Youth and Adults

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Implement Community Support (Rehabilitative) Evidence Based Individual Placement and Supports (Supported) Employment Services.

Objective:

Support quality community mental health services that support recovery and community integration through evidence based employment to youth with serious emotional disturbance and adults with severe disabling mental illness.

Strategies to attain the objective:

Fund, Monitor, and provide Technical Assistance and Training to four (4) contracted programs including: Gallatin Mental Health Center, Beacon Employment Program; Yellowstone Boys and Girls Ranch Community Services Program, and the Center for Children & Families.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Contract with Dartmouth Supported Employment Center

Baseline Measurement: Four Fidelity Reviews

First-year target/outcome measurement: Assist with fidelity reviews for all contracted IPS Programs

Second-year target/outcome measurement: Assist with fidelity reviews for all contracted IPS Programs

Data Source:

Fidelity Reviews

Description of Data:

n/a

Data issues/caveats that affect outcome measures::

n/a

Indicator #:

2

Indicator:

Programs will achieve at or above Good Fidelity

Baseline Measurement:

Fidelity Scores

First-year target/outcome measurement:

Programs under Good Fidelity will Achieve Good Fidelity

Second-year target/outcome measurement:

Programs at or above Good Fidelity will increase their score between 5 and 7 points

Data Source:

Fidelity Score

Description of Data:

25-Item Supported Employment Fidelity Scale

Data issues/caveats that affect outcome measures::

Staff retention as been a challenge for programs
Competition of other community programs - leave for higher salaries

Indicator #:

3

Indicator:

Increase caseloads to full utilization of Employment Specialists - three full staffed programs

Baseline Measurement:

30

First-year target/outcome measurement:

45

Second-year target/outcome measurement:

60

Data Source:

Caseload Roster

Description of Data:

List all those individuals enrolled in IPS Programs in programs with two employment specialists.

Data issues/caveats that affect outcome measures::

two of the programs are smaller and serve youth ... youth dynamics are more challenging

Priority #:

3

Priority Area:

Services to those Under and UnInsured

Priority Type:

MHS

Population(s):

SMI

Goal of the priority area:

Fund psychiatric/prescriber and pharmacy services to those with severe disabling mental illness between 138% and 150% of FPL with no insurance or

other health coverage.

Objective:

Provide psychiatric/prescriber and pharmacy services to those populations not available through the marketplaces, medicaid and other payers.

Strategies to attain the objective:

Determine Eligibility, Enroll and Serve those persons between 138% and 150% of FPL who are not able to pay for psychiatric/prescriber and pharmacy services due to income.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Provide Pharmacy, Prescriber, and Case Management Support Services through fee for service payment schedule for eligible individuals between ages 18 and older.
Baseline Measurement:	5,300 eligible
First-year target/outcome measurement:	3,500 enrolled
Second-year target/outcome measurement:	3,000 enrolled

Data Source:

TESS

Description of Data:

Demographics of Individuals on MHSP
Number of Individuals using Pharmacy and Prescriber Services and Case Management Support Medications

Data issues/caveats that affect outcome measures:

Changes in MHSP related to Medicaid Expansion and other Waiver Services - number of eligible individuals will decrease as Medicaid Expansion proceeds.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$1,230,717	\$0	\$0	\$0	\$0	\$0
8. Mental Health Primary Prevention**		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		\$68,000	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$61,000	\$0	\$0	\$0	\$0	\$0
13. Total	\$0	\$1,359,717	\$0	\$0	\$0	\$0	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	\$
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	\$

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	\$
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	\$
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	\$
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ; Multi-	
family Therapy;	

Consultation to Caregivers;	
Medication Services	\$505,514
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	\$793,203
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	\$
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	\$
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	\$
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	\$
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	\$
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	\$61,000
Total	\$1,359,717

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	20	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	3	
Total Individuals in Recovery, Family Members & Others	11	55%
State Employees	5	
Providers	4	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	9	45%
Individual/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="1"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="0"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Environmental Factors and Plan

The Health Care System and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁶ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁷ It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.²⁸ Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices^{29 30} that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.³¹ Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.³² In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.³³ Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.³⁴ Some patients may seek to self-medicate due to their chronic physical pain or

become addicted to prescribed medications or illicit drugs.³⁵ In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³⁶ SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³⁷ Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.³⁸ Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁹ and ACOs⁴⁰ may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.⁴¹ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.⁴²

One key population of concern is persons who are dually eligible for Medicare and Medicaid.⁴³ Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.⁴⁴ SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.⁴⁵ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.⁴⁶ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.⁴⁷ It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.⁴⁸

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁵⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.⁵¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of

prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016? None
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid? Outreach and enrollment functions will be performed by the federally-facilitated market place. Montana has approved Medicaid Expansion and has submitted a request and waiver to CMS.
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process. Believe by the federally-facilitated market place.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA? Unsure
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package? In beginning process of Medicaid Expansion.
<http://dphhs.mt.gov/medicaidexpansion>
6. Is the SSA/SMHA involved in the various coordinated care initiatives in the state? Medicaid Expansion in Montana may impact this.
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers? Do not know.
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders? Much of work through the State – see below.
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system? Believe would be done by individual provider agencies.
10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - a. Regular screening with a carbon monoxide (CO) monitor
 - b. Smoking cessation classes
 - c. Quit Helplines/Peer supports
 - d. Others _____

State Efforts – Tobacco Prevention:

The Montana Tobacco Use Prevention Program Works!

This program has made significant strides to reduce tobacco use in Montana and continues to help Montanans quit, as well as not start, using tobacco.

- The sale of cigarettes has declined from 89 packs per capita in 1998 to 44 packs per capita in 2013 – more than 50% reduction.
- Cigarette smoking (in the past 30 days) among youth has decreased from 29% in 2001 to 15% in 2013 – more than 40% reduction.
- By September 2014, over 80,000 Montanans had called the Montana Quit Line (800-QUIT-NOW) since 2004, and approximately 32,000 had quit using tobacco by accessing this statewide resource. This is one of the most effective cessation quit lines in the US. In 2013, Montana’s quit rate was 40%.
- In March 2013, the Montana Tobacco Quit Line launched the Pregnancy and Postpartum Program to eliminate the negative effects of smoking while pregnant, such as low birth weight babies. Low birth weight babies cost an average of \$55,393 in their first year compared to \$5,085 for a baby born without complications.
- In January 2014, a new enrollment website was launched, www.QuitNowMontana.com, and it had over 5,300 unique visitors to the site in the first 6 months.
- ReACT groups led 158 tobacco prevention activities in 2014 and 800 youth attended regional reACT summits. Sixteen reACT groups analyzed tobacco advertising in 300 stores in 41 communities across the state.
- MTUPP’s partnership with the Montana High School Rodeo Association has led to the first tobacco free policy in high school rodeo in the nation.
- In 2013, 25% of Montana multi-unit housing renters reported being protected by a smoke free policy, up from 19% in 2009.
- Smoking-attributable cancers account for approximately 18% of the 5,000 cancer cases diagnosed in Montana each year. MTUPP has partnered with MT Cancer Control Coalition to promote cessation and early screening through an awareness campaign in areas with high American Indian population density. <http://tobaccofree.mt.gov>

11. The behavioral health providers screen and refer for:

- a. Prevention and wellness education;
- b. Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
- c. Recovery supports

Environmental Factors and Plan

Health Disparities #2

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁵², [Healthy People, 2020](#)⁵³, [National Stakeholder Strategy for Achieving Health Equity](#)⁵⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).⁵⁵

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁵⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.⁵⁷ This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.⁵⁸ In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age? By race, ethnicity, gender, and age. Some programs may track by other preferences.
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.

Montana Block Grant dollars will be focused on individuals diagnosed with Severe Disabling Mental Illness or transition age youth, 14-17. Montana does not plan to focus on sub-populations; all individuals who are eligible and apply for services under Montana's Block Grant priorities will be provided services. All community mental health centers have non-discrimination policies; the expectation is to serve all those who qualify for services.

3. Are linguistic disparities/language barriers identified, monitored, and addressed? All Medicaid and grant providers have policy related to cultural competence and cultural competency training.
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system. Unsure at this time.

5. Is there state support for cultural and linguistic competency training for providers? Not that aware of.

Environmental Factors and Plan

Use of Evidence in Purchasing Decisions #3

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP⁵⁹ is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁶⁰, The New Freedom Commission on Mental Health⁶¹, the IOM⁶², and the NQF.⁶³ The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶⁴ SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)⁶⁵ are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)⁶⁶ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
 - a. Leadership support, including investment of human and financial resources.
 - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c. Use of financial incentives to drive quality.
 - d. Provider involvement in planning value-based purchasing.
 - e. Gained consensus on the use of accurate and reliable measures of quality.
 - f. Quality measures focus on consumer outcomes rather than care processes.
 - g. Development of strategies to educate consumers and empower them to select quality services.

- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Use of Evidence in Purchasing Decisions Response #3

Montana has historically allocated a significant portion of the Mental Health Block Grant to the purchase of evidence-based or promising practices, and, also to finance services for those un-under insured (SAMHSA priority populations), services critical to recovery for persons with serious disabling mental illness; i.e., prescriber services and evidence based or promising practices, i.e., targeted case management. FY 2012-2013 BG dollars were used to support evidence-based Individual Placement and Supports employment programs and peer run drop-in centers in community mental health centers. Montana community mental health centers serve the greatest share of persons needing mental health services (at least 80-85%).

Two of the programs purchased through Montana's Block Grant are using evidence based practices. It is our goal to use MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches.

- No specific staff are not responsible for tracking all evidence-based or promising practices information. Fidelity reviews have been conducted on specific services, such as PACT, IMR, and Employment services.
- Montana continues to work with Dartmouth University to implement Individual Placement and Supports Supported Employment. Montana utilizes resources from Dartmouth to support providers in IPS implementation.
- Montana has used information used in tracking evidence-based programs, such as PACT and IPS, to assist provider programs reach compliance, improve service delivery, change program process, and support and educate programs. Montana does not educate other State Medicaid agencies on evidence based practices implemented in the adult service division.
- Montana has applied for the SAMHSA Planning Grants for Certified Community Behavioral Health Clinics in the hopes of being able to address some of the items above.

Environmental Factors and Plan

Prevention for Serious Mental Illness #4

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.⁶⁷ The “Prodromal Period” is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.⁶⁸ In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.⁶⁹ The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.^{70 71} This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment. Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Prevention for Serious Mental Illness Response

Please reference Evidence-Based Practices for Early Intervention (5 percent set-aside). Montana is contracting with the Center for Children & Families to plan, develop, and implement a comprehensive Transitions Program, including those youth who may experience a first psychotic episode. The contract includes engagement with stakeholders, assessment of the current capacity to identify youth experiencing first episode psychosis, research protocol for a system of identification, referral, and screening for FEP youth and, to determine what would be needed to fully implement the RAISE or other evidence based model to serve high-risk youth.

Dr. Brenda Roche will serve as the Project Lead and grant administrator for the Center. Dr. Roche serves as the Director of Clinical & Evaluation Services for the Center for Children & Families (Center); the agency identified as the sole source provider for transitional services for high-risk youth. Dr. Roche's is a Clinical Psychologist and Doctor of Philosophy. She has served in her current position with the Center for over 10 years. During this tenure, Dr. Roche has also served as Program Evaluator/Principal Investigator for several grants from federal and state agencies, such as the Administration for Children & Families, SAMHSA, the University of Montana, County Drug Courts, and more.

Dr. Roche will serve as the lead consultant to begin development of Montana's policy and planning infrastructure to serve youth with early serious mental illness, including psychotic disorders. The Center is in a prime position to begin this process by virtue of current partnerships, current work w/families, and Dr. Roche's extensive background in clinical research and grant development.

Environmental Factors and Plan

Evidence-Based Practices for Early Intervention (5 percent set-aside) #5

P.L. 3-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.⁷² SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded [Recovery After an Initial Schizophrenia Episode \(RAISE\) initiative](#)⁷³, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan. See Logic Model attached.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan. See Attached Logic Model
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures. See Transitions FY 2016 Goals
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.

5. The states provision for collecting and reporting data, demonstrating the impact of this initiative. Part of the Contract. See Logic Model.

Environmental Factors and Plan

Participant Directed Care #6

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Participant Directed Care #6 Response

Montana is participating in a Money Follows the Person demonstration program. The program is intended to reduce the use of institutionally based services and increase the use of home and community based services. The Follows the Person (MFP) grant is focused on helping individuals transition from nursing home facilities to the community. The Program vision is to create a sustainable system that supports community options as a first choice for individuals needing long term care services. To date Montana has not discussed a voucher system.

Environmental Factors and Plan

Program Integrity #7

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services **and** providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x-55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate

their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?

Comprehensive Program Integrity activities are managed through the Quality Assurance Division, Program Compliance Bureau of the Montana Department of Public Health and Human Services.

The Program Compliance Bureau encompasses three programs:

- Surveillance and Utilization Review. This unit is responsible for protecting the integrity of the Montana Medicaid Program from fraud and abuse.
- Third Party Liability. This unit identifies Medicaid recipients who have other medical insurance or payment sources with which to pay their health-care costs before they rely on Medicaid.
- Program Integrity. This unit 1) investigates intentional fraud of recipient eligibility in the Food Stamp, Temporary Assistance for Needy Families (TANF), and Medicaid programs; 2) helps establish, monitor, reconcile and negotiate repayments of recipient claims for Food Stamps, TANF, and Medicaid; and 3) performs federally mandated quality-control reviews for the Food Stamp and Medicaid programs.

The State has boiler template for contracts with added required federal language for MHBG and SABG funds.

2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? Completed through contract process based on funding. Program Manager is in communication with providers on a quarterly basis (minimum). Program Manager provides support and technical assistance throughout the contract period based on contractual outcome measures and processes.
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
 1. Budget review – at time of RFP approval and quarterly invoice processes.
 2. Claims/payment adjudication - review of monthly and quarterly payment requests through invoice for review and approval by program officer; paid by contract officer; and, authorized by budget analyst.
 3. Expenditure report analysis;
 4. Compliance reviews;

5. Client level encounter/use/performance analysis data: Review of monthly and quarterly payment requests through invoice for review and approval by program officer; paid by contract officer; and, authorized by budget analyst
 6. Audits: do not request audits unless have compliance concerns. Contract covers review of agency audit reports as needed – mostly A133 Audits
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered. Review of monthly and quarterly payment requests through invoice for review and approval by program officer; paid by contract officer; and, authorized by budget analyst.

Addictive and Mental Disorders Division, Operations Bureau, reviews all budgets monthly through budget status meetings. Expenditures are reviewed and analyzed by AMDD management as well as the Department's Business & Financial Services Division. Utilization reviews are conducted by Mountain Pacific Quality Health. Claims payments are made through MMIS (see Q. Data and Information Technology). Inherent safeguards are built into MMIS to ensure claims are valid, reliable, and are not duplicated. Claims reviewers at Xerox State Healthcare, LLC (under contract with the State to process Medicaid claims) conduct reviews of rejected claims. Encounter and recipient claims data is reviewed by program staff to identify trends and problem areas. Audits are conducted by State Legislative Audit Division under the Single Audit Act.

5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? Yes – through annual contract review, by request, or through payment process.
6. How does the state ensure block grant funds and state dollars are used for the four purposes? The State and the MHOAC review requirements under the Block Grant Application; initiate a planning process; and determine what dollars will be targeted towards in consideration of the four purposes and the priorities defined by the Council and State Agency.

Environmental Factors and Plan

Tribes (8)

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁷⁴ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall **not** require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.

A Department Wide Policy on Tribal Consultation became effective in 2011. The Policy requires that the Department (DPHHS) consult with tribal governments on major new

program or significant policy and administrative rule changes that are determined to have tribal government implications. The FY 2016-2017 MHBG Behavioral Health Assessment and Plan does not include any major new program or significant policy changes since the FY 2014 Tribal Consultation.

2. Describe current activities between the state, tribes and tribal populations.

The Department will hold a formal Tribal consultation with representatives of tribal governments, urban Indian health centers and Indian Health Service on Wednesday, August 19, 2015 beginning at 9:30 a.m. in Helena to discuss specifically how Medicaid expansion will affect Native American people, and, pending State Plan Amendments.

Substance Use Treatment & Prevention through SAMSHA block grant funds:

- Blackfeet – Crystal Creek Lodge Treatment, Browning MT, Provide residential and outpatient treatment and is a contracted Partnership for Success grantee
- Rocky Boy – White Sky Hope, Box Elder MT, Provide residential outpatient treatment and block grant prevention and PFS contract
- Fort Belknap – Fort Belknap Chemical Dependency Center, Harlem, MT Provide outpatient treatment and PFS contract
- Fort Peck – Spotted Bull Resource Center, Poplar MT, provide outpatient treatment and PFS
- Crow Agency – Crow Wellness, Crow Agency MT, provide outpatient treatment and PFS
- Northern Cheyenne – Recovery Center, Lame Deer, outpatient and PFS
- Salish Kootenai – Behavioral Health Program, St. Ignatius MT, outpatient and PFS

- CSKT - Received the Community Based Child Abuse Prevention grant through SAMSHA as well as the SPF TIG grant
- All 7 tribal reservations have signed subcontracts to implement primary prevention activities as outlined in the Partnership for Success (PFS) grant
- The MT 2015 legislature awarded \$250,000 to go to all tribal and urban Indian Health Centers for Suicide prevention.

Environmental Factors and Plan

Primary Prevention for Substance Abuse #9

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- **Education** builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- **Alternatives** provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- **Problem Identification and Referral** aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does **not** include any activity designed to determine if a person is in need of treatment.
- **Community-based Process** provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- **Environmental Strategies** establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.
- States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:
- **Universal:** The general public or a whole population group that has not been identified based on individual risk.

- **Selective:** Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- **Indicated:** Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs. SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse-related attitudes and behaviors. This means that state-funded prevention providers will need to be

able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
 - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
 - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
 - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
 - A statewide licensing or certification program for the substance abuse prevention workforce;
 - A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
 - A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Primary Prevention for Substance Abuse #9 Response

This Section will be addressed in the FY 2016-2017 SABG Behavioral Health Assessment and Plan.

Environmental Factors and Plan

Quality Improvement Plan #10

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states must submit a CQI plan for FY 2016-FY 2017.

Quality Improvement Plan #10 Response

Montana has not based their administrative operations and service delivery on principals of a Continuous Quality Improvement/Total Quality Management (CQI/TQM) Plan for the FY 2014/2105 Block Grant Application. A Continuous Quality Improvement/Total Quality Management (CQI/TQM) Plan will not be submitted for the FY 2016/2017 Block Grant Application. Technical Assistance in this area would be helpful from SAMHSA.

Montana does not currently have the system/processes in place to make provider reimbursement based on performance. We currently provide feedback to providers based on fidelity reviews or on-site monitoring for PATH, IMR, IPS, and PACT.

During the 2015 Legislative Session, HB 422 and SB 418 were introduced and passed. Both Study Bills have been assigned to the Children, Family, Health and Human Services Legislative Interim Committee. HB 422, SB 418, and the Interim Legislative process may provide a template for development of a Continuous Quality Improvement Plan in Montana.

HB 422 is an Act creating a pilot project to improve outcomes for youth in the Children's Mental Health System. The Act requires an Interim Study of evidence-based outcomes; provides for public participation in the development of evidence-based outcomes models; requires collection and analysis of data; and, provides for development of options for performance-based reimbursement.

The legislature believes that implementing a pilot project for improved youth outcomes may benefit Montana youth who are in the children's mental health system because experiences in other states show that linking provider payments to desired outcomes and quality improvements may result in improved access to care, better integration and coordination of services, child-centered and family-focused planning, earlier and less restrictive interventions, and a reduced number of treatment days.

SB 418 is an Act that provides legislative policy on mental health investments as set forth in the General Appropriations Act. A component of the Study Bill provides language on data collection and performance measures.

Section 2 of the Act states:

(1) Pursuant to 53-21-101, in its treatment of the seriously mentally ill, it is the policy of the state of Montana to:

- (a)) provide each person who is suffering from a mental disorder and who requires commitment the care and treatment suited to the needs of the person and to ensure that the care and treatment are skillfully and humanely administered with full respect for the person's dignity and personal integrity;
- (b) accomplish this goal whenever possible in a community-based setting;
- (c)) accomplish this goal in an institutionalized setting only when less restrictive alternatives are unavailable or inadequate and only when a person is suffering from a mental disorder and requires commitment; and
- (d) ensure that due process of law is accorded any person coming under the provisions of this part.

(2) In order to achieve this policy, the legislature directs the department of public health and human services to meet the following objectives:

- (a)) to support a community-based system of care that is demonstrated through increased utilization of community-based crisis intervention services to reduce short-term admissions to the Montana state hospital;
- (b) to provide and reimburse for effective prevention and treatment that enables sustainable recovery in communities, evidenced through quality assurance activities and analyses. The addictive and mental disorders division shall evaluate the delivery of recovery-focused services by providers.
- (c)) to improve outcomes for individuals with serious mental illness and co-occurring substance use disorders, demonstrated through data collection on individual client outcomes for recovery markers and performance measures; and
- (d) to improve collaboration between community mental health providers, nursing homes, and state facilities, demonstrated through an increase in state facility discharge rates with a corresponding decrease in client recidivism to state facilities.

(3) The children, families, health, and human services interim committee shall monitor and evaluate the department's implementation of the objectives identified in this section and provide to the 65th legislature a report that outlines the status of implementation and identifies areas where continued improvement is necessary.

Environmental Factors and Plan

Trauma #11

Trauma is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems⁷⁶. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed

approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”.⁷⁷ This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁷⁸ paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions? Trainings have been provided in past.

Trauma Response #11

Montana provides definition for adult Community-based psychiatric rehabilitation and support; and, “Recovery-oriented” services in Administrative Rule – Mental Health Center Services for adults, Definitions (37.88.901).

"Recovery-oriented mental health services" means:

- (a) respect for and appreciation of the individual that ensures inclusion and participation in all aspects of his or her life;
- (b) individualized and person-centered treatment, based on the individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including **trauma**), and cultural background; and
- (c) empowerment of the individual to choose from a range of options and to participate in decisions and to receive education and support in so doing, and to promote personal responsibility for his or her own recovery.

Montana’s adult mental health providers currently screen for a personal history of trauma during the eligibility process. The Addictive and Mental Disorders Division in partnership with MSH has an active Resident’s Council that has been recognized as one of the best in the country. The Wellness Recovery Action Plan (WRAP) program is in use at MSH and is co-lead by two peer specialists. MSH has also implemented procedures to greatly reduce the use of restraint and seclusion procedures. MSH has played a leadership role in Dialectical Behavioral Therapy (DBT) and Co-Occurring treatment within Montana’s Public Mental Health system. MSH has provided many staff members with training in trauma informed care and other important topics such as the use of “person-first” language to help address stigma.

FFY 2016-2017 Community Mental Health Block Grant (Print)

Montana's community providers and State facilities continue to develop treatment by implementing evidence and best practice models such as dialectical behavioral therapy, parenting and trauma related services.

Children's Mental Health Bureau (CMHB) along with many partners in the State of Montana understand the impact of trauma or adverse experiences can have long term effects for individuals, families, and communities. Research has shown that with proper understanding and targeted care, youth, families, and communities can recover from trauma and reduce its deleterious effects. The Montana CANS offers providers a standard practice for capturing a youth's experience with trauma and the impact of that trauma. The trauma experience information captured in CANS should be used as a lens for individualized treatment planning.

The CANS information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The CAN-Comprehensive is an open domain tool for use in service delivery systems that address the mental health of children, adolescents, and their families. The copyright is held by the Praed Foundation to ensure that it remains free to use for those who are trained and certified in CANS. A large number of individuals have participated in the mass collaboration to develop and refine various versions of the Child and Adolescent Needs and Strengths (CANS) information tool. These include CANS for various child-serving areas such as mental health, developmental disabilities, juvenile justice, child welfare, and the National Child Traumatic Stress network (NCTSN) CANS-Comprehensive.

Beginning December 1, 2011, Montana identified the Child and Adolescent Needs and Strengths (CANS) as the functional assessment tool that state agencies and providers will use to communicate youth and family needs and strengths. This effort is intended to support Montana youth's and families' resilience in their challenges with mental illness. Many assisted with the process of identifying, customizing, and adopting the CANS for Montana. Among those are Montana providers of Children's Mental Health Services and System of Care Planning Committee (SOC) members, which include representatives from:

- ✓ Juvenile Justice
- ✓ Child and Family Services
- ✓ Developmental Disabilities
- ✓ Department of Corrections
- ✓ Board of Crime Control
- ✓ Office of Public Instruction (OPI)
- ✓ Early Childhood Services Bureau
- ✓ Addictive and Mental Disorders Division
- ✓ Utilization management contractor Magellan Medicaid Administration
- ✓ Children's Mental Health Bureau staff
- ✓ CANS consultant, MJ Henry & Associates, Inc.
- ✓ DPHHS administration

In consultation with MJ Henry & Associates, Inc., the Montana Children's Mental Health Bureau and its key stakeholders have customized comprehensive CANS, including information about trauma experiences, for children and youth, birth through twenty-one years of age, receiving

mental health services throughout Montana. Through the promotion of strong, collaborative working relationships among state agencies, providers, and other community stakeholders, the Children's Mental Health Bureau (CMHB) of Montana is committed to strength-based, culturally-informed service delivery that allows children, youth, and families to be served in the least restrictive environments, with the most effective interventions. The CANS offers partners across systems an easy-to-use tool with a straightforward, common language to communicate information about child and youth needs and strengths, as well as to inform treatment decisions.

While no policies exist directly related to connecting individuals with trauma histories to trauma-focused therapies efforts by Children's Mental Health Bureau have been sought to provide opportunities for providers to gain knowledge and experience by offering trauma informed Cognitive Behavioral Therapy. Also efforts by Department of Health and Human Services have offered many Adverse Childhood Experiences trainings through the University of Montana. CMHB has also offered mini grants to encourage provider participation in increasing Crisis Intervention Services to youth many of whom have experienced trauma histories. CMHB has utilized grants to encourage participation in trauma specific interventions. In addition the State of Montana has access to the National Child Traumatic Stress Network (NCTSN) and is housed within The University of Montana's Institute for Educational Research and Service (IERS) in Missoula, Montana. NNCTC staff offer trainings and consultations to community agencies, tribal programs, clinicians, school personnel, technicians, and families on the impacts and prevention of childhood traumatic stress.

The NNCTC staff members are trained educators, counselors and psychologists who work closely with community agencies, tribal programs, clinicians, school personnel, technicians, and families to identify the needs of the community in addressing child traumatic stress. Below is a list of interventions and trainings that are offered by the NNCTC staff:

- Community development for comprehensive behavioral health initiatives
- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Police officer and victim advocates partnerships for domestic violence
- Traumatic grief intervention
- Trauma, academic achievement and school climate programs
- Historical/intergenerational trauma community awareness
- Mental health recovery to emergencies (Psychological First Aid)
- Suicide prevention gatekeeper trainings: Question, Persuade, Refer (QPR) and Applied Suicide Intervention Skills Training (ASIST)
- Mental health practitioner and school consultations

University of Montana link to National Child Traumatic Stress Network (NCTSN)
http://iers.umt.edu/National_Native_Childrens_Trauma_Center/interventions.php

Environmental Factors and Plan

Criminal and Juvenile Justice #12

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.⁷⁹

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{80 81} Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁸²

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance

use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions? Montana is in beginning stages of Medicaid Expansion.

Adults who meet federal income levels would be eligible under Medicaid expansion. Enrollment, to some extent, is facilitated through the marketplace, where all individuals must apply for insurance to meet ACA requirements. Those that meet eligibility criteria for Medicaid are moved to that program rather than a private insurance plan. Pre-trial detainees held in county jails are eligible under federal guidelines although the state has the authority to determine if they are in our eligible population.

The Montana Pre-Adjudicatory Risk Assessment Instrument (RAI) has been used on a pilot basis in Cascade, Hill, Missoula, and Yellowstone Counties since 2009 as part of the pre-dispositional detention decision-making process to determine whether or not juveniles pose a public safety risk if released. The RAI asks questions regarding whether the juvenile has a history of drug or alcohol problems.

2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

Through a collaborative jail advisory group, we are working on uniform screening for behavioral health and suicide risk when in county detention. At this time, the screening instrument is being developed as a web platform that would be available to all booking officers. For post-adjudicated/pre-sentenced offenders, the probation and parole division of Department of Corrections does a pre-sentence investigation that includes medical history/behavioral health history. Unfortunately, the PSI is only as good as the PSI writer and they vary a great deal in how much information is provided. We did pass a bill in 2009 that said that all medical records for an offender, including MH, would travel with the offender when they move between facilities or programs. The goal was to reduce redundant assessments and provide a more complete picture of need at intake. Without electronic health records, this is still a challenge – even if the packet arrives the same day.

3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals? See County Matching Grants – Step 1; Missoula SOAR Project – Step 1.

The Chemical Dependency Bureau, outpatient/residential and inpatient, work with probation and parole closely to transfer clients from incarceration to the community – some of providers have 30% or more of the population served under the SABG block grant as probation and parole. Many SA providers participate and provide staffing for treatment court activities.

4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Cross trainings have been provided. Montana has a strong CIT program – see Comprehensive Continuum of Care. Mental Health training at the Montana law enforcement academy has increased by close to 50% in the past seven years.

Juvenile Probation Officers have received training regarding youth with mental health needs; however, the training is not specifically with mental health providers. Both Agencies are communicating more on training and funding opportunities.

Environmental Factors and Plans

State Parity Efforts #13

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.⁸³

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.⁸⁴

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

The 2015 Montana Legislature voted to support Medicaid expansion. Parity issues will be addressed in the Medicaid expansion waiver – specifically related to Essential Benefits. The RFP (Third Party Administrator Request for Proposal) can be reviewed on Montana's Medicaid Expansion website. <http://dphhs.mt.gov/medicaidexpansion>

Environmental Factors and Plans

Medication Assisted Treatment #14

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁵, 43⁸⁶, 45⁸⁷, and 49⁸⁸. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Medication Assisted Treatment #14 Response

This item will be addressed through the FY 2016-2017 SABG Behavioral Health Assessment and Plan.

Environmental Factors and Plan

Crisis Services #15

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁸⁹,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources.

The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning *
- Psychiatric Advance Directives
- Family Engagement *
- Safety Planning *
- Peer-Operated Warm Lines *
- Peer-Run Crisis Respite Programs
- Suicide Prevention *

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)

- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement *
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers *
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Crisis Services #15 Response

Montana Crisis Services are provided in other sections of the Environment Factors and Plan Section and also under the Planning Steps Step 1: Assess the strengths and needs of the service system to address the specific populations. Some of the services noted above may be being provided although not specifically addressed in other sections.

Environmental Factors and Plans

Recovery #16

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [**SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**](#)

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported employment
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?

AMDD contracts with NAMI Montana the following training and support groups: In Our Own Voice, Family to Family Education and Family to Family Teacher Trainings, Peer to Peer Recovery Course, Parents and Teachers as Allies, NAMI Basics, and Support Groups for Families.

2. How are treatment and recovery support services coordinated for any individual served by block grant funds? Person centered treatment planning and integrated team meetings.

3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others? Unaware of specific services.

4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services? Not at this time. Montana is working on a certification program/process.

5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system? Not aware of research.

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning). Mental Health Oversight Advisory Council; Local Advisory Councils and Service Area Authorities – see Step 1.

7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services? Yes – financial support of NAMI trainings and annual conference.

8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community? Plan to address during Olmstead update.
10. Describe how the state is supporting the employment and educational needs of individuals served. Montana is using Block Grant funds to support four Individual Placement and Supports Supported Employment Programs. Dartmouth University provides technical support and training.

Environmental Factors and Plan

Community Living and the Implementation of Olmstead

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services. (Plan attached – Montana will be updating the Olmstead Plan in 2016.
2. How are individuals transitioned from (state) hospital to community settings? Policy attached.
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved? N/A

Environmental Factors and Plan

Children and Adolescents Behavioral Health Services #18

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁰ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹¹ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹²

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹³ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders. For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's

functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁴

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁵:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
Pages 1 & 2
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use, and co-occurring disorders?
Pages 1, 15-17, 18-19
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)? pages 1&2
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
Pages 15-17
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders? Pages 15-17

6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?

Erin Butts (School Mental Health Contact with OPI) 444-0688 ebutts@mt.gov

7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care. Age 21 we could use some TA in this area. CMHB is not in charge of foster care transition – Children Family Services provides foster care.

Environmental Factors and Plan

Pregnant Women and Women with Dependent Children

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation **requires** the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.

All State-Approved alcohol and drug treatment programs receiving SAPT Block Grant funds are required to develop outreach activities targeting pregnant women and women with dependent children. In addition, programs are required to develop goals and objectives targeting this critical population. Each program has a contractual agreement stating this population is priority admission and admission will occur within 48 hours of initial contact. Programs are required to have partnership agreements or informal agreements with all providers in the community. This is monitored by the Bureau in 4 ways, annual on-site visit by Quality Assurance, the County Planning process (done annually), program officer site visits to communities, and through presentations/meetings with state partners.

2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours. (See #1)
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.

Those programs serving pregnant women and women with dependent children are below. The capacity is not included because it is Montana's belief that this population is treated as needed. Historically, this population is not included on any waiting lists and is required to admit as a priority.

4. Discuss who within your state is responsible for monitoring the requirements in 1-3.

The Chemical Dependency Bureau is responsible for monitoring requirements. Montana is using the NIAtx system to evaluate providers. A second evaluation tool is through an adult and youth client satisfaction survey that is administered annual. A third evaluation tool is the quarterly provider reports produced by the bureau. A fourth evaluation tool is peer review and continuous quality improvement requirements by each facility.

5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care? Rimrock Foundation and the Recovery Center of Missoula only.
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they? Montana is a frontier, thus there are many areas where extensive travel is required to receive services.

6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
- How many of the programs offer medication assisted treatment for the pregnant women in their care? Rimrock Foundation and the Recovery Center of Missoula only.
 - Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they? Montana is a frontier, thus there are many areas where extensive travel is required to receive services.

Name	Location	Substate Planning Area	NFR ID # (I-SAT #)	Type of Care
Alcohol & Drug Services of Gallatin County	Bozeman	Region IV	MT750020 (201)	Outpatient/ Intensive Outpatient
Crystal Creek Lodge	Browning	Region II	MT750038 (212)	Inpatient
Rimrock Foundation	Billings	Region III	MT900278 (202)	Outpatient/ Intensive/ Inpatient, Residential
Southcentral MHC	Billings	Region III	MT300107 (206)	Outpatient/ Intensive
Flathead Chemical Dependency	Kalispell	Region V	MT750129 (209)	Outpatient/ Intensive
District II Alcohol and Drug Services	Glendive	Region I	MT900559 (211)	Outpatient/ Intensive
Boyd Andrew Service Center	Helena	Region IV	MT750111 (222)	Outpatient/ Intensive
Missoula Indian Alcohol and Drug Services	Missoula	Region V	MT900724 (224)	Outpatient
Gateway Recovery	Great Falls	Region II	MT900658 (227)	Outpatient/ Intensive Residential
Southwestern Chem Dependency	Livingston	Region IV	MT900674 (231)	Outpatient/ Intensive

Butte/Silver Bow Alcohol and Drug	Butte	Region IV	MT900583 (234)	Outpatient/Intensive
Turning Point	Missoula	Region V	MT100168 (258)	Outpatient/ Intensive Residential
Hi-Line Recovery	Havre	Region II	MT100233 (259)	Outpatient
New Horizons	Fort Benton	Region II	MT100176 (292)	Outpatient
Billings Indian Health Board	Billings	Region III	MT000001 (277)	Outpatient/Intensive
Center for Mental Health	Choteau	Region II	MT0000142 (283)	Outpatient
Eastern Montana MHC	Miles City	Region I	MT900690 (273)	Outpatient

Environmental Factors and Plan Suicide Prevention #20

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).

Montana Suicide Prevention and Resources: <http://dphhs.mt.gov/amdd/Suicide.aspx>

Environmental Factors and Plans

Support of State Partners #21

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Support of State Partners #21 Response

Montana currently benefits from strategic partnerships with other health, social services, and education providers, as well as other state, local, and tribal governmental entities; albeit, they are all not formalized through letters of agreement or specific planning processes. Some of these partnerships are identified through the FY 2016/2017 Block Grant Application in other Sections—specifically the partnership with the Department of Commerce Housing Division Shelter Plus Care Program.

Montana's Department of Public Health and Safety has successfully negotiated, government-to-government, Master Agreements for all health care dollars passing between the Department and Montana's tribes. This is a Department wide contract that covers all boilerplate contract language with tribal governments and DPHHS. It covers reoccurring negotiation issues such as sovereign immunity, insurance, government-to-government respect, court of competent jurisdiction, among others, so these items do not have to be negotiated every time a contract expires. The Master Agreements were signed for a ten (10) year period, with clauses for amendments if agreed upon. With this overarching Master Agreement, all subsequent contracts will now be designated as "task orders" and fall under the Master Agreement with each Tribal government. Some examples of task orders already in place are Medicaid, Pregnant & Parenting Teens, and Tobacco Prevention.

Environmental Factors and Plan

State Behavioral Health Advisory Council (#22)

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.](#)⁹⁷

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.). MHOAC Minutes and Letter from the Council Chair Attached.

The Council's Executive Committee participates in review of requirements for the Block Grant Plan, and approves the Plan before submission. The full Council provides

recommendation for BG allocation based on their strategic planning process. The full Council approved BG programs and allocation for FY 2016-2017 Block Grant Application.

An opportunity to provide Public Comment was posted on the AMDD website and distributed to the Council and other Interested Parties electronically early August 2015. The July MHOAC minutes include Public Comment on the Community Mental Health Block Grant. (attached under #22).

2. What mechanism does the state use to plan and implement substance abuse services?

Substate Planning

The statewide philosophy for delivery of substance use disorder treatment and prevention services must be sensitive to situations unique to Montana. While Montana ranks fourth in geographical area (145,388 square miles), it ranks 38th among states in population with approximately 5.5 persons per square mile. The racial distribution of the state is 93 percent white, with the remainder being predominately Native American.

In accord with 53-24-211 MCA, local planning for substance use disorder treatment and prevention services is the responsibility of each county's board of commissioners. County plans are developed every four years with an annual action strategy update. County plan guidelines are provided by the Department and a standardized format is used by each county. Data assembled by the State SEOW and state staff is assembled and presented as part of this packed of information. The Data provides outlines of incidence, prevalence and greatest need at each county level. The guidelines also allow for development of multi-county plans. County plans include the following sections:

- 1) County Data presenting, incidence, prevalence, need, and usage of services
- 2) Documentation of County Collaboration
- 3) County Identification/Action Forms
- 4) Description of Service Area and County Planning Process
- 5) Analysis of County Needs
- 6) Primary Prevention Services
- 7) Early Intervention and Treatment Services

County plans provide the Department with uniform planning information, local needs and priorities and solutions to local service delivery problems. As part of the planning process, counties must determine special population needs including Native Americans, pregnant women and women with dependent children, SSI recipients, HIV/AIDS, youth, and repeat DUI offenders. County alcohol tax monies are allocated as part of each year's county plan update subject to approval by the Department of Public Health and Human Services. As part of the county planning process, public meetings must be held as part of the county commissioners meeting. This information must be presented in the packets. This occurs each April or May of each year.

Definition of Substate Planning Area: The Department of Public Health and Human Services, Addictive and Mental Disorders Division (AMDD) utilizes the five health planning regions for purposes of planning and for this block grant application. The Regional Identification number and the counties contained in each region can be found in the SPA Table of this Grant Application.

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

Montana's Substance Use Disorder Treatment and Prevention system is required by Montana Law to have a county planning process as indicated above. Because of the implementation of this process and continued growth and improvement (such as the SEOW), the substance use disorder treatment/prevention process is well implemented. The Chemical Dependency Bureau and the Mental Health Bureau are working in several areas to integrate work. A couple of examples are to expand the SEOW to review mental health data (which there is very little structure) and to include mental health planning input in the county planning process. As information is found, the Chemical Dependency Bureau Chief presents information at the advisory council for information and input. Staff, from both the Chemical Dependency Bureau and the Mental Health Bureau, are located in the same building, work under the same administrator and continue to work together in multiple projects and services to address those in need.

The Council has consistently included a representative with substance use disorder treatment expertise. Representatives from AMDD's Chemical Dependency Bureau plan to attend and actively participate in all Council meetings.

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? Yes – please reference Behavioral Health Advisory Council Members and Council Composition by Member Type.
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Although the focus of the Council is Mental Health, substance use disorder treatment and prevention issues are presented to this committee and will continue to do so until state law can be changed to formally recognize the inclusion of substance use disorder treatment and prevention as part of a behavioral health system.

The following is found in Montana law:

The Montana Mental Health Oversight Advisory Council's mission is to serve as "*Partners in planning for recovery based mental health system throughout Montana.*"

The Council's vision is: *a collaborative public mental health system that promotes independence, self-determination and recovery through individual, family, advocate and community participation. With effective treatment, knowledge and support, Montanans with mental disorders will achieve education, meaningful work, satisfying family relationships, friendships and participation in the community.*

The purpose of the Council as defined in state law (53-21-701(6) (and) is directed to:

- Provide input to the department in the development and management of any public mental health system.
- Provide a summary of each meeting and a copy of any recommendations made to the Department to the Legislative Finance committee and any other designated appropriate legislative interim committee.
- Fulfill any federal advisory council requirements in order to obtain federal funds for this program.

Montana's Current Mental Health Oversight Advisory Council, through bylaw process, consists of the following committees:

EXECUTIVE COMMITTEE: Consists of the Chair, the Vice-Chair, and chairs of the Standing Committees. Chairs of Special Committees may participate in meetings of the Executive Committee when appropriate business is involved. The Executive Committee is responsible to conduct any business that is necessary between meetings of the full Council and will report such business at the next meeting of the Council. The Executive Committee will develop the proposed agenda for the regular and special meetings. The committee will evaluate and make recommendations to the Council regarding the budget.

DEVELOPMENT COMMITTEE: (part of the Executive Committee) will be the Nominating Committee for election of officers. This committee will maintain awareness of attendance at meetings and note vacancies on the Council with responsibility to seek potential replacements for that same position *except for state agency representatives, representatives of SAA's (Service Area Authority), MACo (Montana Association of Counties, and Community Mental Health Centers (CMHC) and the MASP (Montana Addiction Service Providers).* Applications for membership will be accepted, evaluated and presented to the Director of the Department. The committee will draft any proposed amendments to the By-Laws for presentation to the Council. The committee is responsible for orientation of new members.

ADVOCACY COMMITTEE: will prepare recommendations for legislative action as determined and approved by the Council. Committee members will assist the Department in presentations to the Administration and to candidates and legislators, including

testifying before legislative committees. The Committee will work with System of Care Committee, Service Area Authorities, Local Area Councils and other mental health organizations to promote the Mission.

BLOCK GRANT COMMITTEE: (part of the Executive Committee) will work with the appropriate Department personnel on an on- going basis to draft, revise and evaluate the block grant.

Because 51% of the members of this council are consumers and/or family members, consumer input is readily taken as part of the council. Further input is provided to both the Chemical Dependency Bureau and the Mental Health Bureau through the implementation of a consumer survey that is completed on an annual basis.