Montana

UNIFORM APPLICATION
FY 2022/2023 Only ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 03/02/2022 - Expires 03/31/2025
(generated on 02/08/2023 2.33.47 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year 2023

End Year 2024

State DUNS Number

Number TR3DAXR9MCN8

Expiration Date 4/1/2023

I. State Agency to be the Grantee for the Block Grant

Agency Name Montana Department of Public Health and Human Services

Organizational Unit Behavioral Health & Developmental Disabilities Division

Mailing Address PO Box 202905

City Helena

Zip Code 59620-2905

II. Contact Person for the Grantee of the Block Grant

First Name Mary

Last Name Collins

Agency Name Montana Department of Public Health and Human Services

Mailing Address 2007 N Oakes St, Helena, MT 59601

City Helena

Zip Code 59601

Telephone 406-444-9635

Fax 406-444-9389

Email Address mary.collins@mt.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 9/23/2022 6:17:43 PM

Revision Date 1/27/2023 10:11:18 AM

V. Contact Person Responsible for Application Submission

First Name Jami

Last Name Hansen

Telephone 406-444-3055

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Email Address jami.hansen@mt.gov

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2023

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: ______________________

Name of Chief Executive Officer (CEO) or Designee: Charles T. Brereton

Signature of CEO or Designee[1]: ______________________

Title: Director

Date Signed: ______________________

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

SAMHSA
Office of Financial Resources, Division of Grants Management
Center for Substance Abuse Treatment, Division of States and Community Systems
Center for Substance Abuse Prevention, Division of Primary Prevention
Center for Mental Health Services, Division of State and Community Systems Development

Request for No Cost Extension (NCE) for COVID-19 Supplemental Funding

COVID-19 Award Issue Date: 3/11/21 **Approved Expenditure Period:** 3/15/21 through 3/14/23

Instructions: *Current MHBG and SABG grantees may request a No Cost Extension (NCE) for the FY 21 COVID-19 Supplemental Funding Award for an additional expenditure period of up to twelve (12) months, through March 14, 2024. Grantees are required to complete the information below for the proposed use of funds using the NCE, and agree to implement this NCE in accordance with:*

- *the March 11, 2021 Notice of Award (NoA) Terms and Conditions for the MHBG COVID-19 Supplemental Funding or the SABG COVID-19 Supplemental Funding;*
- *the March 11, 2021 COVID-19 Supplemental Funding Guidance Letter to the SSA Directors and the SMHCs from Tom Coderre, then Acting Assistant Secretary for Mental Health and Substance Use; and*
- *the grantee's SAMHSA currently approved MHBG COVID-19 Supplemental Funding Plan, or SABG COVID-19 Supplemental Funding Plan, as previously communicated to the grantee by the CMHS or CSAT State Project Officer.*

Grantees are requested to submit this **Request for No Cost Extension (NCE) for COVID-19 Supplemental Funding** *to their CMHS or CSAT State Project Officer by email as a Word document or PDF file, and to upload this NCE Request as an Attachment in WebBGAS in the FY 23 MHBG Plan, or in the FY 23 SABG Plan. Upon written notification of a grantee's intention to file a NCE Request, the CMHS or CSAT State Project Officer will be requested to create and send the grantee a Revision Request in the FY 23 MHBG Plan or FY 23 SABG Plan in WebBGAS, with instructions for uploading the NCE Request as an Attachment in the FY 23 MHBG Plan or the FY 23 SABG Plan. Separate NCE Requests are required for approval for either a MHBG NCE Request or a SABG NCE Request. Grantees are requested to complete and submit the NCE Request, as instructed above, no later than Friday, September 9, 2022, at 12:00 midnight EST. Further information about this process may be requested from your CMHS, CSAT, or CSAP State Project Officer. Thank you.*

Check One Only (✓): _____Request for NCE for FY 21 **MHBG** COVID-19 Supplemental Funding
✓ Request for NCE for FY 21 **SABG** COVID-19 Supplemental Funding

A. Name of MHBG or SABG Grantee Organization	Montana Department of Public Health & Human Services Behavioral Health & Developmental Disabilities Division		
B. Date of Submission of NCE Request	September 9, 2022	C. Length of Time Requested (in Months) for NCE (12 Mo. Max. through 3/14/24)	Request for 12-month extension through 3/14/24

D. Name and Title of Grantee Finance Official	Natacha Bird Operations Bureau Chief

Approving This NCE Request			
E. Name and Title of Grantee Program Official Approving This NCE Request	Jami Hansen Block Grant Section Supervisor		
F. Name and Title of Other Grantee Official Approving This NCE Request	Mary Collins Prevention Bureau Chief		
G. COVID-19 Award Total $ Amount Issued in NoA of 3/11/2021	$6,530,972	H. COVID-19 Award Total $ Amount Expended as of NCE Request Date Above	$1,074,332
I. COVID-19 Award Total $ Amount Planned to be Expended through 3/14/2023	$2,717,816	J. COVID-19 Award Total $ Amount Requested for NCE	$3,813,156

K. Please provide a brief listing of your grantee actual itemized expenditures for your COVID-19 Supplemental Funding approved projects, activities, and purchases, that have been completed with your current COVID -19 Supplemental Funding, through the date of your submission of your NCE Request.

- Expand primary SUD prevention services to 16 counties and 3 reservations that currently do not have any prevention funding to dedicate 1.0 FTE to coordination of prevention services in the community. These communities will identify whether the 1.0 FTE will be dedicated to: community-based prevention to identify community priorities and develop and implement messaging and outreach activities addressing youth and adult use/misuse of substances; or dedicated to Communities That Care (CTC) prevention efforts by working through the CTC process for advancing youth substance use prevention. The contractors to cover these 31 new sites will be identified through administrative procurement process and will be awarded approximately $100,000 for each county to cover personnel expenses, planning and costs associated with implementing universal and/or targeted evidence-based prevention interventions and utilization of texting and mobile health messaging and web-based interventions for juvenile / criminal justice populations.
    - **Expenditures to date: $392,817**

- Expand funding to the current 28 counties and 5 reservations with dedicated prevention funding to ensure funding will allow for dedicated 1.0 FTE for either prevention specialist or CTC (in communities where there is only a 0.5 FTE) and add additional intervention funds to implement messaging and outreach activities utilizing texting and mobile health messaging and web-based interventions for juvenile/criminal justice populations. The current counties receive $56,000 for current services; an additional $44,000 per county will be provided to cover the recommended services under this supplemental funding.
    - **Expenditures to date: $130,939**

- Expand funding to the existing Regional Technical Assistance Leaders who provide technical assistance to the prevention specialists to include funding for an additional

1.0 FTE to develop and implement a statewide communication plan that aligns with the messaging and outreach activities. This plan will be developed in collaboration with AMDD and will be based on effective messaging as developed by SAMHSA or Mountain Plains Prevention Technology Center.

  - **Expenditures to date: $164,386**

- Implement statewide implementation and evaluation of risk messaging campaign, as developed and disseminated in communities, to monitor reach and efficacy of risk messaging campaign. A contract will be awarded by the administrative procurement process for developing mobile health messaging, media dissemination, and evaluation of the media campaign and mobile health outreach.
  - **Expenditures to date: $51,155**

- Implement screening and brief intervention for early substance use/misuse for youth and adults within primary care, hospital, public health or other healthcare settings. This project will include training on validated and recommended screening tools, training on conducting an effective brief intervention based on motivational interviewing, identifying community resources for potential referral needs, as well as identifying system development and technical workflow needs, electronic medical record systems for tracking, outcomes and referral to community resources. This will work in tandem with the screening and brief intervention training provided under the MHBG COVID-19 Planning grant to ensure the healthcare providers are able to successfully implement screening and referral workflows that currently face system barriers and prevent full implementation. A contract will be awarded through administrative procurement process to an entity with experience conducting healthcare training as well as quality improvement processes to support effective implementation and $17utilization of SBIRT.
  - **Expenditures to date: $0**

- Increase the number of schools implementing PAX Good Behavior Game or similar school-based/family-oriented evidence-based strategies that promote enhanced social-emotional behaviors and self-regulation that have a direct impact on preventing substance use and other behavioral health risks. The training will be targeted for school leaders, paraprofessionals, school counselors, and parents/grandparents/guardians on how to build resiliency skills among MT youth.
  - **Expenditures to date: $255,292**

- Expand access to Peer-led Recovery Supported Communities by funding four Drop-In Centers in areas that currently have limited resources and demonstrated need for behavioral health services. The Drop-In Centers are a safe place for individuals to gather with peers and engage in activities that support recovery and behavioral health. Montana currently has seven Drop In Centers, four of which are in the larger urban communities (Missoula, Billings) and three are in smaller rural communities. The additional four Drop-In Centers will be located in Northeast, Northwest, Central, Eastern MT and South-Central MT. Each Drop-In Center will be operated by peers and will funded to cover personnel services and low-cost activities that support recovery and social connectedness at $100,000 per site.
  - **Expenditures to date: $40,303**

- Montana's Addictive and Mental Disorders Division (AMDD) in the Montana Department of Public Health and Human Services (DPHHS) has been partnering with key stakeholders and local communities in our state to plan for and pilot regional crisis receiving and stabilization facilities that align with SAMHSA's National Guidelines for Behavioral Health Crisis Care. With the COVID Supplemental funds, the project can expand to include start-up funding for regional crisis receiving and stabilization facilities that will each serve a multi-county region inclusive of rural and frontier communities. The facilities will provide regions with alternatives to jails, emergency rooms, and the Montana State Hospital by providing 24/7/365 crisis care, accepting all referrals, and fulfilling the role of a designated drop-off location for first responders, law enforcement and mobile crisis response teams. Historically, Montana's crisis system solely served those with a mental health need. This project will assist with planning for needs and providing crisis care for persons with a substance use disorder.
    - **Expenditures to date: $0**

- MT is initiating a NARR Affiliate under the SOR grant this spring and will award a non-profit a contract through the administrative bid process to establish the affiliate and provide technical assistance to recovery residences in MT to become a member of the affiliate and implement the NARR standards. The SABG Coronavirus Supplemental funds will provide funding to the NARR affiliate member recovery residences to support the initial housing expenses, until the homes can secure sustainable funding.
    - **Expenditures to date: $0**

- Administration
    - **Expenditures to date: $39,440**

L. Please provide a brief listing of your grantee estimated itemized expenditures for your COVID-19 Supplemental Funding approved projects, activities, and purchases, that are planned to be completed with your current COVID -19 Supplemental Funding, from the date of this Request through the end of the current expenditure period of March 14, 2023.

- Expand primary SUD prevention services to 16 counties and 3 reservations that currently do not have any prevention funding to dedicate 1.0 FTE to coordination of prevention services in the community. These communities will identify whether the 1.0 FTE will be dedicated to: community-based prevention to identify community priorities and develop and implement messaging and outreach activities addressing youth and adult use/misuse of substances; or dedicated to Communities That Care (CTC) prevention efforts by working through the CTC process for advancing youth substance use prevention. The contractors to cover these 31 new sites will be identified through administrative procurement process and will be awarded approximately $100,000 for each county to cover personnel expenses, planning and costs associated with implementing universal and/or targeted evidence-based prevention interventions and utilization of texting and mobile health messaging and web-based interventions for juvenile / criminal justice populations.
    - **Projected expenditures through 3/14/23: $350,000**

- Expand funding to the current 28 counties and 5 reservations with dedicated prevention funding to ensure funding will allow for dedicated 1.0 FTE for either prevention specialist or CTC (in communities where there is only a 0.5 FTE) and add additional intervention funds to implement messaging and outreach activities utilizing texting and

mobile health messaging and web-based interventions for juvenile/criminal justice populations. The current counties receive $56,000 for current services; an additional $44,000 per county will be provided to cover the recommended services under this supplemental funding.

  - **Projected expenditures through 3/14/23: $200,000**

- Expand funding to the existing Regional Technical Assistance Leaders who provide technical assistance to the prevention specialists to include funding for an additional 1.0 FTE to develop and implement a statewide communication plan that aligns with the messaging and outreach activities. This plan will be developed in collaboration with AMDD and will be based on effective messaging as developed by SAMHSA or Mountain Plains Prevention Technology Center.
  - **Projected expenditures through 3/14/23: $150,000**

- Implement statewide implementation and evaluation of risk messaging campaign, as developed and disseminated in communities, to monitor reach and efficacy of risk messaging campaign. A contract will be awarded by the administrative procurement process for developing mobile health messaging, media dissemination, and evaluation of the media campaign and mobile health outreach.
  - **Projected expenditures through 3/14/23: $200,000**

- Implement screening and brief intervention for early substance use/misuse for youth and adults within primary care, hospital, public health or other healthcare settings. This project will include training on validated and recommended screening tools, training on conducting an effective brief intervention based on motivational interviewing, identifying community resources for potential referral needs, as well as identifying system development and technical workflow needs, electronic medical record systems for tracking, outcomes and referral to community resources. This will work in tandem with the screening and brief intervention training provided under the MHBG COVID-19 Planning grant to ensure the healthcare providers are able to successfully implement screening and referral workflows that currently face system barriers and prevent full implementation. A contract will be awarded through administrative procurement process to an entity with experience conducting healthcare training as well as quality improvement processes to support effective implementation and utilization of SBIRT.
  - **Projected expenditures through 3/14/23: $0**

- Increase the number of schools implementing PAX Good Behavior Game or similar school-based/family-oriented evidence-based strategies that promote enhanced social-emotional behaviors and self-regulation that have a direct impact on preventing substance use and other behavioral health risks. The training will be targeted for school leaders, paraprofessionals, school counselors, and parents/grandparents/guardians on how to build resiliency skills among MT youth.
  - **Projected expenditures through 3/14/23: $300,000**

- Expand access to Peer-led Recovery Supported Communities by funding four Drop-In Centers in areas that currently have limited resources and demonstrated need for behavioral health services. The Drop-In Centers are a safe place for individuals to gather with peers and engage in activities that support recovery and behavioral health. Montana currently has seven Drop In Centers, four of which are in the larger urban

communities (Missoula, Billings) and three are in smaller rural communities. The additional four Drop-In Centers will be located in Northeast, Northwest, Central, Eastern MT and South-Central MT. Each Drop-In Center will be operated by peers and will funded to cover personnel services and low-cost activities that support recovery and social connectedness at $100,000 per site.

   - **Projected expenditures through 3/14/23: $200,000**

- Montana's Addictive and Mental Disorders Division (AMDD) in the Montana Department of Public Health and Human Services (DPHHS) has been partnering with key stakeholders and local communities in our state to plan for and pilot regional crisis receiving and stabilization facilities that align with SAMHSA's National Guidelines for Behavioral Health Crisis Care. With the COVID Supplemental funds, the project can expand to include start-up funding for regional crisis receiving and stabilization facilities that will each serve a multi-county region inclusive of rural and frontier communities. The facilities will provide regions with alternatives to jails, emergency rooms, and the Montana State Hospital by providing 24/7/365 crisis care, accepting all referrals, and fulfilling the role of a designated drop-off location for first responders, law enforcement and mobile crisis response teams. Historically, Montana's crisis system solely served those with a mental health need. This project will assist with planning for needs and providing crisis care for persons with a substance use disorder.
   - **Projected expenditures through 3/14/23: $0**

- MT is initiating a NARR Affiliate under the SOR grant this spring and will award a non-profit a contract through the administrative bid process to establish the affiliate and provide technical assistance to recovery residences in MT to become a member of the affiliate and implement the NARR standards. The SABG Coronavirus Supplemental funds will provide funding to the NARR affiliate member recovery residences to support the initial housing expenses, until the homes can secure sustainable funding.
   - **Projected expenditures through 3/14/23: $200,000**

- Administration
   - **Projected expenditures through 3/14/23: $33,000**

M. Please provide a brief summary of the challenges that your program has experienced in fully expending the current COVID-19 Supplemental Funding by March 14, 2023, and what steps the grantee will be implementing to ensure that approved NCE COVID-19 Supplemental Funding will be fully expended by the end of the NCE period of expenditure requested above.

Although the contract was awarded for the project period of 3/15/21 to 3/14/23, funding for projects did not occur as expected. Staffing changes and shortages at both the state and local level have affected the Department's ability to develop and issue Requests for Proposals and finalize contracts for new programs. As the COVID-19 pandemic has begun to subside, we have increased our internal capacity and community-based providers are more willing to take on new projects and programs.

N. Please provide a brief listing of your grantee <u>planned itemized expenditures</u> for your COVID-19 Supplemental Funding approved projects, activities, and purchases, that are <u>requested to be supported</u> with the No Cost Extension for the COVID-19 Supplemental Funding amount that is identified above, for the NCE expenditure period that is identified above. All planned expenditures that are requested to be supported in an approved NCE must be fully within the current scope of the

grantee's SAMHSA currently approved MHBG COVID-19 Supplemental Funding Plan or currently approved SABG COVID-19 Supplemental Funding Plan.

- Expand primary SUD prevention services to 16 counties and 3 reservations that currently do not have any prevention funding to dedicate 1.0 FTE to coordination of prevention services in the community. These communities will identify whether the 1.0 FTE will be dedicated to: community-based prevention to identify community priorities and develop and implement messaging and outreach activities addressing youth and adult use/misuse of substances; or dedicated to Communities That Care (CTC) prevention efforts by working through the CTC process for advancing youth substance use prevention. The contractors to cover these 31 new sites will be identified through administrative procurement process and will be awarded approximately $100,000 for each county to cover personnel expenses, planning and costs associated with implementing universal and/or targeted evidence-based prevention interventions and utilization of texting and mobile health messaging and web-based interventions for juvenile / criminal justice populations.
  - **Projected expenditures through 3/14/24: $1,157,183**

- Expand funding to the current 28 counties and 5 reservations with dedicated prevention funding to ensure funding will allow for dedicated 1.0 FTE for either prevention specialist or CTC (in communities where there is only a 0.5 FTE) and add additional intervention funds to implement messaging and outreach activities utilizing texting and mobile health messaging and web-based interventions for juvenile/criminal justice populations. The current counties receive $56,000 for current services; an additional $44,000 per county will be provided to cover the recommended services under this supplemental funding.
  - **Projected expenditures through 3/14/24: $1,121,061**

- Expand funding to the existing Regional Technical Assistance Leaders who provide technical assistance to the prevention specialists to include funding for an additional 1.0 FTE to develop and implement a statewide communication plan that aligns with the messaging and outreach activities. This plan will be developed in collaboration with AMDD and will be based on effective messaging as developed by SAMHSA or Mountain Plains Prevention Technology Center.
  - **Projected expenditures through 3/14/24: $110,484**

- Implement statewide implementation and evaluation of risk messaging campaign, as developed and disseminated in communities, to monitor reach and efficacy of risk messaging campaign. A contract will be awarded by the administrative procurement process for developing mobile health messaging, media dissemination, and evaluation of the media campaign and mobile health outreach.
  - **Projected expenditures through 3/14/24: $98,845**

- Implement screening and brief intervention for early substance use/misuse for youth and adults within primary care, hospital, public health or other healthcare settings. This project will include training on validated and recommended screening tools, training on conducting an effective brief intervention based on motivational interviewing, identifying community resources for potential referral needs, as well as identifying system development and technical workflow needs, electronic medical record systems

for tracking, outcomes and referral to community resources. This will work in tandem with the screening and brief intervention training provided under the MHBG COVID-19 Planning grant to ensure the healthcare providers are able to successfully implement screening and referral workflows that currently face system barriers and prevent full implementation. A contract will be awarded through administrative procurement process to an entity with experience conducting healthcare training as well as quality improvement processes to support effective implementation and utilization of SBIRT.

  - **Projected expenditures through 3/14/24: $250,000**

- Increase the number of schools implementing PAX Good Behavior Game or similar school-based/family-oriented evidence-based strategies that promote enhanced social-emotional behaviors and self-regulation that have a direct impact on preventing substance use and other behavioral health risks. The training will be targeted for school leaders, paraprofessionals, school counselors, and parents/grandparents/guardians on how to build resiliency skills among MT youth.
  - **Projected expenditures through 3/14/24: $444,708**

- Expand access to Peer-led Recovery Supported Communities by funding four Drop-In Centers in areas that currently have limited resources and demonstrated need for behavioral health services. The Drop-In Centers are a safe place for individuals to gather with peers and engage in activities that support recovery and behavioral health. Montana currently has seven Drop In Centers, four of which are in the larger urban communities (Missoula, Billings) and three are in smaller rural communities. The additional four Drop-In Centers will be located in Northeast, Northwest, Central, Eastern MT and South-Central MT. Each Drop-In Center will be operated by peers and will funded to cover personnel services and low-cost activities that support recovery and social connectedness at $100,000 per site.
  - **Projected expenditures through 3/14/24: $159,697**

- Montana's Addictive and Mental Disorders Division (AMDD) in the Montana Department of Public Health and Human Services (DPHHS) has been partnering with key stakeholders and local communities in our state to plan for and pilot regional crisis receiving and stabilization facilities that align with SAMHSA's National Guidelines for Behavioral Health Crisis Care. With the COVID Supplemental funds, the project can expand to include start-up funding for regional crisis receiving and stabilization facilities that will each serve a multi-county region inclusive of rural and frontier communities. The facilities will provide regions with alternatives to jails, emergency rooms, and the Montana State Hospital by providing 24/7/365 crisis care, accepting all referrals, and fulfilling the role of a designated drop-off location for first responders, law enforcement and mobile crisis response teams. Historically, Montana's crisis system solely served those with a mental health need. This project will assist with planning for needs and providing crisis care for persons with a substance use disorder.
  - **Projected expenditures through 3/14/24: $200,000**

- MT is initiating a NARR Affiliate under the SOR grant this spring and will award a non-profit a contract through the administrative bid process to establish the affiliate and provide technical assistance to recovery residences in MT to become a member of the affiliate and implement the NARR standards. The SABG Coronavirus Supplemental funds will provide funding to the NARR affiliate member recovery residences to support the initial housing expenses, until the homes can secure sustainable funding.

- **Projected expenditures through 3/14/24: $27,553**

- Administration
  - **Projected expenditures through 3/14/24: $254,109**

O. Please provide any other relevant information about the current use of this COVID-19 Supplemental Funding, with actual itemized expenditures, and/or the proposed use of this COVID-19 Supplemental Funding, with estimated itemized expenditures, through a SAMHSA approved NCE for projects, activities, and purchases approved for expenditure under this funding.

End of NCE Request. Thank you.

SAMHSA
Office of Financial Resources, Division of Grants Management
Center for Substance Abuse Treatment, Division of States and Community Systems
Center for Substance Abuse Prevention, Division of Primary Prevention
Center for Mental Health Services, Division of State and Community Systems Development

Request for No Cost Extension (NCE) for COVID-19 Supplemental Funding

COVID-19 Award Issue Date: 3/11/21 **Approved Expenditure Period:** 3/15/21 through 3/14/23

Instructions: *Current MHBG and SABG grantees may request a No Cost Extension (NCE) for the FY 21 COVID-19 Supplemental Funding Award for an additional expenditure period of up to twelve (12) months, through March 14, 2024. Grantees are required to complete the information below for the proposed use of funds using the NCE, and agree to implement this NCE in accordance with:*

- *the March 11, 2021 Notice of Award (NoA) Terms and Conditions for the MHBG COVID-19 Supplemental Funding or the SABG COVID-19 Supplemental Funding;*
- *the March 11, 2021 COVID-19 Supplemental Funding Guidance Letter to the SSA Directors and the SMHCs from Tom Coderre, then Acting Assistant Secretary for Mental Health and Substance Use; and*
- *the grantee's SAMHSA currently approved MHBG COVID-19 Supplemental Funding Plan, or SABG COVID-19 Supplemental Funding Plan, as previously communicated to the grantee by the CMHS or CSAT State Project Officer.*

Grantees are requested to submit this **Request for No Cost Extension (NCE) for COVID-19 Supplemental Funding** *to their CMHS or CSAT State Project Officer by email as a Word document or PDF file, and to upload this NCE Request as an Attachment in WebBGAS in the FY 23 MHBG Plan, or in the FY 23 SABG Plan. Upon written notification of a grantee's intention to file a NCE Request, the CMHS or CSAT State Project Officer will be requested to create and send the grantee a Revision Request in the FY 23 MHBG Plan or FY 23 SABG Plan in WebBGAS, with instructions for uploading the NCE Request as an Attachment in the FY 23 MHBG Plan or the FY 23 SABG Plan. Separate NCE Requests are required for approval for either a MHBG NCE Request or a SABG NCE Request. Grantees are requested to complete and submit the NCE Request, as instructed above, no later than Friday, September 9, 2022, at 12:00 midnight EST. Further information about this process may be requested from your CMHS, CSAT, or CSAP State Project Officer. Thank you.*

Check One Only (✓): _____Request for NCE for FY 21 **MHBG** COVID-19 Supplemental Funding
✓ Request for NCE for FY 21 **SABG** COVID-19 Supplemental Funding

<table>
<tr><td>A. Name of MHBG or SABG Grantee Organization</td><td colspan="3">Montana
Department of Public Health & Human Services
Behavioral Health & Developmental Disabilities Division</td></tr>
<tr><td>B. Date of Submission of NCE Request</td><td>September 9, 2022</td><td>C. Length of Time Requested (in Months) for NCE (12 Mo. Max. through 3/14/24)</td><td>Request for 12-month extension through 3/14/24</td></tr>
</table>

D. Name and Title of Grantee Finance Official	Natacha Bird Operations Bureau Chief

Approving This NCE Request			
E. Name and Title of Grantee Program Official Approving This NCE Request	Jami Hansen Block Grant Section Supervisor		
F. Name and Title of Other Grantee Official Approving This NCE Request	Mary Collins Prevention Bureau Chief		
G. COVID-19 Award Total $ Amount Issued in NoA of 3/11/2021	$6,530,972	H. COVID-19 Award Total $ Amount Expended as of NCE Request Date Above	$1,074,332
I. COVID-19 Award Total $ Amount Planned to be Expended through 3/14/2023	$2,717,816	J. COVID-19 Award Total $ Amount Requested for NCE	$3,813,156

K. Please provide a brief listing of your grantee actual itemized expenditures for your COVID-19 Supplemental Funding approved projects, activities, and purchases, that have been completed with your current COVID -19 Supplemental Funding, through the date of your submission of your NCE Request.

- Expand primary SUD prevention services to 16 counties and 3 reservations that currently do not have any prevention funding to dedicate 1.0 FTE to coordination of prevention services in the community. These communities will identify whether the 1.0 FTE will be dedicated to: community-based prevention to identify community priorities and develop and implement messaging and outreach activities addressing youth and adult use/misuse of substances; or dedicated to Communities That Care (CTC) prevention efforts by working through the CTC process for advancing youth substance use prevention. The contractors to cover these 31 new sites will be identified through administrative procurement process and will be awarded approximately $100,000 for each county to cover personnel expenses, planning and costs associated with implementing universal and/or targeted evidence-based prevention interventions and utilization of texting and mobile health messaging and web-based interventions for juvenile / criminal justice populations.
    - **Expenditures to date: $392,817**

- Expand funding to the current 28 counties and 5 reservations with dedicated prevention funding to ensure funding will allow for dedicated 1.0 FTE for either prevention specialist or CTC (in communities where there is only a 0.5 FTE) and add additional intervention funds to implement messaging and outreach activities utilizing texting and mobile health messaging and web-based interventions for juvenile/criminal justice populations. The current counties receive $56,000 for current services; an additional $44,000 per county will be provided to cover the recommended services under this supplemental funding.
    - **Expenditures to date: $130,939**

- Expand funding to the existing Regional Technical Assistance Leaders who provide technical assistance to the prevention specialists to include funding for an additional

1.0 FTE to develop and implement a statewide communication plan that aligns with the messaging and outreach activities. This plan will be developed in collaboration with AMDD and will be based on effective messaging as developed by SAMHSA or Mountain Plains Prevention Technology Center.
    - **Expenditures to date: $164,386**

- Implement statewide implementation and evaluation of risk messaging campaign, as developed and disseminated in communities, to monitor reach and efficacy of risk messaging campaign. A contract will be awarded by the administrative procurement process for developing mobile health messaging, media dissemination, and evaluation of the media campaign and mobile health outreach.
    - **Expenditures to date: $51,155**

- Increase the number of schools implementing PAX Good Behavior Game or similar school-based/family-oriented evidence-based strategies that promote enhanced social-emotional behaviors and self-regulation that have a direct impact on preventing substance use and other behavioral health risks. The training will be targeted for school leaders, paraprofessionals, school counselors, and parents/grandparents/guardians on how to build resiliency skills among MT youth.
    - **Expenditures to date: $255,292**

- Expand access to Peer-led Recovery Supported Communities by funding four Drop-In Centers in areas that currently have limited resources and demonstrated need for behavioral health services. The Drop-In Centers are a safe place for individuals to gather with peers and engage in activities that support recovery and behavioral health. Montana currently has seven Drop In Centers, four of which are in the larger urban communities (Missoula, Billings) and three are in smaller rural communities. The additional four Drop-In Centers will be located in Northeast, Northwest, Central, Eastern MT and South-Central MT. Each Drop-In Center will be operated by peers and will funded to cover personnel services and low-cost activities that support recovery and social connectedness at $100,000 per site.
    - **Expenditures to date: $40,303**

- Administration
    - **Expenditures to date: $39,440**

L. Please provide a brief listing of your grantee estimated itemized expenditures for your COVID-19 Supplemental Funding approved projects, activities, and purchases, that are planned to be completed with your current COVID -19 Supplemental Funding, from the date of this Request through the end of the current expenditure period of March 14, 2023.

- Expand primary SUD prevention services to 16 counties and 3 reservations that currently do not have any prevention funding to dedicate 1.0 FTE to coordination of prevention services in the community. These communities will identify whether the 1.0 FTE will be dedicated to: community-based prevention to identify community priorities and develop and implement messaging and outreach activities addressing youth and adult use/misuse of substances; or dedicated to Communities That Care (CTC) prevention efforts by working through the CTC process for advancing youth substance use prevention. The contractors to cover these 31 new sites will be identified through administrative procurement process and will be awarded approximately

$100,000 for each county to cover personnel expenses, planning and costs associated with implementing universal and/or targeted evidence-based prevention interventions and utilization of texting and mobile health messaging and web-based interventions for juvenile / criminal justice populations.
  - **Projected expenditures through 3/14/23: $350,000**

- Expand funding to the current 28 counties and 5 reservations with dedicated prevention funding to ensure funding will allow for dedicated 1.0 FTE for either prevention specialist or CTC (in communities where there is only a 0.5 FTE) and add additional intervention funds to implement messaging and outreach activities utilizing texting and mobile health messaging and web-based interventions for juvenile/criminal justice populations. The current counties receive $56,000 for current services; an additional $44,000 per county will be provided to cover the recommended services under this supplemental funding.
  - **Projected expenditures through 3/14/23: $200,000**

- Expand funding to the existing Regional Technical Assistance Leaders who provide technical assistance to the prevention specialists to include funding for an additional 1.0 FTE to develop and implement a statewide communication plan that aligns with the messaging and outreach activities. This plan will be developed in collaboration with AMDD and will be based on effective messaging as developed by SAMHSA or Mountain Plains Prevention Technology Center.
  - **Projected expenditures through 3/14/23: $150,000**

- Implement statewide implementation and evaluation of risk messaging campaign, as developed and disseminated in communities, to monitor reach and efficacy of risk messaging campaign. A contract will be awarded by the administrative procurement process for developing mobile health messaging, media dissemination, and evaluation of the media campaign and mobile health outreach.
  - **Projected expenditures through 3/14/23: $200,000**

- Increase the number of schools implementing PAX Good Behavior Game or similar school-based/family-oriented evidence-based strategies that promote enhanced social-emotional behaviors and self-regulation that have a direct impact on preventing substance use and other behavioral health risks. The training will be targeted for school leaders, paraprofessionals, school counselors, and parents/grandparents/guardians on how to build resiliency skills among MT youth.
  - **Projected expenditures through 3/14/23: $300,000**

- Expand access to Peer-led Recovery Supported Communities by funding four Drop-In Centers in areas that currently have limited resources and demonstrated need for behavioral health services. The Drop-In Centers are a safe place for individuals to gather with peers and engage in activities that support recovery and behavioral health. Montana currently has seven Drop In Centers, four of which are in the larger urban communities (Missoula, Billings) and three are in smaller rural communities. The additional four Drop-In Centers will be located in Northeast, Northwest, Central, Eastern MT and South-Central MT. Each Drop-In Center will be operated by peers and will funded to cover personnel services and low-cost activities that support recovery and social connectedness at $100,000 per site.

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- MT is initiating a NARR Affiliate under the SOR grant this spring and will award a non-profit a contract through the administrative bid process to establish the affiliate and provide technical assistance to recovery residences in MT to become a member of the affiliate and implement the NARR standards. The SABG Coronavirus Supplemental funds will provide funding to the NARR affiliate member recovery residences to support the initial housing expenses, until the homes can secure sustainable funding.
  - **Projected expenditures through 3/14/23: $200,000**

- Administration
  - **Projected expenditures through 3/14/23: $33,000**

M. Please provide a brief summary of the challenges that your program has experienced in fully expending the current COVID-19 Supplemental Funding by March 14, 2023, and what steps the grantee will be implementing to ensure that approved NCE COVID-19 Supplemental Funding will be fully expended by the end of the NCE period of expenditure requested above.

Although the contract was awarded for the project period of 3/15/21 to 3/14/23, funding for projects did not occur as expected. Staffing changes and shortages at both the state and local level have affected the Department's ability to develop and issue Requests for Proposals and finalize contracts for new programs. As the COVID-19 pandemic has begun to subside, we have increased our internal capacity and community-based providers are more willing to take on new projects and programs.

N. Please provide a brief listing of your grantee planned itemized expenditures for your COVID-19 Supplemental Funding approved projects, activities, and purchases, that are requested to be supported with the No Cost Extension for the COVID-19 Supplemental Funding amount that is identified above, for the NCE expenditure period that is identified above. All planned expenditures that are requested to be supported in an approved NCE must be fully within the current scope of the grantee's SAMHSA currently approved MHBG COVID-19 Supplemental Funding Plan or currently approved SABG COVID-19 Supplemental Funding Plan.

- Expand primary SUD prevention services to 16 counties and 3 reservations that currently do not have any prevention funding to dedicate 1.0 FTE to coordination of prevention services in the community. These communities will identify whether the 1.0 FTE will be dedicated to: community-based prevention to identify community priorities and develop and implement messaging and outreach activities addressing youth and adult use/misuse of substances; or dedicated to Communities That Care (CTC) prevention efforts by working through the CTC process for advancing youth substance use prevention. The contractors to cover these 31 new sites will be identified through administrative procurement process and will be awarded approximately $100,000 for each county to cover personnel expenses, planning and costs associated with implementing universal and/or targeted evidence-based prevention interventions and utilization of texting and mobile health messaging and web-based interventions for juvenile / criminal justice populations.
  - **Projected expenditures through 3/14/24: $1,157,183**

- Expand funding to the current 28 counties and 5 reservations with dedicated prevention funding to ensure funding will allow for dedicated 1.0 FTE for either prevention specialist or CTC (in communities where there is only a 0.5 FTE) and add additional

intervention funds to implement messaging and outreach activities utilizing texting and mobile health messaging and web-based interventions for juvenile/criminal justice populations. The current counties receive $56,000 for current services; an additional $44,000 per county will be provided to cover the recommended services under this supplemental funding.
  - **Projected expenditures through 3/14/24: $1,121,061**

- Expand funding to the existing Regional Technical Assistance Leaders who provide technical assistance to the prevention specialists to include funding for an additional 1.0 FTE to develop and implement a statewide communication plan that aligns with the messaging and outreach activities. This plan will be developed in collaboration with AMDD and will be based on effective messaging as developed by SAMHSA or Mountain Plains Prevention Technology Center.
  - **Projected expenditures through 3/14/24: $110,484**

- Implement statewide implementation and evaluation of risk messaging campaign, as developed and disseminated in communities, to monitor reach and efficacy of risk messaging campaign. A contract will be awarded by the administrative procurement process for developing mobile health messaging, media dissemination, and evaluation of the media campaign and mobile health outreach.
  - **Projected expenditures through 3/14/24: $98,845**

- Implement screening and brief intervention for early substance use/misuse for youth and adults within primary care, hospital, public health or other healthcare settings. This project will include training on validated and recommended screening tools, training on conducting an effective brief intervention based on motivational interviewing, identifying community resources for potential referral needs, as well as identifying system development and technical workflow needs, electronic medical record systems for tracking, outcomes and referral to community resources. This will work in tandem with the screening and brief intervention training provided under the MHBG COVID-19 Planning grant to ensure the healthcare providers are able to successfully implement screening and referral workflows that currently face system barriers and prevent full implementation. A contract will be awarded through administrative procurement process to an entity with experience conducting healthcare training as well as quality improvement processes to support effective implementation and utilization of SBIRT.
  - **Projected expenditures through 3/14/24: $250,000**

- Increase the number of schools implementing PAX Good Behavior Game or similar school-based/family-oriented evidence-based strategies that promote enhanced social-emotional behaviors and self-regulation that have a direct impact on preventing substance use and other behavioral health risks. The training will be targeted for school leaders, paraprofessionals, school counselors, and parents/grandparents/guardians on how to build resiliency skills among MT youth.
  - **Projected expenditures through 3/14/24: $444,708**

- Expand access to Peer-led Recovery Supported Communities by funding four Drop-In Centers in areas that currently have limited resources and demonstrated need for behavioral health services. The Drop-In Centers are a safe place for individuals to gather with peers and engage in activities that support recovery and behavioral health.

Montana currently has seven Drop In Centers, four of which are in the larger urban communities (Missoula, Billings) and three are in smaller rural communities. The additional four Drop-In Centers will be located in Northeast, Northwest, Central, Eastern MT and South-Central MT. Each Drop-In Center will be operated by peers and will funded to cover personnel services and low-cost activities that support recovery and social connectedness at $100,000 per site.

  - **Projected expenditures through 3/14/24: $159,697**

- Montana's Addictive and Mental Disorders Division (AMDD) in the Montana Department of Public Health and Human Services (DPHHS) has been partnering with key stakeholders and local communities in our state to plan for and pilot regional crisis receiving and stabilization facilities that align with SAMHSA's National Guidelines for Behavioral Health Crisis Care. With the COVID Supplemental funds, the project can expand to include start-up funding for regional crisis receiving and stabilization facilities that will each serve a multi-county region inclusive of rural and frontier communities. The facilities will provide regions with alternatives to jails, emergency rooms, and the Montana State Hospital by providing 24/7/365 crisis care, accepting all referrals, and fulfilling the role of a designated drop-off location for first responders, law enforcement and mobile crisis response teams. Historically, Montana's crisis system solely served those with a mental health need. This project will assist with planning for needs and providing crisis care for persons with a substance use disorder.
  - **Projected expenditures through 3/14/24: $200,000**

- MT is initiating a NARR Affiliate under the SOR grant this spring and will award a non-profit a contract through the administrative bid process to establish the affiliate and provide technical assistance to recovery residences in MT to become a member of the affiliate and implement the NARR standards. The SABG Coronavirus Supplemental funds will provide funding to the NARR affiliate member recovery residences to support the initial housing expenses, until the homes can secure sustainable funding.
  - **Projected expenditures through 3/14/24: $27,553**

- Administration
  - **Projected expenditures through 3/14/24: $254,109**

O. Please provide any other relevant information about the current use of this COVID-19 Supplemental Funding, with actual itemized expenditures, and/or the proposed use of this COVID-19 Supplemental Funding, with estimated itemized expenditures, through a SAMHSA approved NCE for projects, activities, and purchases approved for expenditure under this funding.

End of NCE Request. Thank you.

OFFICE OF THE GOVERNOR
STATE OF MONTANA

GREG GIANFORTE
GOVERNOR

KRISTEN JURAS
LT. GOVERNOR

August 10, 2022

Ms. Odessa Crocker
Grants Management Officer
Division of Grants Management
5600 Fishers Ln
Rockville, MD 20857

Re: Funding Agreement for Certification and Assurances SABG.

Dear Ms. Crocker,

As the Governor of the State of Montana, for the duration of my tenure, I delegate authority to the current Director of the Department of Public Health and Human Services, Charles T. Brereton, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG).

Sincerely,

Greg Gianforte
Governor

STATE CAPITOL • P.O. BOX 200801 • HELENA, MONTANA 59620-0801
TELEPHONE: 406-444-3111 • FAX: 406-444-5529 • WEBSITE: WWW.MT.GOV

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name

Mary Collins

Title

Prevention Bureau Chief

Organization

State of Montana - Behavioral Health & Developmental Disabilities Division

Signature: Date:

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Mary Collins

Title

Prevention Bureau Chief

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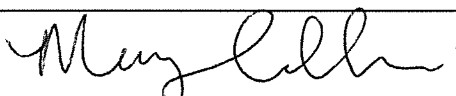
State of Montana - Behavioral Health & Developmental Disabilities Division

Signature:  Date: 8/10/2022

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

States must project how they will use SABG funds to provide authorized services as required by the SABG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2022 and FFY 2023 SABG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2022 Planning Period End Date: 9/30/2023

	FFY 2022			FFY 2023		
Expenditure Category	**FFY 2022 SA Block Grant Award**	**COVID-19 Award[1]**	**ARP Award[2]**	**FFY 2023 SA Block Grant Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[5]	$4,230,462.00	$1,427,423.00	$633,366.00	$4,365,462.00	$1,427,423.00	$0.00
2 . Primary Substance Use Disorder Prevention	$2,576,411.00	$2,351,817.00		$2,576,411.00	$2,351,817.00	$0.00
3 . Tuberculosis Services	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4 . Early Intervention Services for HIV[6]	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
5 . Administration (SSA Level Only)	$348,423.00	$326,549.00	$282,019.00	$348,423.00	$326,549.00	$0.00
6. Total	**$7,155,296.00**	**$4,105,789.00**	**$915,385.00**	**$7,290,296.00**	**$4,105,789.00**	**$0.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental

expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[3]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[4]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022- September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[5]Prevention other than Primary Prevention

[6]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

With the potential to receive the No Cost Extension, we will be using all CRRSAA funding for fy2023..

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2022 Planning Period End Date: 9/30/2023

	A	B			B		
Strategy	IOM Target	FFY 2022			FFY 2023		
		SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]	SA Block Grant Award	COVID-19 Award[4]	ARP Award[5]
1. Information Dissemination	Universal	$440,575	$469,341	$0	$440,575	$469,341	$0
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$440,575**	**$469,341**	**$0**	**$440,575**	**$469,341**	**$0**
2. Education	Universal	$110,618	$592,733	$0	$110,618	$592,733	$0
	Selected	$2,105	$1,765	$0	$2,105	$1,765	$0
	Indicated	$4,832	$4,051	$0	$4,832	$4,051	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$117,555**	**$598,549**	**$0**	**$117,555**	**$598,549**	**$0**
3. Alternatives	Universal	$180,544	$151,353	$0	$180,544	$151,353	$0
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$20,018	$16,782	$0	$20,018	$16,782	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$200,562**	**$168,135**	**$0**	**$200,562**	**$168,135**	**$0**
4. Problem Identification and Referral	Universal	$14,565	$12,210	$0	$14,565	$12,210	$0
	Selected	$20,847	$17,476	$0	$20,847	$17,476	$0
	Indicated	$33,997	$28,500	$0	$33,997	$28,500	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$69,409**	**$58,186**	**$0**	**$69,409**	**$58,186**	**$0**
	Universal	$819,252	$759,254	$0	$819,252	$759,254	$0

5. Community-Based Processes	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$819,252**	**$759,254**	**$0**	**$819,252**	**$759,254**	**$0**
6. Environmental	Universal	$93,465	$78,353	$0	$93,465	$78,353	$0
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$93,465**	**$78,353**	**$0**	**$93,465**	**$78,353**	**$0**
7. Section 1926 Tobacco	Universal	$236,266	$0	$0	$236,266	$0	$0
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$236,266**	**$0**	**$0**	**$236,266**	**$0**	**$0**
8. Other	Universal	$0	$0	$0	$0	$0	$0
	Selected	$0	$0	$0	$0	$0	$0
	Indicated	$0	$0	$0	$0	$0	$0
	Unspecified	$0	$0	$0	$0	$0	$0
	Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$1,977,084**	**$2,131,818**		**$1,977,084**	**$2,131,818**	**$0**
Total SABG Award[3]		**$7,155,296**	**$4,105,789**	**$915,385**	**$7,290,296**	**$4,105,789**	**$0**
Planned Primary Prevention Percentage		**27.63 %**	**51.92 %**	**0.00 %**	**27.12 %**	**51.92 %**	

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

[4]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[5]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

We are planning to receive a No Cost Extension, therefore, we will use the CRRSAA funding for fiscal year 2023..

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2022 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	FFY 2022 COVID-19 Award[1]	FFY 2022 ARP Award[2]	FFY 2023 SA Block Grant Award	FFY 2023 COVID-19 Award[3]	FFY 2023 ARP Award[4]
Universal Direct	$350,873	$794,142	$0	$350,873	$794,142	$0
Universal Indirect	$1,544,418	$1,269,102	$0	$1,544,418	$1,269,102	$0
Selected	$22,952	$19,241	$0	$22,952	$19,241	$0
Indicated	$58,847	$49,332	$0	$58,847	$49,332	$0
Column Total	**$1,977,090**	**$2,131,817**		**$1,977,090**	**$2,131,817**	**$0**
Total SABG Award[5]	**$7,155,296**	**$4,105,789**	**$915,385**	**$7,290,296**	**$4,105,789**	**$0**
Planned Primary Prevention Percentage	**27.63 %**	**51.92 %**	**0.00 %**	**27.12 %**	**51.92 %**	

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[3]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[4]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[5]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

We are planning to receive a No Cost Extension, therefore, we will use the CRRSAA funding for fiscal year 2023..

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities - Required

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2022 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☑	☐
Tobacco	☑	☑	☐
Marijuana	☑	☑	☐
Prescription Drugs	☑	☑	☐
Cocaine	☑	☑	☐
Heroin	☑	☑	☐
Inhalants	☐	☐	☐
Methamphetamine	☑	☑	☐
Targeted Populations			
Students in College	☑	☑	☐
Military Families	☑	☑	☐
LGBTQ+	☑	☑	☐
American Indians/Alaska Natives	☑	☑	☐
African American	☐	☐	☐
Hispanic	☐	☐	☐
Homeless	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☑	☑	☐
Underserved Racial and Ethnic Minorities	☑	☑	☐

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:

We are planning to receive a No Cost Extension, therefore, we will use the CRRSAA funding for fiscal year 2023..

Planning Tables

Table 6 Non-Direct-Services/System Development

Please enter the total amount of the SABG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2022 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022					FFY 2023				
	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[4]	E. ARP[5]
1. Information Systems	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
2. Infrastructure Support	$10,000.00	$0.00	$0.00	$0.00	$0.00	$50,000.00	$0.00	$0.00	$0.00	
3. Partnerships, community outreach, and needs assessment	$10,000.00	$0.00	$0.00	$0.00	$0.00	$10,000.00	$0.00	$0.00	$0.00	
4. Planning Council Activities (MHBG required, SABG optional)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
5. Quality Assurance and Improvement	$100,000.00	$0.00	$0.00	$0.00	$0.00	$100,000.00	$0.00	$0.00	$0.00	
6. Research and Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
7. Training and Education	$0.00	$599,322.00	$0.00	$220,000.00	$0.00	$20,000.00	$599,322.00	$0.00	$220,000.00	
8. Total	**$120,000.00**	**$599,322.00**	**$0.00**	**$220,000.00**	**$0.00**	**$180,000.00**	**$599,322.00**	**$0.00**	**$220,000.00**	**$0.00**

[1] Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[3] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2022 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures reflecting the President's FY 2022 enacted budget for the FFY 2022 SABG Award year that is October 1, 2021 - September 30, 2022. For purposes of this table, all planned ARP expenditures between October 1, 2021 and September 30, 2022 should be entered in this column.

[4] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

[5] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**. Per the instructions, the FFY 2023 SABG Award amount reflects the 12 month planning period for the standard SABG expenditures, also reflecting the President's FY 2022 enacted budget for the FFY 2023 SABG Award that is October 1, 2022 - September 30, 2023. For purposes of this table, all planned ARP expenditures between October 1, 2022 and September 30, 2023 should be entered in this column.

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Footnotes:

We are planning to receive a No Cost Extension, therefore, we will use the CRRSAA funding for fiscal year 2023..

Environmental Factors and Plan

15. Crisis Services - Required MHBG, Requested SABG

Narrative Question

SAMHSA is directed by Congress through the Consolidated Appropriations Act, 2021 and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260], to set aside 5 percent of the MHBG allocation for each state to support evidence-based crisis systems. The appropriation bill includes the following budget language that outlines the new 5 percent set- aside:

> *Furthermore, the Committee directs a new five percent set- aside of the total for evidence-based crisis care programs addressing the needs of individuals with serious mental illnesses and children with serious mental and emotional disturbances. The Committee directs SAMHSA to use the set-aside to fund, at the discretion of eligible States and Territories, some or all of a set of core crisis care elements including: centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or State-wide crisis call centers coordinating in real time.*

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-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources.

SAMHSA recently developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with SMI or children with SED. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

Please refer to the **https://www.samhsa.gov/sites/default/files/grants/fy22-23-block-grant-application.pdf [samhsa.gov]** for additional information.

1. Briefly narrate your state's crisis system. Include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

Starting on July 16, 2022, the current ten-digit Suicide Prevention Lifeline will change over to 988. The Behavioral Health and Developmental Disabilities Division (BHDD) currently funds seven mobile crisis teams throughout the state. Montana currently has one crisis receiving center and six crisis stabilization centers throughout the state. Montana's crisis system has been implemented through several different programs. The current landscape creates reimbursement, messaging, and management inefficiencies that has resulted in insufficient crisis system utilization, unmet needs within the communities, and gaps in outcome reporting. The difference between current state and Medicaid services creates a lack of a unified message, which can cause confusion for both providers and the individuals they serve. In addition, the majority of the current crisis services have a very limited providers who can access them at this time. BHDD has an opportunity to address these issues and develop more succinct crisis-related programming to streamline crisis services, create administrative efficiencies, and enhanced quality oversite. The object is to design a statewide high quality crisis system through Medicaid and mirror that in Montana's state funded programs. By creating a Medicaid crisis benefit package based upon best practice guidelines and mirroring our state services and programs to the Medicaid benefit, we can implement a cohesive system between state and Medicaid programs and: • increase access to services and improved service delivery; • fill current gaps in the crisis continuum of care; and • streamline utilization and outcome reporting for crisis services. This effort is expected to be completed by October 1, 2022.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

a) The Exploration stage: is the stage when states identify their communities's needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.
b) The Installation stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. this includes coordination, training and community outreach and education activities.
c) Initial Implementation stage: occurs when the state has the three-core crisis services in place and agencies begin to put into practice the SAMHSA guidelines.
d) Full Implementation stage: occurs once staffing is complete, services are provided, and funding streams are in place.
e) Program Sustainability stage: occurs when full implementation has been achived, and quality assurance mechanisms are in place to assess the effectiveness

and quality of the crisis services.

1. Someone to talk to: Crisis Call Capacity
- *a. Number of locally based crisis call Centers in state*
  - *i. In the Suicide lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as MH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis capacity
- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employ peers*

3. Place to go
- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavior health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23 hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Available to less than 25% of people in state	Middle Implementation Available to about 50% of people in state	Majority Implementation Available to at least 75% of people in state	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☑	☐
Someone to respond	☐	☐	☑	☐	☐	☐
Place to go	☐	☐	☑	☐	☐	☐

b. Briefly explain your stages of implementation selections here.

Someone to talk to: All calls to the Montana Lifeline are answered by trained crisis workers at three regional call centers around the state. All three call centers will soon add chat and text to their modalities. All three of Montana's call centers currently handling telephonic Lifeline network calls now provide 24/7 with primary and backup coverage across the state and are operating within the 90 percent standard of performance required by the 988 grant. Together, they provide coverage to every county in Montana. Someone to respond: Mobile crisis teams exist in Butte-Silver Bow, Cascade, Flathead, Gallatin, Lewis and Clark, Lincoln, Missoula, and two that are in planning stages in Park and Yellowstone counties. Montana plans to add mobile crisis to Montana's Medicaid state plan benefit in January 2023. Somewhere to go: Montana has one crisis receiving center located in Billings, MT. Additionally, there are six crisis stabilization centers located in Missoula, Kalispell, Butte, Bozeman, Polson, and Hamilton which account for a total of 33 crisis beds. There has been positive movement in crisis stabilization programming throughout the past two years that include: • funding for TA and start-up funding for regional crisis stabilization through the Crisis Diversion Grant, • the addition of outpatient crisis stabilization (less that 23 hours and 59 minutes) to Montana's Medicaid benefit plan, and • a statewide assessment of crisis stabilization being completed by the Western Interstate Commission for Higher Education.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

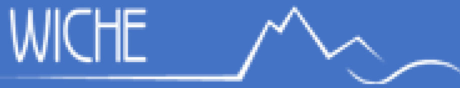
Montana's crisis system has been implemented through several different programs. The current landscape creates reimbursement, messaging, and management inefficiencies that has resulted in insufficient crisis system utilization, unmet needs within the communities, and gaps in outcome reporting. The difference between current state and Medicaid services creates a lack of a unified message, which can cause confusion for both providers and the individuals they serve. In addition, the majority of the current crisis services have a very limited providers who can access them at this time. BHDD has an opportunity to address these issues and develop more succinct crisis-related programming to streamline crisis services, create administrative efficiencies, and enhanced quality oversite. The object is to design a statewide high quality crisis system through Medicaid and mirror that in Montana's state funded programs. By creating a Medicaid crisis benefit package based upon best practice guidelines and mirroring our state services and programs to the Medicaid benefit, we can implement a cohesive system between state and Medicaid programs and: • increase access to services and improved service delivery; • fill current gaps in the crisis continuum of care; and • streamline utilization and outcome reporting for crisis services. This effort is expected to be completed by October 1, 2022.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

Montana is using the framework of the Behavioral Health Crisis System Strategic Plan that was developed to seek stakeholder engagement and collaboration and leverage multiple funding sources for crisis services within the state. Montana continues to be actively involved in several program development and technical assistance initiatives, including the implementation of 988, the development of a mobile crisis response Medicaid benefit, the development of crisis receiving and stabilization facilities, the development of a bed board, increasing utilization of Certified Behavioral Health Peer Support Specialists in crisis services, and the development of a public-facing crisis system data dashboard.

OMB No. 0930-0168 Approved: 03/02/2022 Expires: 03/31/2025

Footnotes:



Western Interstate Commission
for Higher Education

Behavioral Health Program

ALASKA

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CALIFORNIA

COLORADO

COMMONWEALTH OF THE
NORTHERN MARIANA ISLANDS

GUAM

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NEW MEXICO

NORTH DAKOTA

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SOUTH DAKOTA

UTAH

WASHINGTON

WYOMING

Planning for Crisis Receiving and Stabilization Facilities

Prepared for

The Montana Department of Public Health and Human Services,

Addictive and Mental Disorders Division

August 2021

Montana's Crisis Servcies

Planning for Crisis Receiving and Stabilization Facilities

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We are grateful for the dedication and efforts being put forth by members of the Cascade, Gallatin, Lewis and Clark, and Missoula Counties behavioral health coalitions and planning groups as they strive to build crisis services and systems for the people of their communities.

We especially wish to acknowledge the individuals and groups who dedicated their time, shared their data and insights, and responded to our inquires while preparing this report, including:

- Cascade County Strategic Alliance for the Crisis Intervention Program
- The Strategic Alliance for the Gallatin County Behavioral Health Crisis System (aka Gallatin County's Crisis Redesign Alliance)
- Lewis and Clark County's Behavioral Health System Improvement Leadership Team
- Missoula Strategic Alliance for Improved Behavioral Health
- Mary Collins, Special Populations Section Supervisor, Montana Addictive and Mental Disorders Division, Montana Department of Public Health and Human Services
- Scott Malloy, Program Director, Montana's Healthcare Foundation
- Kirsten Smith, Principal/Bloom Consulting, Project Coordinator, The Strategic Alliance for the Gallatin County Behavioral Health Crisis System (aka the Crisis Redesign Alliance)
- Jolene Jennings, Behavioral Health Systems Improvement Specialist, Lewis and Clark County Behavioral Health System Improvement Leadership Team
- Terry Kendrick, Project Facilitator, Missoula Strategic Alliance for Improved Behavioral Health
- Trista Besich, Alluvion Health, Cascade County Strategic Alliance for the Crisis Intervention Program

Executive Summary

No one is immune from experiencing a mental health crisis. It can happen at any point in a person's lifetime regardless of their age, economic status, religious beliefs, family, relationships, race, ethnicity, education, marital status, social status, physical health, career, or location. A mental health crisis can be triggered by trauma, loss of a loved one, head injury, substance use, mental illness, financial hardship, health issues, isolation, and so many other physical, emotional, and mental health experiences that can happen over a lifetime.

Organization and formalization of services for people in crisis reportedly began in the United States in the 1940's after a tragic fire in a Boston nightclub devasted a community. Twenty years later in the 1960's, when the Community Mental Health Act was enacted, community mental health centers were required to provide crisis services. Twenty years after that, Crisis Intervention Teams (CIT) – a training program created in 1988 by Major Sam Cochran of the Memphis Police Department to effectively handle mental health related calls -- became a major milestone in the development of crisis services. Within the next 20 years, law enforcement agencies across the United States adopted CIT training and CIT became a best practice in law enforcement and community-based crisis intervention services. As a result of more and more police officers trained in CIT, pressure mounted on community organizations, especially community mental health centers, to provide professional, responsive, mental health crisis care 24 hours a day, every day of the year. That pressure, coupled with increasing rates of suicide, hospital emergency rooms overwhelmed with mental health and substance use patients, and the collective voice of mental health advocates, gradually changed the delivery of crisis care in our country. Crisis services began to unfold in urban and rural communities. Now, over 75 years after the first crisis service was organized in our country, the cornerstones of crisis services – CIT, Crisis Lines, Mobile Crisis, and Crisis Receiving and Stabilization Centers -- have become a standard in mental health programs and systems.

Adding to the continuing advancement of crisis services is the implementation of 988 -- a 911-like system that will be the national suicide prevention and emergency mental health phone number. Connected to local crisis lines across the country, 988 will operate in every state by July 2022. It will partner with local systems of care that specialize in crisis prevention, intervention and support and operate 24 hours a day, every day of the year. Needless to say, 988 is expected to have a dramatic impact on state and local crisis systems.

Preparing for 988 and building services to support people in crisis is a challenging endeavor, to say the least. Although there are models, resources and research to help guide the development of crisis services, each state, region, and community faces unique challenges as they mold and build their crisis systems. Fortunately, for the past 10 years the Montana Department of Public Health's Human Services Addictive and Mental Disorders Division (AMDD) has been facilitating and supporting the development of crisis services across the state. In addition, for the past three years the Montana Healthcare Foundation (MHCF) has supported the advancements of crisis services by funding and facilitating the development of community coalitions, system analysis, mapping, and strategic planning activities. Seeing the potential impact of joining forces and resources, in 2018, AMDD and MHCF joined together

to support implementation and advancements in crisis prevention, intervention, stabilization, and recovery services across the state. Their efforts continue to this day as they work together with local communities and stakeholders to support strategic planning and implementation of the three cornerstones of crisis services: 24/7 Crisis Lines, Mobile Crisis Teams, and Crisis Receiving/ Stabilization facilities. Along these lines, it should be noted that each City and County of Montana has been responsible for streamlining their efforts to examine the resources and collaborations necessary to build and strengthen these components of a functional crisis system in their respective region. This work has been both necessary and essential towards the goal of improved crisis management across the State

In yet another step toward supporting the development of crisis services in Montana, in July of 2021, Montana Department of Public Health's Addictive and Mental Disorders Division contracted with the Western Interstate Commission on Higher Education/Behavioral Health Program (WICHE/BHP) to support planning for Crisis Receiving and Stabilization Facilities for four counties: Cascade, Lewis and Clark, Gallatin, and Missoula. Envisioned as a two-phase project, Phase One[1] of the project was six weeks long; the deliverables (and the focus of this report) were fourfold:

1) Use currently available data to analyze crisis services operating in the four counties;
2) Compare the current operations in the four counties to model programs and national best practices for Crisis Receiving and Stabilization Facilities;
3) Project utilization and capacity needs for Crisis Facilities in the four counties; and,
4) Offer recommendations to inform the crisis system planning occurring within each of the four counties.

In addition, this report offers decision-making information for the state of Montana and the counties as they prepare plans for crisis facility (or facilities) compatible with their regional crisis systems and unique to their communities, including:

- Models of crisis facilities
- Expectations and best practices for crisis facilities
- Planning resources for crisis facility operations, etc.
- Crisis bed capacity projection and estimation tools

Importantly, although the focus of the following report is on Crisis Receiving and Stabilization Facilities, the significance of the findings and recommendations *within the context of a crisis system (*including the core services of 24/7 Call Center, Crisis Intervention Teams and Mobile Crisis) for each of the communities cannot be understated. Leading proponents and experts of crisis service systems uniformly agree that crisis facilities are an essential element of a crisis system; that is, they offer a crucial service within a system, as opposed to a sole source of crisis care and service.

[1] Subject to funding, Phase Two will entail review of the State's policies regarding crisis facilities to ensure the framework is in place to support best practices in crisis receiving and stabilization services. As outlined in the "Summary of Recommendations" of this report, Phase Two will also entail a deeper dive to support each county's unique plans and key decisions, ranging from facility location and staffing, to licensing and partner agreements.

For the past 30 years, crisis centers have opened in communities across the country. Behavioral health providers, hospitals, first responders, and human service organizations have discovered methods for operating crisis services and systems effectively with a "no wrong door" approach. Working in partnership, they have successfully diverted an untold number of people in crisis from unnecessary transfers to emergency rooms and jails to lifesaving and life changing behavioral health services.

Today, from community to community, Montana is progressively developing a crisis system. Many stakeholders and leaders are united in believing the time is right and the time is now for instituting crisis facilities in their communities. We applaud the many groups and individuals in Montana who are on a mission to serve people in crisis through a "no wrong door" approach with compassion and expertise.

Methodology

To assist AMDD and the four communities with their strategic planning endeavors, WICHE/BHP conducted an analysis of current crisis service offerings, strengths, needs, and gaps in the continuum of care for each of the four communities/regions. Per the Statement of Work, WICHE/BHP:

1. Worked in partnership with AMDD staff to identify key stakeholders.
2. Interviewed key stakeholders in each region using an AMDD approved interview template.
3. Gathered and analyzed available data, including: a) population of each county and its surrounding region; b) emergency room usage; and c) reports produced by JG Research and Evaluation.
4. Analyzed data on current continuum of care and gaps that exist in the continuum to ensure consistency between community leaders and consumers with regard to needs and gaps.

As outlined below, WICHE/BHP also reviewed published reports and documents that inform strategic considerations and plans for crisis facilities. Of note is the comprehensive reports prepared for each of the four communities by JG Research and Evaluation; using the context of the model components of crisis services, their reports provide an impressive analysis of the current landscape of crisis services for each of the counties. In addition, WICHE/BHP utilized reports and papers on national best practices.

Source	Focus/Topics
TBD Solutions	Crisis Residential Best Practices Toolkit: Practical Guidelines and Solutions Crisis Residential Best Practices Toolkit (crisisnow.com)
MT Hospital Assoc.	ER Usage for Missoula, Cascade, Gallatin, and Lewis and Clarke Counties
NASMHPD	National Guidelines for Crisis Care 2020 Paper national-guidelines-for-behavioral-health-crisis-care-02242020.pdf (samhsa.gov)
SAMHSA	National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Crisis Services: Meeting Needs, Saving Lives (Dec. 2020)
MT DPHHS	Crisis Facility Toolkit Report (2020)
National Council for Behavioral Health	Road Map to the Ideal Crisis System: Essential Elements Measurable Standards and Best Practices for Behavioral Health Crisis Response (3/2021) 031121_GAP_Crisis-Report_Final.pdf (thenationalcouncil.org)
JG Research and Evaluation (MT)	- Gallatin County Behavioral Health Crisis System Analysis (6/2020) - Analysis of the Lewis and Clarke Behavioral Health Crisis System (8/2021) - Analysis of the Missoula County Behavioral Health Crisis System (6/2021)

These comprehensive reports were invaluable for informing this report. Additionally, although we did not use the learning lessons webinars presented by Addictive and Mental Health Disorders Division and the Montana Healthcare Foundation, these webinars are an impressive resource for additional information on crisis models, as well as the application of

best practices in Montana. [2] We strongly encourage each of the Coalitions'/communities', as well as the state agencies who are influencing and supporting the development of crisis services (i.e., Montana Department of Public Health and Human Services and the Addictive and Mental Disorders Division, the Montana Healthcare Foundation, and the Montana Hospital Association) to utilize these resources in their individual and collective strategic planning for crisis facilities.

In addition, WICHE has interviewed and sought information, insight, and clarification from key informants, including:

- *Mary Collins*, Special Populations Section Supervisor, Montana Addictive and Mental Disorders Division, Montana Department of Public Health and Human Services
- *Scott Malloy*, Program Director, Montana's Healthcare Foundation
- *Kirsten Smith*, Principal/Bloom Consulting, Project Coordinator, The Strategic Alliance for the Gallatin County Behavioral Health Crisis System (aka the Crisis Redesign Alliance)
- *Terry Kendrick*, Project Facilitator, Missoula Strategic Alliance for Improved Behavioral Health
- *Jolene Jennings*, Behavioral Health Systems Improvement Specialist, Lewis and Clark County Behavioral Health System Improvement Leadership Team
- *Trista Besich*, Alluvion Health, Cascade County Strategic Alliance for the Crisis Intervention Program

Findings and Data Analysis

According to the National Council for Behavioral Health's "Road Map to the Ideal Crisis System":

> "Many communities across the United States have limited or no access to true "no wrong door" crisis services; defaulting to law enforcement operating as community-based mental health crisis response teams with few options to connect individuals experiencing a mental health crisis to care in real time. The available alternatives represent systemic failures in responding to those in need; including incarceration for misdemeanor offences or drop-off at hospital emergency departments that far too often report being ill-equipped to address a person in mental health crisis. Unacceptable outcomes of this healthcare gap are (1) high rates of incarceration for individuals with mental health challenges, (2) crowding of emergency departments that experience lost opportunity costs with their beds and (3) higher rates of referral to expensive and restrictive inpatient care with extended lengths of stay because lower levels of intervention that better align with person's needs are not available. For many others in crisis, individuals simply fail to get the care they need."[3]

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[2] Montana Healthcare Foundation Crisis Videos on Vimeo. https://vimeo.com/search?q=montana%20healthcare%20foundation%20crisis

[3] Road Map to the Ideal Crisis System: Essential Elements Measurable Standards and Best Practices for Behavioral Health Crisis Response (3/2021).

Indeed, the absence of crisis services plays a heavy toll on communities – resulting in economic, social, and humanitarian hardship for health and human service providers, criminal justice systems, hospitals, first responders and (most importantly) individuals in crisis. Yet, that's not to say that developing crisis services and systems is easy. Indeed, it is a challenging and complex endeavor. Still, many communities across the United States have successfully formed collaborative and strategic partnerships that have resulted in the creation of effective crisis services for urban and rural communities.

Fortunately, Montana is also persevering and investing in the development of crisis services. For the purpose of this report, that "investment" includes developing a clear understanding of what would be required to institute crisis receiving and stabilization facilities for Cascade, Lewis and Clark, Gallatin, and Missoula counties. That understanding begins with an assessment of crisis receiving and stabilization services as they exist or operate today.

Crisis Receiving and Stabilization Facilities in the Four Counties

When operated within best practice standards, crisis receiving and stabilization facilities serve everyone who comes through their doors from all referral sources.

As reflected in the table below, apart from hospital emergency rooms, there are no crisis receiving units (defined as operating 24/7/365 and providing less than 24 hours of care) in any of the four counties. Further, only two counties, Gallatin and Missoula -- which have Western Montana Mental Health Center (WMMHC) Hope House and Dakota Place, respectively -- have standalone crisis stabilization facilities (defined as providing services 24/7/365 with a length of stay from 24 hours to [an average length of stay] of 3 - 5 days). However, currently both centers are operating under capacity due to staffing challenges.

Current Crisis Receiving and Stabilization Facilities

	Cascade	Gallatin	Lewis and Clark	Missoula
Crisis Receiving	NO	NO	NO	NO
Crisis Stabilization	NO	WMMHC/Hope House. 8 beds/2 involuntary Note: operating under capacity (due to staff shortage)	NO Note: WMMHC's Journey Home closed Jan. 2020	WMMHC's Dakota Place. 7 beds/2 involuntary Note: operating under capacity (due to staff shortage)

Given the absence of crisis receiving facilities in all four counties and that the two stabilization facilities in Missoula and Gallatin Counties operate under capacity, it is not surprising that hospital emergency rooms have become the De Facto mental health and substance use crisis receiving and (for those patients who stay longer than longer than 24 hours) stabilization facilities in all four counties – as indicated in the sheer number of mental health and substance use visits the hospitals reported in 2019.

2020 Behavioral Health Emergency Room Visits

COUNTY	Total Hospital Mental Health Visits	Total Hospital Substance Use Visits	Total Hospital Behavioral Health Visits
Cascade	1588	5647	7235
Gallatin	1335	3887	5222
Lewis and Clark	4025	7673	11,698
Missoula	1594	6995	8589

Clearly, the counties and communities are fortunate to have hospital emergency departments that serve as the communities' crisis receiving resource for first responders, families, and individuals. However, hospital emergency rooms (ERs) are not designed for behavioral health crisis intervention, management, or treatment. In addition to being one of the highest cost centers for healthcare, the facilities themselves are furnished, equipped, and staffed for rapid assessment, stabilization and treatment of medical emergencies. Although they may be capable of handling mental health and substance use emergencies, ER staff, physicians, and nurses are not typically trained in psychiatric or behavioral health assessments and clinical care. Further, when the emergency room serves as the community's or region's crisis receiving center, it can quickly become overwhelmed with behavioral health patients, some of whom may pose safety risks to ER staff and other patients. Finally, and most importantly, people in crisis who walk in or are transported to the emergency room for a mental health and/or substance use related crisis often will not receive the amount of time and the level of behavioral health care, expertise, and follow-up that may be needed to help stabilize their situation and connect them to services that can support their well-being post release. Hence, the not uncommon result of "streeting" in which people are released from the ER without supports and the ensuing "revolving door" of the same patient being seen multiple times for crisis and behavioral health related care.

Data suggests that a high proportion of people in crisis who are evaluated for hospitalization … can be safely cared for in a crisis facility and that the outcomes for these individuals are at least as good as hospital care while the cost of crisis care is substantially less than the costs of inpatient care and accompanying emergency department "medical clearance" charges. - NBHCC, "Road Map to the Ideal Crisis System", 3/2021

On the other hand, Crisis Receiving and Stabilization Facilities (or Centers) can provide the appropriate level of behavioral health crisis intervention, assessment, and stabilization. Unlike hospital emergency rooms, crisis facilities are purposefully intended to serve people experiencing mental health and or substance use related crisis. The facilities themselves are designed to be a comforting, home-like, environment while also adhering to the health and safety standards of hospital-like operations. Rather than staffed by emergency medical teams, they are staffed by behavioral health experts including psychiatrists and/or psychiatric nurses, licensed counselors and clinicians, and peer support specialists. In delivering services, the staff at crisis facilities can use a combination of the facility environment, their collective behavioral health expertise, and their vast knowledge of

community and financial resources to help stabilize people in crisis and connect them to appropriate levels of care.

Models: Receiving, Stabilization and Receiving/Stabilization Centers

In determining the type of crisis facility that a community needs, it's important to understand the differences between the three models of crisis facilities or centers: 1) *Receiving Center/Facility*; 2) *Stabilization Center/Facility*; and 3) *Combined Receiving & Stabilization Center/Facility.*

Note that regardless of the model adopted, all three models operate within a collaboration of crisis service providers (including 24/7 Crisis Call Lines, Mobile Crisis Teams, First Responders) to create a "no wrong door" service for people seeking crisis care who:

- may have a mental health, substance use, or co-occurring diagnosis;
- may be experiencing their first psychiatric episode; and/or
- may need supportive counseling or outpatient care as opposed to more intensive behavioral health or psychiatric services.

The documents and reports referenced on page six of this report provide in-depth descriptions of the components and operational requirements for each of the crisis facility models. The following tables are intended to provide a high-level comparative overview of the models.

Model Type: Crisis Receiving Center

Purpose	▪ In-person, 24/7, 365 days a year ▪ Support, Assessment, Rapid Stabilization (including Sobering) ▪ ER and Jail Diversion ▪ Refer/Link to Care
Length of Stay	▪ Under 24 hours
Capacity	▪ Typical: 4 – 24 Observation Reclining Chairs/Beds
Intake/Access	▪ Referral Sources: Law Enforcement, Mobile Crisis, Emergency Room, Healthcare, Behavioral Health Providers, Crisis Call/Text Lines ▪ Law Enforcement and Mobile Crisis Portal/Hand Off ▪ Walk in
Admissions Policies/Criteria	▪ All people, often related to mental health, substance use, and co-occurring issues ▪ Voluntary and/or Involuntary Care (Unlocked and/or Locked facility) ▪ Medical status appropriate for setting; i.e.; Medical Clearance
Staffing	▪ Professionally licensed/credentialed staff: Prescribing Nurse Practitioners, Psychologists, Clinicians, Addiction Counselors, Social Workers, consulting Psychiatrist (including tele-psychiatry) ▪ Administrative Support and Security
Licensing	▪ If operated by licensed Mental Health Center: Meets requirements of Admin. Rule MT (ARM) 37.106.1976, "Outpatient Crisis Stabilization Facility" and endorsed as Outpatient Crisis Facility. ▪ If operated by licensed Hospital: Endorsed as Outpatient Crisis Facility.

Model Type: Crisis Stabilization Center

Purpose	▪ In-person, 24/7, 365 days a year ▪ ER and Jail Diversion, Alternative to Inpatient Behavioral Health Hospitalization ▪ Assessment, Stabilization, Support, Treatment ▪ Refer/Connect to Care
Length of Stay	▪ 24 hours to 10 days (average length of stay, 3 days)
Capacity	▪ Typical: 4 – to no more than 16 Beds
Intake/Access	▪ Referral Sources: Hospital, Healthcare, Behavioral Health Providers ▪ Mobile Crisis, Law enforcement, Ambulance Transfer
Admissions Policies/Criteria	▪ Behavioral health patient needing/seeking 24 hour+ treatment but not needing hospital-level acute inpatient care ▪ Typically, both Voluntary and Involuntary Treatment (Locked facility) ▪ Medical Status and Clearance Appropriate for Setting
Staffing	▪ Professionally licensed/credentialed staff: Psychiatrist, prescribing Nurse Practitioners and/or Physicians Assistants, Psychologists, Clinicians, Addiction Counselors, Social Workers ▪ Peer Specialists ▪ Administrative Support and Security Staff
Licensing	▪ Licensed MHC endorsed as an Inpatient Crisis Facility per the standards for BH Inpatient Facilities (ARM Subchapter 37.106.17) plus requirements specified in ARM 37.106.1946.

Model Type: Combined Crisis Receiving & Stabilization Center

Purpose	▪ In-person, 24/7, 365 days a year ▪ ER and Jail Diversion, Alternative to Inpatient Behavioral Health Hospitalization ▪ Assessment, Stabilization, Support, Mental Health and Co-occurring Treatment ▪ Seamless transfer from Receiving Facility to Stabilization Facility/Services ▪ Refer/Connect to Care
Length of Stay	▪ Receiving: under 24 hours. Stabilization: 24 hours up to 10 days (avg. LOS, 3 days)
Capacity	▪ 4 – 24 Observation Recliners (Receiving). 6 – 16 Beds (Stabilization)
Intake/Access	▪ Referral Sources: Hospital, Healthcare, Behavioral Health Providers ▪ Mobile Crisis Teams, Law enforcement, Ambulance Transfer
Admissions Policies/Criteria	▪ Persons in crisis needing rapid stabilization, support, assessment and/or sobering ▪ Behavioral health patient needing/seeking 24+ treatment but not needing hospital-level inpatient care ▪ Typically, both Voluntary and Involuntary Treatment (Locked facility) ▪ Medical Status/Clearance Appropriate for Setting
Staffing	▪ Professionally licensed/credentialed: Psychiatrist, prescribing Nurse Practitioners and/or Physicians Assistants, Psychologists, Addiction Counselors, Social Workers ▪ Peer Specialists ▪ Admin. Support and Security Staff
Licensing	▪ Licensed MHC endorsed as an Inpatient Crisis Facility per the standards for BH Inpatient Facilities (ARM Subchapter 37.106.17) plus requirements specified in ARM 37.106.1946.

Crisis facilities are designed to operate in a home-like environment as opposed to a medical or clinical environment. Notably, the receiving facilities (referred to in some literature as "psychiatric emergency rooms") are most often furnished with recliner-type chairs, which are conducive to rapid assessments (including observation), shorter lengths of stay (i.e., under 24 hours), as well as increased communication between staff and "guests" (i.e., patients) and between guests.

On the other hand, given longer lengths of stay (over 24 hours), stabilization facilities are furnished with beds rather than recliners. According to RI International (a consulting organization specializing in crisis system development and operations), stabilization units "serve approximately 30% of the population that are not stabilized in the 23-hour observation unit during the first day, with an average length of stay between 2.5 and 3 days." Both the receiving and stabilization facilities may be operated by a community behavioral health provider in affiliation with the hospital, or as a standalone facility operated by another organization.

Medical clearance for people with substances "onboard" are often a major concern of communities and providers who are developing crisis facilities. Crisis center providers across the country have established medical clearance criteria, practices, and protocols to accept and serve people at crisis receiving and stabilization facilities who have indications of substance use, intoxication and/or addiction-related complications.

Importantly, crisis facilities serve all people, regardless of whether they present with mental health, substance use, or co-occurring (i.e., mental health and substance use) needs. Both those people who arrive voluntarily and those who are placed on involuntarily holds are served. The culture and guiding principles of both receiving and stabilization facilities reflect a "no wrong door" service, in which all "guests" who are brought to, or walk-in to, the facilities are welcomed and served with compassionate, supportive, professional care. Services are provided by medical and behavioral health professionals, including psychiatrists, psychiatric nurse practitioners, nurses, licensed and credentialed mental health and addiction clinicians, as well as peer recovery specialists. These facilities are licensed as residential sub-acute and or hospital beds.

Notably, medical clearance for people with substances "onboard" are often a major concern of communities and providers who are developing crisis facilities. SAMHSA's National Survey on Drug Use and Health (NSDUH) report from 2018 notes that approximately 3.7% of adults had a combination of any mental illness and a substance use disorder (9.2 million adults)[4]. Given the number of people who will use crisis services and who may likely have recently

[4] *Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/pep19-5068.pdf

used or over-used substances, crisis facilities must -- as opposed to "weeding out" people who have indications of intoxication when they arrive at the crisis center -- adopt best practices in admission and medical clearance protocols. Indeed, to avoid unnecessary transports to emergency departments, providers across the country have established medical clearance criteria, practices, and protocols to accept and serve people at crisis receiving and stabilization facilities who have indications of substance use, intoxication and/or addiction-related complications. However, best practices include protocols that if, after being initially assessed by a medical professional at the crisis facility (or an EMS provider), a person has indications of needing life-saving medical care, the crisis facility prepares for immediate transport to medical emergency facilities.

Additional Considerations

Minimum Expectations and Best Practices

In 2020, the National Association of State Mental Health Program Directors (NASMHPD) adopted the "NASMHPD National Guidelines for Crisis Care". Within the Guidelines is a review of "minimum expectations and best practices to operate crisis receiving and stabilization services", as outlined below. We strongly recommend each of the communities encourage (if not require) their crisis facility provider(s) meet the National Guidelines' expectations and best practices.

NASMHPD Minimum Expectations and Best Practices for Crisis Receiving and Stabilization

	✓ Operate 24/7 365 days a year. ✓ Include beds within a real-time regional bed registry system to support efficient connection to needed resources.
Intake	✓ Offers walk-in and first responder drop-off options. ✓ Offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders. ✓ Does not require medical clearance prior to admission; provides assessment and support for medical stability while in the program.
Staffing	✓ 24/7 multidisciplinary team able to meet needs of individuals experiencing all levels of crisis. ✓ Includes psychiatrists or psychiatric nurse practitioners, nurses, licensed/credentialed clinicians, peers with lived experience.
Services	✓ Addresses mental health and substance use crisis issues. ✓ Assesses physical health needs and deliver care for most minor physical health challenges with an identified pathway to transfer the individual to more medically staffed services if needed. ✓ Screen for suicide risk and violence risk and, when clinically indicated, complete comprehensive suicide risk and/or violence risk assessments and planning. ✓ Incorporate some form of intensive support beds into a partner program (within the services' own program or within another provider) to support flow for individuals who need additional support. ✓ Coordinate connection to ongoing care.

Collaboration, Communication, Transparency

Although this report and corresponding recommendations are focused on crisis receiving and stabilization facilities for each of the communities/regions, the *importance of the findings and recommendations within the context of a crisis system* (which includes the three foundational elements: call center, mobile crisis response, and crisis facilities) *cannot be understated*. While crisis facilities offer a crucial service and link in the system, they are just one factor in a comprehensive "no wrong door" behavioral health crisis system that operates graduated levels of intervention, care, and treatment. High levels of service coordination, collaboration, and transparency between first responders, hospitals, health and medical providers, and behavioral health treatment providers is crucial to the success of any "no wrong door" crisis systems.

High levels of service coordination, collaboration, and transparency between first responders, hospitals, health and medical providers, and behavioral health treatment providers is crucial to the success of the "no wrong door" crisis system.

County Comparisons

A shared mission and agreement between providers to the "no wrong door" philosophy is pivotal to the design and operation of crisis receiving and stabilization facilities. Collaborative communication and transparency between the entities that will operate, support and utilize the services must exist for both functionality and the intended impact. The fact that four coalitions -- The Strategic Alliance for the Gallatin County Behavioral Health Crisis System (aka the Crisis Redesign Alliance), Missoula Strategic Alliance for Improved Behavioral Health, Lewis and Clark County's Behavioral Health System Improvement Leadership Team, and the Cascade County Strategic Alliance for the Crisis Intervention Program --- shared resources to conduct an analysis and develop plans is remarkable and most certainly a testament to their commitment to collaboration.

Crisis receiving, stabilization and support services are especially robust if mutual goals, agreements, understanding, and transparency exists – especially between providers and first responders. The Crisis Response Center in Pima County, Arizona, reflects how the power of community determination and collaboration can lead to the creation of a crisis stabilization center that has grown to become a national model in crisis services. (Story next page)

Solving the Mental Health Crisis Through Community Collaboration

(*Joint Commission **. Blog Post. 6/8/21*)

"Our colleagues in behavioral health are all too familiar with the saying, "it's easier to get into heaven than to access psychiatric care." This is especially the case during a crisis.

Unlike medical emergencies, a 911 call for a behavioral health emergency often results in a police response. Individuals in mental health crisis account for a quarter of officer-involved shootings, and the prevalence of individuals with mental health conditions in jails and prisons is three to four times that of the general population.

Those who make it to the hospital don't fare much better. More than 80% of emergency departments (EDs) report boarding psychiatric patients on any given day, and 64% report they have no psychiatric services available while patients are awaiting admission or transfer, according to a survey by the American College of Emergency Physicians. All of this comes at a high cost—approximately $2,300 per patient and a poor experience for patients, families, and ED staff.

Our community wanted to change that.

In 2009, the citizens of Pima County, Arizona, voted to build a crisis center to meet the community need for psychiatric emergency care. The Crisis Response Center (CRC) opened in 2011, eight months after the Jan. 8 shooting that occurred outside a Tucson grocery store in which six people were killed. In addition, the former U.S. Representative, Gabrielle Giffords and 12 others were wounded by the gunman who was diagnosed with schizophrenia.

"No Wrong Door" in a Crisis

The revolutionary mission of the CRC is to reduce the number of individuals with mental illness in jails and EDs by making it easier and faster for law enforcement to bring them to the crisis center for treatment. The CRC's "no wrong door" policy means that officers are never turned away, eliminating the need for them to navigate a complicated system of hospitals, detox centers or clinics. The drop off process is less than 10 minutes, which is considerably faster than what it would be at a jail or ED.

Today, the CRC serves 12,000 adults and 2,400 youth annually. Services include 24/7 walk-in urgent care and 23-hour observation. About half of our patients are brought directly from the field by law enforcement, with the remainder arriving via mobile crisis teams, walk-in or transfer from emergency rooms. Reasons for presentation include:

- danger to self/others
- acute agitation
- psychosis
- substance intoxication and withdrawal

Even highly acute and potentially violent patients are accepted in care without the use of security staff. Care is provided by an interdisciplinary team of psychiatric practitioners, social workers, nurses, behavioral health technicians, peer support specialists

To rapid assessment, early intervention, proactive discharge planning and close collaboration with community providers, the majority of patients are stabilized and connected to appropriate community-based care without the need for hospitalization. For those who need it a 15-bed adult sub-acute unit provides three to five days of continued stabilization.

** *The Joint Commission accredits over 22,000 hospitals and health care organizations in the US. The Commission develops performance standards to address crucial elements of operation including patient care, medical safety, infection control, and consumer rights.*

Current Crisis Services

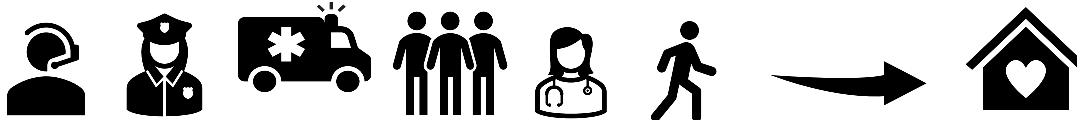
Crisis receiving and stabilization facilities are pivotal in a crisis system. The plans, design and capacity of the facilities should take into consideration the full spectrum of crisis services operating (or in development) in the community. Toward that end, the WICHE/BHP team considered both the crisis services and behavioral health services in operation and/or actively being developed in the four communities/regions. The table below offers a snapshot of those services; it includes hospital ERs as they have a major role in the crisis continuum and seem to be the only active, 24/7, receiving facility for the four counties at this point in time.

Snapshot: Current Crisis Services

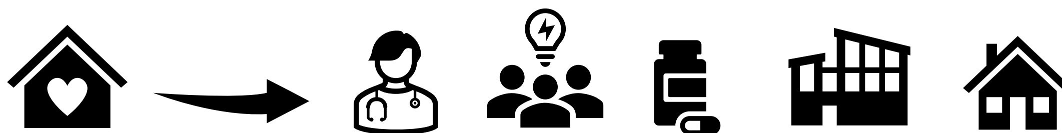
	Cascade	Gallatin	Lewis and Clark	Missoula
Crisis Line (24/7)	Voices of Hope MT (serves 43 counties and MT's Native American communities)	The Help Center	Voices of Hope	WMMHC Crisis Line (new)
CIT Officers	PD and SO	PD and SO	PD and SO	PD and SO
Mobile Crisis	Alluvion(FQHC) with Great Falls Police Dept. and Cascade County Sheriffs Office	Western Montana Mental Health Ctr, with Gallatin Police Dept.	St. Peter's Mobile Crisis Response Team	Partnership Health (FQHC) and Missoula Fire Dept.
Crisis Receiving	NO Receiving Facility	NO Receiving Facility	NO Receiving Facility	NO Receiving Facility
Crisis Stabilization	NO Stabilization Facility	WMMHC/Hope House. 8 beds vol./2 involuntary	NO Stabilization Facility	WMMHC's Dakota Place. (7 beds/2 involuntary)
Hospital ER*	Great Falls Clinic ER Benefis Hospital ER	Bozeman Health ER Big Sky Med. Ctr ER	St. Peter's Medical Center ER	Providence St. Patrick's ER Community Medical Center
Behavioral Health Inpatient	Benefis (10 beds) for adults	NO Behavioral Health Inpatient Unit	St Peter's BH Inpt. (24 beds) Shodair Children's Inpt. psychiatric services	Providence St Patrick's Psych Inpt. (22 adult + 14 adolescent beds)

Crisis Services in the Counties

Pathways Into Crisis Facilities/Centers: There are multiple pathways into crisis receiving and stabilization facilities. Typically, those pathways include: Crisis Call Center referrals, Law Enforcement and (when allowed per insurance and regulatory agencies) EMS first responders, Mobile Crisis Teams, Hospital Emergency Room staff, Community Healthcare Providers and Walk Ins.



Post Crisis Pathway: Pathways out of crisis receiving and stabilization services to follow-up treatment and/or support services once the crisis has been resolved or stabilized, are a second cornerstone of the crisis systems. Those options include referrals to comprehensive/intensive outpatient treatment (Program for Assertive Community Treatment -PACT), connections, and/or transfers to inpatient care or recovery centers.



Indeed, connecting people experiencing a crisis to appropriate levels of care and, post-crisis, to continued services and support, is a cornerstone of all crisis systems. Hence the crucial need for collaboration and cooperation between first responders, human/social service agencies, and healthcare (including behavioral health) providers.

Mapping the pathways into the crisis facilities, and pathways to services once the crisis has been stabilized, is vital to crisis system flow. In determining the model each community will adopt, the strengths and gaps of each community's pathways, as well as strategies to build upon strengths and minimize gaps, will be critical.

Although 24/7 call centers, community-based mobile crisis teams, and crisis receiving and stabilization centers have been shown to dramatically decrease the number of people who use or are transported to emergency rooms for crisis services, crisis receiving and stabilization centers do not replace or eliminate a community's need for inpatient behavioral health services.

Although there are not community-based crisis receiving and stabilization services operating in all four counties, there are other important crisis services that are in place, being expanded, and being developed in each of the counties, including 24/7 Call Centers, Crisis Intervention Team (CIT) trained officers, and Mobile Crisis. An additional important piece of this system are Programs for Assertive Community Treatment (PACT) teams. These teams provide comprehensive wrap-around services to clients providing clinical support by psychiatrists and nurses, access to employment and housing specialists, and peer specialists. PACT teams are operating within all four communities and AMDD is ensuring, through regular fidelity reviews, that services on these teams are being delivered to national standards. These teams can help reduce the need for the crisis system by providing comprehensive treatment which can significantly

reduce the frequency of behavioral health crisis; the PACT teams also deliver services to clients in crisis, often de-escalating the situation and helping the client to remain in the community and with their natural supports. In addition to being able to reduce the likelihood of current PACT clients needing crisis services, these teams are an ideal outpatient treatment model for people who have experienced a crisis and need support when they return to the community. The fact that these crisis services are in place and are being developed is very positive.

As pathways in and out, each of the services will be instrumental in interfacing with and collaborating with the crisis receiving and stabilization provider(s) once they are in place. The programs and services shown in the proceeding table will have a major impact on crisis response and services – including both the pathways in and the pathways out of the Crisis Receiving and Stabilization facilities.

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Snapshot: Behavioral Health Programs and Services

**This table highlights primary "public" or "public/private" behavioral health providers' services that may play a key role or function in developing and operating crisis centers. The table is not a complete overview of all behavioral health services or providers in the four counties. Montana and the four counties listed here have a wide range of private practices, practitioners, clinicians, clinics, recovery services and treatment centers.*

COUNTY	MENTAL HEALTH	SUBSTANCE USE	BH/PSYCH INPATIENT
Cascade	Center for Mental Health Alluvion (FQHC): Mobile Crisis, Jail Diversion, Jail Service, Integrated BH Urban Indian Ctr: Integrated BH	Gateway- currently moving under Center for Mental Health Sober Living: Peer Support Services	Benefits inpatient unit for adults with SUD and co-occurring"
Gallatin	Western Montana Mental Health Center (WMMHC) Community Health Partners (FQHC/integrated BH) Bozeman Health, integrated BH Gallatin Mental Health Center/ BH Urgent Care Center Intermountain and CHP: School-Based Health Services	Community Health Partners (FQHC: integrated BH) Bozeman Health, integrated BH Alcohol and Drug Services of Gallatin County	
Lewis and Clark	Center for Mental Health: PACT AWARE: PACT Intermountain: child and family MH services Shodair Children's Hospital: psychiatric services Fort Harrison VA Medical Center Urban Indian Ctr integrated BH	Fort Harrison VA Medical Center All Nations Health Center, Urban Indian Health Center: Recovery/SUD Treatment Boyd Andrews Instar Community Services	St. Peter's Health Behavioral Health Unit Shodair Children's Hospital, Psychiatric Inpatient
Missoula	WMMHC (including PACT) Providence St. Patrick's Fort Harrison VA Med. Ctr. Clinic All Nations Health Center, Winds of Change MG Center	WMMHC Recovery Center Missoula: Inpatient SUD Open Aid Alliance: Peer Support	Providence St Patrick Hospital

Facility-based Behavioral Health Crisis and Urgent Care Services: Current and Planned

Given this report is focused on facility-based crisis services, it's especially important to note the services/providers that are currently operating (or are planning to operate in the near future), *facility-based* urgent, inpatient, and/or stabilization services in each of the counties. Those providers include:

Cascade:

- ✓ Benefis Hospital: Inpatient unit for Substance Use and Co-occurring Treatment

Gallatin:

- ✓ WMMHC Campus:
  - → Gallatin Mental Health: Behavioral Health Urgent Care Center
  - → Walk-In Center
  - → Hope House Stabilization Facility
- ✓ *Bozeman Health Deaconess Hospital:*
  - → *Psychiatric ER Unit (planning/future)*
  - → *Crisis Receiving/Stabilization Facility (planning/future)*

Lewis and Clark:

- ✓ St. Peter's Health Regional Medical Center: Behavioral Health Inpatient Unit
- ✓ Shodair Children's Hospital: Psychiatric Inpatient and Outpatient Services

Missoula:

- ✓ WMMHC: Dakota Place Crisis Stabilization Facility
- ✓ Providence Saint Patrick's Inpatient Psychiatric Unit

State:

- ✓ Montana State (psychiatric) Hospital, Warm Springs

Agreements and MOU's

To ensure there is "no wrong door" for accessing crisis care, services are well-coordinated, and resources are used wisely in the region and across the state, Operating Agreements and/or Memorandums of Understanding between providers and the Crisis Receiving/Stabilization providers will be crucial. We suggest the topics that should be addressed in the Agreements include (at a minimum):

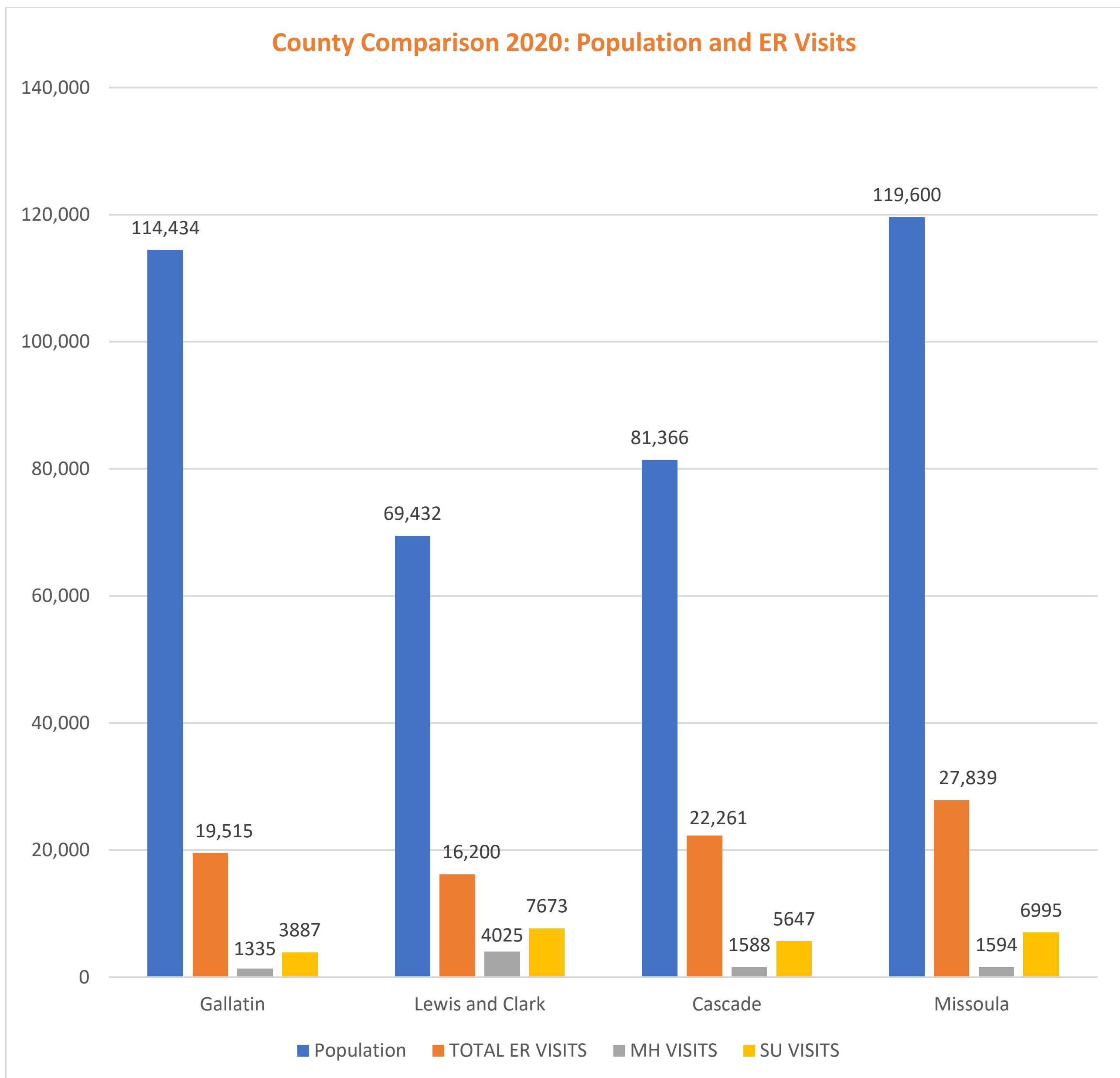
- the role of each of the facility-based and community-based crisis providers;
- their referral, intake and admissions practices;
- their patient/consumer transfer practices;
- the services they are committed to delivering;
- their contributions (i.e., resources) to the region's/community's crisis system; and
- their approach and agreement to track and share information regarding their service utilization, service availability, and capacity (this will be especially important if/when a crisis and inpatient bed tracking program is instituted).

Comparison of Populations and Emergency Room Utilization

As part of this project, WICHE/BHP was asked to review the populations and emergency room usage data for each of the four counties.

COUNTY	POPULATION (2020)	POP. OF PRIMARY LOCATION FOR BH SERVICES
Cascade	81,366	Great Falls: 58,434 (2019)
Gallatin	114,434	Bozeman: 49,831 (2019)
Lewis and Clark	69,432	Helena: 33,124 (2019)
Missoula	119,600	Missoula: 75,516 (2019)

NOTE: City population numbers are the 2019 estimate, as currently reported in 2020 US Census Report.



1. **Population**
2. **Emergency Room (ER) Visits**
3. **Mental Health related ER Visits**
4. **Substance Use related ER Visits**

Clearly, hospital emergency room visits related to substance use far exceeds mental health related visits. The data, system analysis reports, and key informant input point to the fact that withdrawal management and sobering services for people in crisis is a major gap in all four counties. Community-based withdrawal management and sobering facilities could help fill that gap. However, we would suggest the communities begin to address this need by initially focusing on developing and operating the one crisis service that does not exist in any of the counties: Crisis Receiving facilities. If operated under the best practice models and protocols of crisis care, people who have indications of substance use will be served at the Crisis Receiving facilities. Consequently, once those crisis facilities are operating, each of the counties will be able to reassess the need for community-based withdrawal and/or sobering facilities.

Withdrawal management and sobering services for people in crisis is a major gap in all four counties. Sobering facilities could help fill that gap. However, we would suggest the communities begin to address this need by initially focusing on developing and operating the one crisis service that does not exist in any of the counties: Crisis Receiving facilities.

Forecasting Need and Utilization

Paramount in planner's and stakeholder's minds is the question: "How many 'beds' will our crisis centers need?" In researching forecasting tools and formulas specific to crisis centers, we identified three calculation methods cited by SAMSHA, NASMHPD, and the National Behavioral Health Council -- all of which included the "Crisis Now Crisis System Calculator" and tools developed by RI International, a national consulting firm specializing in crisis services. Based on those sources, we were able to provide preliminary forecasting for each of the counties.

Utilization Projections: Per RI International's Crisis Now guidelines, it is estimated that:

> "For every 100,000 members of a representative population, 200 of those population members will experience a crisis that requires something more than a typical outpatient or phone intervention. Research has enabled the utilization of data to stratify the service level needs of those individuals; and that data can be applied to most efficiently design a cost-effective service delivery system."

As reported by RI International, if the ratio of 200 individuals per 100,000[5] will experience a crisis that requires a service level more acute than can be accommodated by outpatient services or a phone intervention, Montana (with a population in 2020 of 1,084,225) would be expected to have over 2,168 individuals annually who would be in need of more intensive crisis services. If 54% of those individuals are expected to require admission to a crisis facility, the number of admissions would be 1,170. Similarly, if 32% require a Mobile Crisis Team intervention, that annual number would be 694 individuals. Further, if 14% require acute psychiatric care, that would equal 304 admissions to inpatient care.

[5] RI International / Crisis Now Consultation to Alaska. *Transforming Crisis Services is Within Our Reach*.

When the utilization formula is applied to the four counties, the data in the following tables are produced[6].

COUNTY	POPULATION (2020 Census)	PROJECTED # NEEDING INTENSE CRISIS SERVICES **	EXPECTED TO REQUIRE ADMISSION TO CRISIS FACILITY (54%)	REQUIRE MOBILE CRISIS TEAM INTERVENTION (32%)	REQUIRE ACUTE INPATIENT (14%)
Cascade	81,366	163	88	52	23
Gallatin	114,434	229	124	73	32
Lewis and Clark	69,432	139	75	45	20
Missoula	119,600	239	129	77	34

*** Population, divided by 100,000 x 200*

Level of Care Utilization (LOCUS) Projections: Using the statewide crisis line data set[7], Georgia conducted an analysis of over a decade of Level of Care Utilization System (LOCUS) data. The analysis included a total of 1.2 million records, 431,690 of which met the criteria of individuals being engaged by a face-to-face crisis response service by facility-based or mobile team providers. According to SAMSHA's "National Guidelines for Behavioral Health Crisis Care" the Georgia LOCUS analysis resulted in a "breakdown that can be used to inform optimal initial referral paths within a system of care that includes a continuum of crisis services."

- 14% (59,269 of 431,690) LOCUS 6: Direct Referral to Acute Hospital.
- 54% (234,170 of 431,690) LOCUS 5: Referral to Crisis Receiving and Stabilization Facility.
- 32% (138,251 of 431,690) LOCUS 4-1: Evaluation by Crisis Mobile Team/Referral to Care.

Using the 2019 hospital emergency room visits for behavioral health data, and the Georgia LOCUS analysis cited by SAMHSA, we were able to make very preliminary assumptions regarding projected utilization of Receiving/Stabilization Centers.

COUNTY	*# MH Visits in Hospital*	*# SU Visits in Hospital*	*Total # BH Visits in Hospital*
Cascade	1588	5647	7235
Gallatin	1335	3887	5222
Lewis and Clark	4025	7673	11,698
Missoula	1594	6995	8589

Assuming the key functions of crisis services (i.e., 24/7 Call Center, Mobile Crisis Teams, CIT, and Receiving/Stabilization Facilities) are operating, behavioral health visits to the ER would be triaged more broadly rather than in the one "crisis facility" (i.e., hospital ER) that currently exists. In that case, utilization may be projected as shown in the tables below.

[6] The numbers shown are based on county population. In a state like MT, the facilities would be serving a broader population from surrounding counties.

[7] National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit, Knowledge Informing Transformation. national-guidelines-for-behavioral-health-crisis-care-02242020.pdf (samhsa.gov)

LOCUS MODEL Monthly Utilization Projections:
Based on annual total Behavioral Health ER Visits

COUNTY	Refer to Acute Hospitalization (14%)	Refer to Crisis Facility (54%)	Refer to Mobile Crisis/ Follow up (32%)
Cascade	84	325	193
Gallatin	61	235	139
Lewis and Clark	136	526	312
Missoula	100	386	229

LOCUS MODEL Monthly Utilization Projections:
Based on annual total Mental Health ER Visits

COUNTY	Refer to Acute Hospitalization (14%)	Refer to Crisis Facility (54%)	Refer to Mobile Crisis/Follow up (32%)
Cascade	19	71	42
Gallatin	16	60	36
Lewis and Clark	47	181	107
Missoula	19	72	43

LOCUS Model (Annual and Monthly) Projections:
Based on Annual Total Behavioral Health ER Visits

CASCADE

Annual Projections:
- 14%: 1,013 interactions directly referred to *Acute Hospitalization*
- 54%: 3,907 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 2,315 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

Monthly Projections:
- 14%: 84 interactions directly referred to *Acute Hospitalization*
- 54%: 326 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 192 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

LEWIS AND CLARK

Annual Projections
- 14%: 1,632 interactions directly referred to *Acute Hospitalization*
- 54%: 6,312 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 3,744 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

Monthly Projections:
- 14%: 136 interactions directly referred to *Acute Hospitalization*
- 54%: 526 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 312 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

GALLATIN

Annual Projections:

- 14%: 731 interactions directly referred to *Acute Hospitalization*
- 54%: 2,820 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 1,671 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

Monthly Projections:

- 14%: 61 interactions directly referred to *Acute Hospitalization*
- 54%: 235 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 139 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

MISSOULA

Annual Projections:

- 14%: 1,202 interactions directly referred to *Acute Hospitalization*
- 54%: 4,636 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 2,747 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

Monthly Projections:

- 14%: 100 interactions directly referred to *Acute Hospitalization*
- 54%: 386 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 229interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

It is important to note that while the LOCUS projections may seem overwhelming for a crisis facility and crisis services, *the data reflect "engagements" and "visits" rather than individuals who will present with a wide range of needs and levels of acuity.* Further, although 24/7 call centers, community-based mobile crisis, and crisis receiving and stabilization centers have been shown to dramatically decrease the number of people who use or are transported to emergency rooms for crisis services, crisis receiving and stabilization centers do not replace or eliminate a community's need for inpatient behavioral health services.

The National Council for Behavioral Health's publication, "Capacity Projections for Crisis Residential Settings[8]" also references RI International's Crisis Now projections to forecast capacity, bed days, and utilization. According to the Council, the composition of the crisis continuum can be determined by the size and geographical distribution of the population to be served:

> "Based on the Crisis Now "How Does Your Crisis Flow?" diagram, a significant percentage of the total adult crisis presentations (200 individuals per 100,000 residents per month) were served in crisis residential settings. If that percentage is even as low as 30%, a community of 500,000 people would generate 300 residential crisis admissions per month and, if we assume an average length of stay of five days, that would require 50-60 residential crisis beds (5 x 300 = 1,500 bed days, divided by 30 for approximate utilization)."

[8] The National Council for Mental Wellbeing's Roadmap to the Ideal Crisis System, "Capacity Projections for Crisis Residential Settings", pgs. 108 – 109

That is, in the example cited by the National Council, the assumptions used are:

- ✓ Adult Presentations in Crisis: 200 individuals per 100,000 residents per month = 0.2%
- ✓ Thirty percent (30%) of the 200 (0.2%) adults need crisis facility
- ✓ Average Length of Stay (LOS) is 5 days

Based on those assumptions, we calculate the number of "bed days" and crisis "beds" needed per population size (which can be useful in terms of projecting "days and beds" for a region) would be:

Population	Adults in Crisis per month (pop. x 0.2%)	Needing Crisis Facility per Month (x 30%)	Bed Days (Admissions x 5 day LOS)	# Crisis "beds" (Bed Days/30 Approx. Utilization)
125,000	250	75	375	13
100,000	200	60	300	10
65,000	130	40	200	7

RI International has also developed a calculator to project capacity needs as well as the projected costs, and cost savings, of operating crisis services and centers. In preparing this report, WICHE/BHP reached out to RI International who, in turn, entered Montana's total population into the calculator to demonstrate the tool's value, as shown on the following page.

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Crisis Now Crisis System Calculator (Basic)		
	No Crisis Care	**Crisis Now**
# of Crisis Episodes Annually *(200/100,000 Monthly)*	24,000	24,000
# Initially Served by Acute Inpatient	16,320	3,360
# Referred to Acute Inpatient From Crisis Facility	-	1,336
Total # of Episodes in Acute Inpatient	16,320	4,696
# of Acute Inpatient Beds Needed	**348**	**100**
Total Cost of Acute Inpatient Beds	**$ 97,104,000**	**$ 27,938,820**
# Referred to Crisis Bed From Stabilization Chair	-	5,342
# of Short-Term Beds Needed	**-**	**41**
Total Cost of Short-Term Beds	**$ -**	**$ 11,352,600**
# Initially Served by Crisis Stabilization Facility	-	12,960
# Referred to Crisis Facility by Mobile Team	-	2,304
Total # of Episodes in Crisis Facility	-	15,264
# of Crisis Receiving Chairs Needed	**-**	**48**
Total Cost of Crisis Receiving Chairs	**$ -**	**$ 16,218,000**
# Served Per Mobile Team Daily	4	4
# of Mobile Teams Needed	**-**	**8**
Total # of Episodes with Mobile Team	-	7,680
Total Cost of Mobile Teams	**$ -**	**$ 2,160,000**
# of Unique Individuals Served	**16,320**	**24,000**
TOTAL Inpatient and Crisis Cost	**$ 97,104,000**	**$ 57,669,420**
ED Costs ($520 Per Acute Admit)	**$ 8,486,400**	**$ 2,441,712**
TOTAL Cost	**$ 105,590,400**	**$ 60,111,132**
TOTAL Change in Cost		**43%**

Per our communications with Wayne Lindstrom, PhD, Vice President for the Western US for RI International, *"From this, you can glean a variety of capacity and cost projections. However, we would urge any locality to further refine the data so that the Calculator takes into account current crisis resources and costs. For example, projections will vary based on a nascent system versus one that is mature and has been optimized over time."*

Summary of Recommendations

As outlined in this report, we offer the following guidelines and recommendations for the creation of crisis receiving and stabilization facilities for Cascade, Lewis and Clark, Gallatin and Missoula Counties.

- Crisis facilities are designed to operate within *a crisis system,* which includes the additional core services of 24/7 Call Center, CIT Team (and/or trained) Law Enforcement Officers, and Mobile Crisis. Mapping the pathways into the crisis facilities, and pathways to services once the crisis has been stabilized (or if the crisis center guest/patient requires higher levels of care), is vital to crisis system flow. In determining the crisis receiving and/or stabilization facility model each community will adopt, the pathways should be taken into consideration.

- Seeing, first-hand, model crisis facilities and systems is invaluable. Walking though the facilities (noting location, design and layout), seeing intake and operations, meeting with staff, and seeing demonstrations of reporting and system tracking tools will inform both practical and forward-thinking plans customized for communities. We strongly recommend Montana organize site visits to model crisis facilities/systems by teams of interprofessional organizational leaders and decisionmakers who represent the communities' primary stakeholder groups, including: CIT and law enforcement leaders, hospital ERs, psychiatric and substance use inpatient hospitals, community behavioral health providers (including FQHC's), elected officials, funders, and consumer/family advocates.

- Each community/county should consider developing a crisis facility/center business plan specific to the model their community/county will adopt. National Council for Behavioral Health's 2021 publications, "Map to the Ideal Crisis System: Essential Elements Measurable Standards and Best Practices for Behavioral Health Crisis Response", is an excellent reference tool for business planning.

- Tools exist to project crisis facility utilization, "beds", and capacity. The base data used to create the projections should be analyzed and updated to reflect the nuances of population needs, community resources, and funding. RI International is most often cited as the organization that has developed and tested calculation tools based on the Crisis Now best practices.

- High levels of service coordination and transparency between first responders, hospitals, health and medical providers, and behavioral health treatment providers is crucial to the success of any "no wrong door" crisis systems. Agreements and/or Memorandums of Understanding between the Crisis Facility provider(s) and primary community organizations/agencies that provide/support crisis and behavioral health services will help define expectations and support a cohesive system of crisis care.

- Withdrawal management and detoxification services is a major gap in all four counties. However, if operated under the best practice models and protocols of crisis care, people who have indications of substance use will be served at the Crisis Receiving facilities. Consequently, once the crisis facilities are fully operational, each community should reassess the need for additional substance withdrawal and/or sobering facilities.

- Staffing and workforce development is a major concern for organizations that are currently operating community-based crisis stabilization facilities in Gallatin and Missoula counties (i.e., WMMHC), as well as for those agencies evaluating the possibility of developing/operating crisis facilities. SAMSHA, the National Council for Behavioral Health, and RI international offer resources and ideas to help communities forecast staffing needs based on the model of care as well as other determinants. Training and employing Peer Specialists is another best practice in crisis services and centers we strongly recommend. In addition, telehealth (for medical clearance and evaluations), and telepsychiatry (for evaluation, psychiatric consultation, prescribing) are approaches that should be considered.

Next Steps

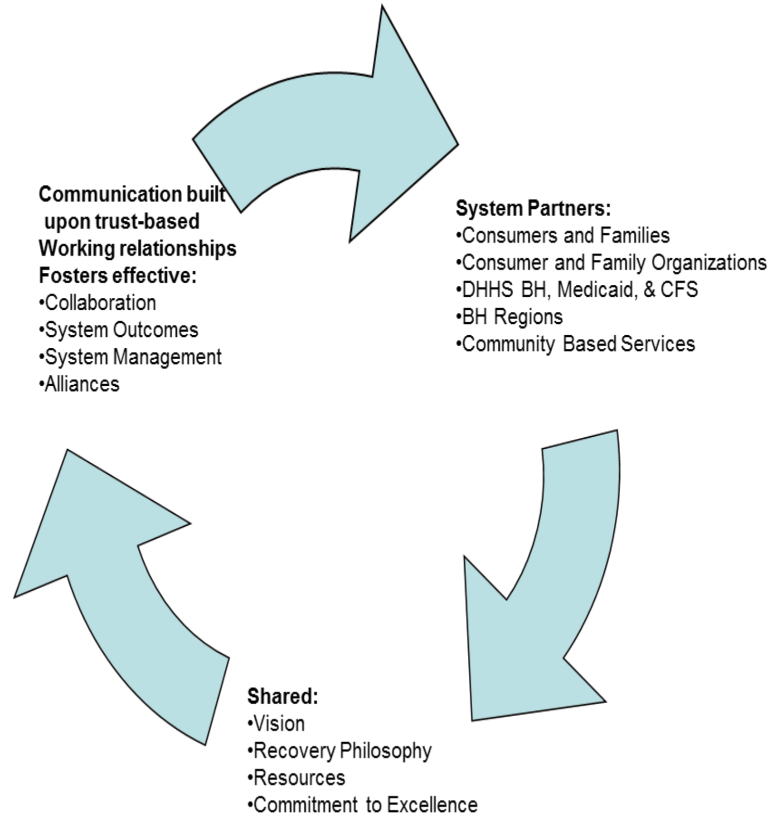
Stakeholders of all four counties are eager to begin planning for crisis facilities based specifically on their community's resources and needs. Toward that end, subject to funding, Phase Two of this project and the future consultation will focus on the following for each county within their local systems:

- Facility: Recommendations regarding the crisis receiving and stabilization facility/facilities within the scope of each county's resources and needs, including consideration of existing resources such as a currently closed facility or services that may be repurposed and/or strategically positioned.
- Agreements: Recommendations regarding partnership agreements and MOU's unique to each county.
- Program Flow and Pathways: Mapping and definition of programmatic and systematic flow as well as service pathways for each county – from initial assessment to connection to services.
- Policies: Review of State policy landscape of crisis receiving and stabilization services and facilities to ensure that policy framework (licensing, regulations, etc.) are in place to support best practices crisis receiving and stabilization models.
- Staffing: Crisis Facility staffing projections and recommendations (i.e., credentials, licenses, expertise, etc.) to ensure coverage and capacity to receive individuals (without any additional routing to the ER for medical concerns) – including applications and utilization of telehealth.
- Expenses: Facility expense forecasts, including start-up expenses, staffing, operational, and administrative cost projections.
- Funding: Analysis of sustainable funding sources and/or needed policy changes. For example, Medicaid coverage for "ineligible" persons and safety net funding.

Behavioral Health System Strategic Planning - Framework

Develop a plan for a high-performing Montana behavioral health system to include the following:

- ❖ Vision for the future
- ❖ Incorporate objectives with clear outcomes and accountability
- ❖ Analyze the role of the public behavioral health stakeholders



Objectives

1) Identify structural elements required to operationalize the system vision statement
2) Review the effectiveness and plus/minuses of state and regional funding/division structure
3) Conduct gap analysis comparing the current Montana behavioral health system with the system vision
4) Analyze the role and financing of the Montana State Hospital and or the impact of a regional approach within the system
5) Recommend specific changes needed to achieve the envisioned system

6) Develop a road map for the envisioned system – steps in the process to design, develop, implement, and operationalize and associated timeline for such steps
7) Conduct a fiscal analysis of each recommendation
8) Incorporate characteristics of best practice purchasing (system performance measures, value-based contracting, etc.) in the system design
9) Demonstrate how the plan would be cost sensitive to the State budget realities in the short term and address long-term sustainability
10) Develop strategy action document
11) Prioritize legislative initiatives for the behavioral health system

Strategic Planning Framework

I. History of Montana Behavioral Health System
   a. Legislative milestones
   b. Mental Health Oversight Advisory Council (MHOAC)
   c. Local Advisory Councils on Mental Health
   d. Children's System of Care Planning Committee – Administrators and Community members
      e. Improving Montana's Mental Health System – Final Report; Technical Assistance Collaborative, Inc.
      f. DMA Health Strategies Final Report

II. Behavioral Health System Structure
   a. Population
      i. Population characteristics
      ii. Medicaid population
      iii. Montanan's served by Mental health Service Plan (MHSP) funding
      iv. Prevalence rates
      v. Penetration rates
      vi. Gaps
   b. Behavioral health delivery system structure (adult & children)
      i. Institutional care
         1. Montana State Hospital
         2. Department of Corrections
         3. Montana Chemical Dependency Center
         4. Montana Development Center
      ii. Community-based care

iii. Licensed community health centers (27)
1. MHSP funded
2.

iv. Tribal system(s)
v. Addiction services

III. Behavioral Health System Funding
a. Service funding matrix by payer source (needs to be developed)
b. Access to services
c. Workforce development
d. New payor models
i. Fee for service
ii. Shared risk contracts
iii. Episodic care
iv. Consumer driven
v. Incentivized community care
vi. Medical home
vii. Integrated delivery
e. Total behavioral health system funding
i. Medicaid Behavioral Health
1. State Match
ii. Medicare
iii. Federal Block Grant
iv. State General Funds
1. Crisis services
v. Local City/County Funding
vi. Private provider grant funding
vii. Department of Public Health & Human Services
1. Children's Mental Health Bureau
2. Addictive & Mental Disorders Division
viii. Mental Health Service Plan
ix. Montana Mental Health Trust
x. Magellan Administrative Contract
xi. Other

IV. Behavioral Health System Performance Measurement Data
a. Total # Using Medicaid-Funded Services Only

b. Total # Using DPHHS-Funded Services Only
c. Total # Using Both Medicaid & DBH Services
d. Total # Using Provider Charity Care
e. Total # of Montana living with a diagnosable mental Illness
f. Total # who get diagnosed
g. Total # of follow through with a treatment regimen
h. Tools to monitor beyond utilization data
i. Tools to learn more about those utilizing care through a "level of care" assessment tool
j. Performance tool coupled with payment for providers
k. Evidence-based & practice-based service models
l. Consumer driven care in comparison to provider driven care
m. Quality measures not connected to cost
n. Community or County report card
o. Suicide rate

V. Overview of Key National Trends With Implications For Behavioral Health System Planning
   a. Parity legislation now in place
   b. Health care reform initiated January 1, 2014
   c. Montana did not expand Medicaid
   d. IMD waivers and current ruling
   e. Medicaid program integrity and audits
   f. Comparative effectiveness – clinical decision-making models developing
   g. Intrusive technologies
   h. Electronic Medical Record (EMR) mandates
   i. System change (and opportunities) with telehealth
   j. Virtual consumer implications

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, 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.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ○ No

b) Posting of the plan on the web for public comment? ○ Yes ◉ No

If yes, provide URL:

https://dphhs.mt.gov/BHDD/Prevention/index

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://dphhs.mt.gov/amdd/

c) Other (e.g. public service announcements, print media) ◉ Yes ○ No

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Footnotes:

1/30/23 The new URL for the updated Behavioral Health & Developmental Disabilities Division. Our state has experienced many divisional merges. BHDD was formerly AMDD, therefore the website is being updated and may be a bit before all the website information is available. JH 1/30/23

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf** ,

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf** ,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

Syringe services are not paid for by the SABG but the state is using the SOR grant to provide funds for safe syringe programs, not the purchase of syringes.

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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Footnotes:

The state does not fund syringe services through the block grant.