MONTANA
PUBLIC HEALTH INSTITUTE

Unlocking the Potential of Public Health to Address Behavioral Health in Montana

AN ENVIRONMENTAL SCAN

Contents

Preface

The purpose of this document is to help unlock the untapped potential of Montana's public health system to promote mental wellness, resilience, and protective factors critical to improving the health of Montanans. For more than 18 months, the creators and contributors to this effort have interviewed public health professionals, studied the structure, systems, and organizations working in the field, and explored scientific literature and the work of others seeking to understand this complex issue. The effort has taken longer than expected and revealed a system that is complex, fragmented, and averse to simple solutions.

One might ask the question: Why? Why take on this challenge? Why devote time and energy to connecting our public health system to our behavioral health system?

The clearest answer to these questions is also the simplest: We have no choice. This mixing and merging of behavioral health needs and services with our public health system is happening now and will continue to happen. Throughout Montana, local and tribal health departments are being confronted by the tragedy and trauma of a behavioral health system struggling, sometimes failing, to meet the needs of Montanans. Suicide. Substance use. Incarceration. Child abuse and neglect. Mental health crisis systems - local law enforcement agencies and healthcare providers -- unable to serve the needs of people in crisis. Public health leaders are pulled into this work, in part, because the needs are so evident, so urgent, and so impactful on virtually all health outcomes. They are also being pulled into this work by community leaders and elected officials struggling for answers to the latest cluster of suicides, rising numbers of overdoses or crisis calls, or parents' concern about alcohol or substance use.

Throughout Montana, we found public health agencies and professionals working diligently and imaginatively to meet the challenge.

We talked to a tribal health director who – on her own, without funding, and in the midst of a viral pandemic – organized a community effort to design and deliver a series of evidence-based trainings to address her community's outsized mortality rates and resulting grief, trauma, and loss. In the midst of a generational public health crisis, Crow Tribal Health Director Lee Ann Bruised Head worked with colleagues and community partners to provide mental health first aid classes, a suicide prevention training, and structured support for those experiencing grief,

loss, and trauma. Bruised Head said the tragedy of the loss of so many loved ones was compounded by the inability to practice the traditions of communal grieving due to concerns about further spreading the virus. “It was very personal,” she said. “I lost 20 family members to COVID.”

In Teton County, MT, we talked to a local public health director who began a concerted effort six years ago to channel community concern about substance use into creating a community behavioral health coalition. Teton Health Director Melissa Moyer recruited partners in law enforcement, emergency medical services, schools, churches, and local elected leaders. The group initially had virtually no funding, but Moyer and others worked to channel its energy and expand its vision. Moyer helped the group merge with another community group, composed of many of the same people. She pressed for evidence-based work, such as the PAX Good Behavior Game, Mental Health First Aid, and a postpartum depression class. Slowly, over time, the coalition grew from a concern about substance misuse into a coalition also focused on the upstream drivers of behavioral health outcomes. Moyer credits this work with helping her build trust and partnership that was invaluable when the pandemic arrived. “This coalition, in some ways, saved our bacon when it comes to our social capital,” Moyer said.

These are not the only examples of local and tribal health leaders working imaginatively and energetically to address these issues. But too often, this work has been underfunded, disconnected from a comprehensive statewide system or plan, and reliant on the energy of individuals.

In other communities, we found recently-hired public health directors and staff working overtime to understand and manage contracts and deliverables for those public health programs that are funded by the state health department and federal agencies: communicable disease response, food safety, immunization services, maternal and child health, and public health emergency preparedness. But these new public health leaders rarely inherited resources – money, expertise, or funded time and effort – to prepare them to respond to rising community alarm about suicides, or overdoses, or people in mental health crisis. And the community imperative to address the most urgent needs allowed even less time and space to address prevention-focused work to build resilience and mental wellness.

Erin Cross, a former emergency room nurse from Carbon County, was appointed public health director in September, 2021 and walked into a department with no staff and empty offices, just as the Delta variant of COVID was sweeping across the country. As Cross worked to organize COVID immunization clinics and re-build

the health department, local leaders asked that she also help lead a local mental health crisis response coalition and rebuild local mental health services. She said she took on the challenge because of need. "It's obvious that mental health in our community has always been rough," Cross said. "There just aren't a lot of resources."

In Helena, we found divisions and offices within the Montana Department of Public Health and Human Services (DPHHS) responsible for behavioral health services that have experienced substantial, in some cases seismic, staff turnover. The personnel churn compounds an already daunting challenge of delivering prevention-focused behavioral health services in 56 counties and seven American Indian reservations using a patchwork of federal funding sources, each connected to its own set of rules and grant requirements.

Most funding intended for community-based prevention services tends to flow towards regionally-organized treatment providers and community organizations. With a few exceptions, public health departments that provide disease prevention and health promotion services in each of Montana's 56 counties typically receive extremely limited or no direct funding dedicated to providing staffing, in-house expertise, or programming for prevention-focused behavioral health work. As a result, the health department staff who work to prevent tobacco use, cancer occurrences, communicable diseases and maternal mortality are not funded to help lead similar work in behavioral health.

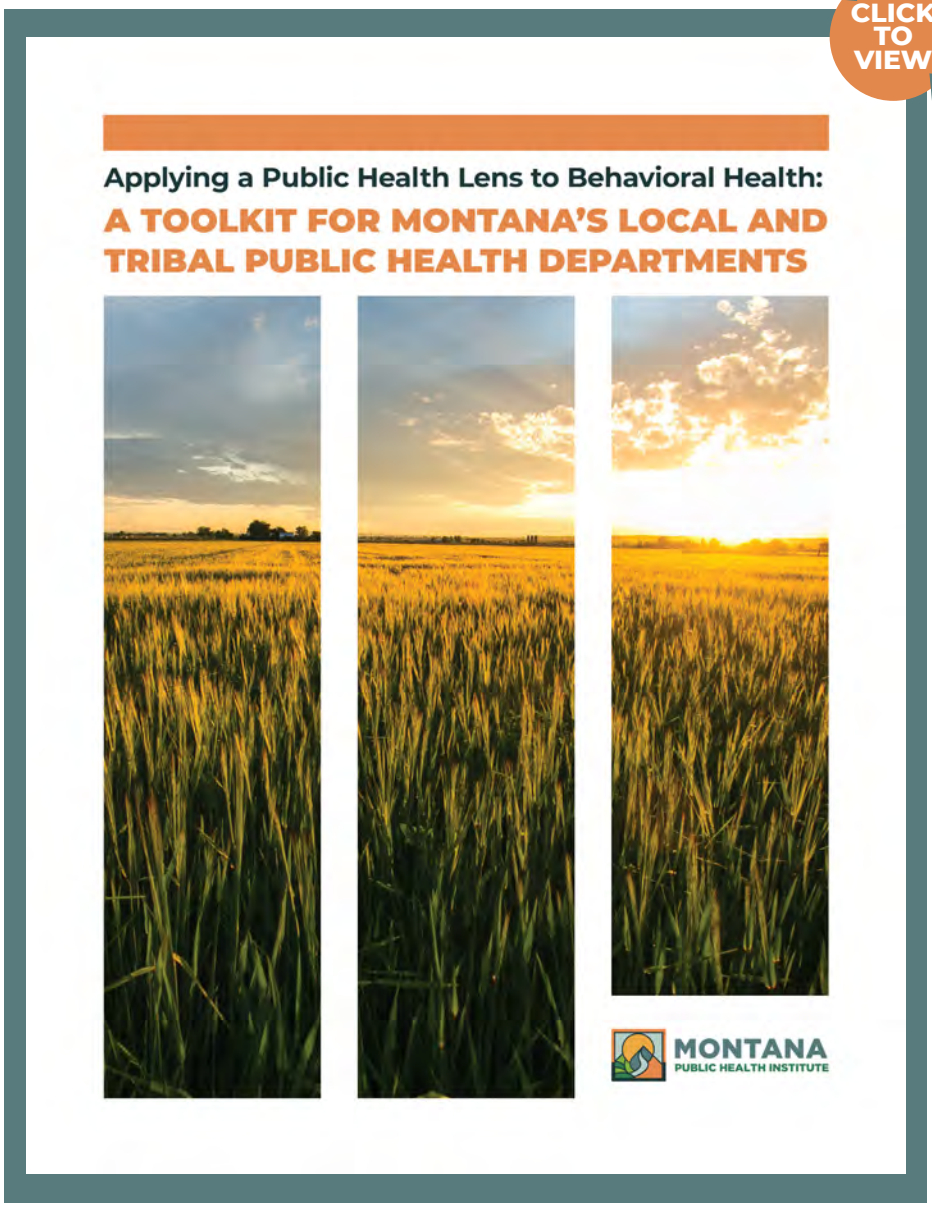
To be clear, unlocking the potential of our public health system to address behavioral health cannot mean that public health or local community-based organizations replace well-performing treatment providers and regional organizations. That would be an insufficient result. Rather, this effort seeks to find ways that local and tribal public health agencies and other local community-based organizations can be supported (and funded) to address substance use and mental wellness using the same skills and assets that public health can and does bring to bear for so many other public health challenges: assessing community needs and capacity, building close community relationships, engaging community leaders, coordinating and leading effective, community-driven and evidence-based efforts.

This document is aimed at understanding the landscape and structure of prevention-focused services in Montana, and suggesting ways to use public health to strengthen that system. We seek to examine the concepts of prevention-focused behavioral health work and the system used to fund and support this work in Montana, including funding streams, organizations, and programs

and interventions being pursued. A companion resource entitled, **Applying a Public Health Lens to Behavioral Health: A Toolkit for Montana's Local and Tribal Health Departments**, provides a resource manual for local public health practitioners working to address community behavioral health priorities. Together, our hope is that the documents provide a road map for both navigating and improving the systems we use to build resilience and mental wellness in Montana.

Finally, it must be noted that we view this work not as a finished product, but as a resource that helps with some initial steps and sets a foundation for future work. It must also be noted that this work draws on lessons learned and research done by many, including JG Research, Stellar Group, DPHHS, BMT Consulting and many others. We thank those who have helped create this work, and those who have pursued related efforts that helped inform our thinking. We honor their time and energy, while acknowledging that this work is incomplete.

CLICK TO VIEW



Key takeaways

- This report is motivated by the reality that ongoing efforts in Montana to address exigent behavioral health outcomes (mental health crisis, overdose, self-harm, and incarceration) will likely continue to produce ever-increasing and unsustainable resource demands without sustained statewide efforts to promote emotional wellness, resilience, and protective factors for all Montanans;
- Currently, Montana does not have a statewide plan to deliver these prevention-focused behavioral health services. Current efforts are driven by a patchwork of funding streams from a number of federal agencies, each with varying requirements, objectives and deliverables;
- Montana's local and tribal public health departments offer a promising but underutilized statewide resource for these prevention-focused efforts. The foundational capabilities of high-performing public health agencies – community assessment and partnership development, communications, and preparedness – could be leveraged to organize, support and coordinate community action to address behavioral health;
- Many local health departments and community organizations are engaged in this work, but seldom receive direct funding or support for prevention-focused behavioral health expertise and programs;
- Currently, most prevention-focused substance use prevention funding in the state is distributed through five regional organizations charged with serving all 56 counties and 12 tribes. This regionalized system has produced mixed results, with many local public health officials reporting that the feel disconnected from these efforts;
- Current funding for substance use prevention services has increased in recent years through the use of pandemic-era funding, but DPHHS officials expect large shortfalls starting in 2024, imperiling this work;
- Local public health leaders interviewed urged state officials to sustain this work and allow local agencies – including but not limited to health departments – to access prevention funding to allow local leaders to lead this work for their communities;
- Successful and ongoing public health efforts could provide blueprints for connecting local public health agencies and communities to statewide behavioral health efforts. These possible models include state-local efforts to address commercial tobacco use, chronic disease prevention, cancer mortality, and maternal and child health.

Part One: Behavioral Health through a Public Health Lens

Imagine that you are a newly hired director of a local health department of a rural county in Montana. A county commissioner, a member of your Board of Health, comes to you to discuss her concerns about a recent overdose death and a second near overdose by a local high school student within the past three months. The commissioner wants the health department to explore ways to lead an advertising campaign to prevent use of the drug that caused both overdoses.

As the local public health director, parent of two children, and member of the community, you share the commissioner's concern and you sense a moment of opportunity to channel this energy into effective action. But you are unsure that an advertising campaign urging kids to "say no" will accomplish much, or is even possible without funding to do the work. Adding to your worries are the ongoing demands of the COVID-19, rising syphilis rates in Montana, and five or six contracts with DPHHS that are not directly related to behavioral health. You have no funding to do this substance abuse work, and as a result, no dedicated staffing or expertise in-house. A part-time prevention specialist hired by a regional non-profit organization three counties west of you has been assigned to your county, but he doesn't work for the health department and lives in the county to the east.

Despite all of this, you were born and raised in this community, and returned after earning a nursing degree from MSU and a public health certificate from UM. You know this community. People know your family and remember when you played basketball for the local high school. You are part of the community and can help lead action.

As the lead local public health staffer, you attend monthly meetings of a committee trying to improve the crisis mental health system. You go to other meetings of the Drunk Driving Task Force and the county's Mental Health Local Advisory Committee, a group of behavioral health system consumers and stakeholders charged with providing local perspective to state leaders. You do this work because the community, your community, needs someone to do it. You also are always mindful that Montana state law assigns responsibility to local health departments to address the issues of public health importance. The problem is that your department does not receive funding or support to hire staff to do this work.

Instead, it lives at the edge of your desk, waiting for you to finish the annual budget, reports and deliverables for five prevention-focused grants that are funded (tobacco cessation, cancer prevention, emergency preparedness, immunization services, and maternal and child health). Other items in your in-box include vaccine clinics, board of health meetings, and managing three other staff members.

While each of Montana's 56 counties and seven American Indian reservations are unique communities with varying capacities and needs, the scenario above, or some close version of it, likely rings familiar for the vast majority of local public health leaders in Montana. For many good reasons, they are pushed and pulled to help address the urgent needs of crisis services, or suicides, or overdoses, or drunk driving crashes happening in their communities. As a result, public health is sometimes pulled away from behavioral health work that is based in public health's foundational capacities and skills: community assessment and convening, collaboration and leadership for prevention-focused programs that promote wellness and resilience and, over time, can reduce the crisis events.

Acknowledging this tension, naming public health's foundational capacities, and understanding those capacities in the context of behavioral health, is a necessary first step to unlocking the potential of the public health system.

Mental Health Spectrum

An important preamble to understanding the system is understanding what we know about the potential of behavioral health efforts that focus on emotional wellness, resilience, and protective factors. These ideas are at the foundation of a sound public health approach to behavioral health.

It is recognized globally that mental health is more complex than the absence of clinical mental illness or psychopathology. Mental health exists on a continuum, which places mentally healthy and mentally disordered states at opposite ends of a spectrum, and these states are broadly characterized by affect and levels of functioning. There are many conceptual definitions of psychological well-being and related concepts such as flourishing and positive mental health. The two parts of the term "well-being" bluntly describe its meaning: it involves "being" and "well," in essence, living in a state that is judged as good. It involves physiological, social, and psychological aspects (Warr, 2012).

Other constructs, such as flourishing, denote being mentally healthy, whereas languishing is the state when subjective well-being and psychological and social

functioning are lower but not disordered. Essentially, a person can be said to be flourishing if they perceive that their life is going well. Flourishing is a combination of feeling good and functioning effectively (Keyes, 2002). As displayed in Figure 1, most of the population has moderate mental health. But no matter where the mental health of an individual may be on the spectrum at a given time, individuals can move up or down throughout their lives. Importantly, mental health state is not necessarily dependent on mental health, meaning that individuals who have been clinically diagnosed can flourish, and those who have not been diagnosed can experience mental disorder.

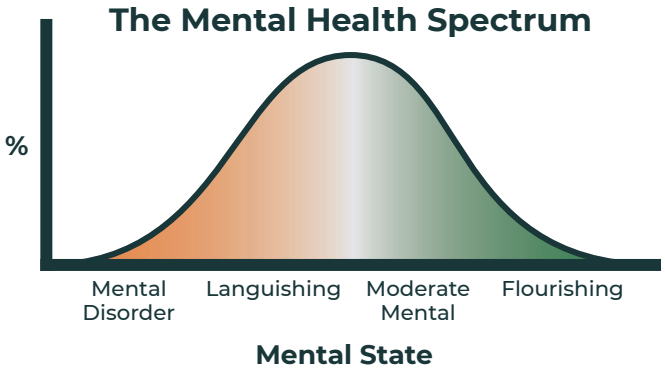


Figure 1. The mental health spectrum

Individuals who are flourishing learn more effectively, have higher work productivity, have better social relationships, are more likely to contribute to their community, and have improved health and life expectancy (Diener et al., 2009; Kern et al., 2015; Huppert, 2009). High levels of flourishing in a community are also associated with economic benefits due to less absenteeism and under-performance in schools and workplaces, lower healthcare costs, and less need for expenditure on the effects of social disintegration (Diener & Seligman, 2004; Rothman, et al. 2020).

One important way that public health can strengthen the behavioral health system is to create supports so that individuals who begin to languish can become engaged, stabilized, and move toward flourishing.

There are clear benefits to positive mental health during adulthood. Completely mentally healthy adults (i.e., individuals without a mental disorder for 12-months and flourishing) report fewer missed days of work, fewer half-day or work cutbacks, the healthiest psychosocial functioning (i.e., low helplessness, well-defined life goals, high resilience, and high intimacy), the lowest risk of cardiovascular disease, the lowest number of chronic physical diseases with age, the fewest health limitations in activities of daily living, and lower health care utilization. However, only 20% of the adult population was considered flourishing (Keyes, 2007). The distribution of individuals across the mental health spectrum provides opportunities for engagement and supports, as health departments consider shifting toward a focus on the middle of the curve, rather than only the tails.

Resilience

By focusing on the development of factors that promote resilience, local health departments can strengthen the capacity of all members of a community to respond to difficulty.

In recent decades, a significant strand of mental health research has shifted from concentrating on the identification of risk and psychopathology to the promotion of factors such as resilience. Resilience is a dynamic process whereby individuals, communities, and systems adapt and thrive in response to external stressors, including economic and social pressures and environmental threats. A key underlying component to resilience is the presence of adaptation and/or coping in response to risk, adversity, and challenges (Windell, 2011; Manjula & Srivastava, 2022; Masten, 2018). At an individual level, resilience is associated with healthy development, positive health outcomes, and ability to withstand stressors in one's life (Yates et al., 2015).

By establishing processes that can be protective factors, community systems can be leveraged to provide supports when there is adversity.

Positive Psychology

A focus on supporting positive emotions, through community activities, individual programs, and collaborations can decrease likelihood that community members will languish.

Positive mental health involves several psychological domains which contribute to optimal functioning, including emotion (affect, feelings, mood), cognition (perception, thinking, reasoning), social (relationships with others and society), and coherence (sense of meaning and purpose in life) (Friedli, 2009). A growing number of studies have established that each of these domains predicts outcomes such as longevity, physical health, quality of life, criminality, drug and alcohol use,

employment, and pro-social behavior, e.g., volunteering (Pressman & Cohen 2005; Lyubomirsky et al., 2005; Dolan et al., 2006).

Research consistently demonstrates that positive emotions improve one's ability to cope with stress (Burns et al., 2008; Livingstone & Srivastava, 2012), and improved coping subsequently bolsters resiliency (Ong et al., 2006; Tugade et al., 2004). Positive emotion theories suggest that positive emotions can widen the range of potential coping strategies that come to mind and therefore enhance resilience to stress. Positive emotions may enhance resilience directly and indirectly through the mediating role of adaptive coping strategies. Although stress is unavoidable and its influences on anxiety and depressive symptoms are clear, the likelihood of developing negative mental health symptoms may be lessened by implementing programs designed to increase positive emotions, adaptive coping strategies, and resilience (Gloria & Steinhardt, 2016).

Health Departments can incorporate concepts from positive psychology in their active program areas, thereby increasing the likelihood that those who are languishing may be supported and strengthened.

Protective and Risk Factors

A public health approach to behavioral health seeks to create population-level circumstances within a community through which individuals and groups are more likely to flourish and develop resilience.

This work involves an effort to recognize risk and protective factors that impact emotional wellness and resilience. Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes. Some risk and protective factors, such as genetics and biology, do not change over time. But many risk factors do change over time. Variable risk factors include income level, peer group, adverse childhood experiences (ACEs), and employment status.

A public health approach to this work seeks to build protective factors that help counter or mitigate risk factors. With children, for example, risk factors could include poverty, abuse or neglect, and violence. Protective factors, meanwhile, include safe relationships with trusted adults, well-developed problem-solving skills, and positive self-esteem. These protective factors can happen at the individual level

(such as a positive self image) as well as the environmental level (such as living in a safe and supportive community). The more protective factors that are present, the better health outcomes one can expect.

The risk and protective factors affecting an individual can and do change over time and environment. All individuals have biological and psychological characteristics that make them vulnerable to, or resilient to, possible behavioral health issues. Because individuals have relationships within their communities and larger society, each person's biological and psychological characteristics exist in multiple contexts and can lead to different outcomes. For example, a person may feel relaxed in one context, and anxious in another.

Likewise, communities exist within a complex constellation of risk and protective factors. Some of those factors can be changed over time. Within the context of behavioral health, some examples of this would be efforts to reduce stigma associated with mental illness, programs that engage young people or forge connections for groups that are more likely to be disconnected, such as seniors. Addressing risk factors through upstream interventions, while enhancing resilience within individuals, organizations, and communities can build a community's ability to respond to difficulties when they arise. But this work will look very different from one community to the next because of the complex, variable nature of risk and protective factors. Efforts to build protective factors in Billings will look different than efforts happening in Lame Deer, which will look different from efforts in Browning or Libby.

Montana's system of local and tribal health departments are uniquely positioned to help drive this work through community engagement, existing relationships, and expertise and experience in the concepts and approaches described above.

Public Health Pushing Upstream

Reframing behavioral health concerns along the mental health spectrum enables practitioners and communities they serve to shift a focus away from chasing crises and toward focusing on processes and programs which help the community to rebound and remain stable in the midst of life challenges. This is done with a recognition that all members of a community vary in their own personal risk factors for adverse mental health or substance use outcomes. Focusing on supporting promotive and protective factors that help to support individuals across the risk spectrum is core to this work. This spectrum-spanning approach includes a commitment to harm reduction for some in the community as well as primary prevention work aimed at the entire population.

Also critical to this work is the need to coordinate community action in a way that makes impact through coordinated efforts and transparent goals. One potentially powerful way for local health departments to help lead work in their community is through a structured, transparent, and clear conceptual framework. Working collaboratively is simplified with the use of a framework, as it can generate buy-in from partners, structure thinking among partners, and identify pathways for engagement that align with the strengths of each organizational partner. There are a host of frameworks that may guide efforts.

One framework worth exploring is the Social-Ecological Model (SEM) used by the U.S. Centers for Disease Control and Prevention (CDC). We have selected to focus on the CDC's model for health promotion. This version narrows the focus from the seven levels to four levels. Those four levels include individual, relationship, community, and societal. As seen in Figure 5, this updated model again shows how an individual's health is connected and that the varying levels interact with each other.

Figure 2. The social-ecological model: a framework for prevention

The individual level refers to an individual's own knowledge, attitude, values, and beliefs about specific health behaviors that have an impact on their health. The relationship level involves a person's immediate social circle such as family, friends, partner, etc. This level looks at how an individual's own perceptions about a specific health behavior and the influence of the relationships around them impact their health outcomes. The third level is community, which includes the settings where people interact with others, like school and work. The final level is societal, which involves social norms and policies that interact with socioeconomic inequalities between social groups. Each level is connected, and each level can impact health at the individual level as well as at the community level.

This model can be used to identify factors at the various levels and develop approaches to address each of those factors within their respective level. In the context of this resource, the modified SEM can inform how communities select an intervention to address an identified need.

How to apply the social-ecological model: An example

As an example, think of there being a recent high-visibility suicide in a community. In that community, there is an existing coalition that has called an emergency meeting for how to best support the community following the most recent suicide. The existing coalition feels strongly that they need to create a media campaign to provide awareness about suicide and what the community can do to prevent suicide. A well-trained and supported public health professional may help channel this concern to also consider implementing support groups or services for survivors and families, such as the LOSS Teams that exist in Lewis & Clark County, MT. (A more in-depth look at LOSS teams can be found on page 42.) The community might also consider training its members to use QPR (Question, Persuade, and Refer) classes, a recognized suicide prevention training to help participants recognize the warning signs of suicide and question, persuade, and refer people at risk for suicide for help. Figure 3 below modifies the social-ecological framework for this project to focus on three areas where local health departments can most readily influence. In this example, we can see how all three levels in the framework are helping to inform the selection and implementation of multiple interventions to respond to concerns generated by a recently completed suicide in the community.

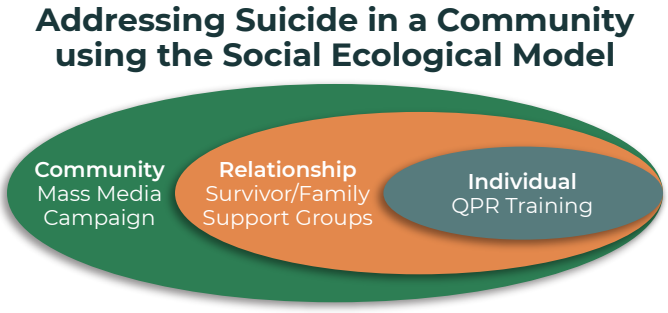


Figure 3. Addressing suicide in a community using the social ecological model

Individual Level: The coalition member offering QPR training to the community is focused on providing individuals in the community with resources to respond to suicide in their own lives.

Relationship Level: The Survivor/Family Support Groups provided tailored support to the survivors and families following the event.

Community Level: The other members in the coalition focused on a targeted media campaign (social and other media) is a strategy to provide education to the community.

As we can see through this example, the coalition is able to enact a response that applies to multiple levels of the social-ecological model to generate a multi-pronged and effective response to the topic of concern. The ability to enact multiple and coordinated programs to respond to a concern will depend on the capacity of a

given community. However, the use of the model can inform decision-making and program selection regardless of capacity, as even communities that can only enact one model will benefit from an intentional process of identifying which level should be targeted.

A Statewide Framework in Montana

In 2021, Montana Gov. Greg Gianforte and the Montana Legislature acknowledged the need for a framework to work across the broad spectrum of behavioral health needs as they passed the Healing and Ending Addiction Through Recovery and Treatment (HEART) Initiative. In a later section, we will examine in more depth how the HEART Initiative fits into Montana's behavioral health system. But as we consider the principles of public health's role in the behavioral health system, it is important to understand that the HEART Initiative seeks to strengthen a full continuum of behavioral health services in Montana, including prevention-focused and community coordination services that are foundational capacities of well-functioning, local public health agencies. In some ways, the HEART Initiative also provides a useful way to visualize the individual, relationship and community levels at the core of the Social-Ecological Model.

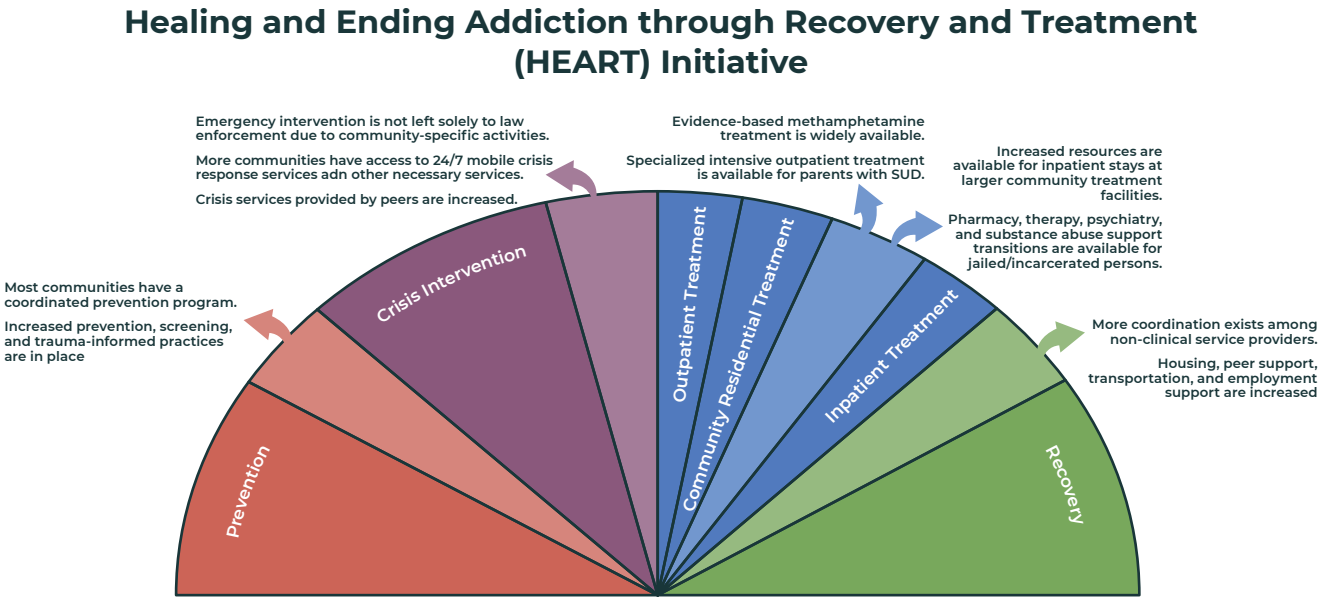


Figure 4. HEART Initiative spectrum

Figure 4 illustrates the HEART Initiative and helps visualize this full spectrum of behavioral health services, with the center (purple and blue) elements of the spectrum focused on those services (crisis response, treatment, inpatient facilities) that so often create the most urgent and evident impacts on a community. The edges of this HEART Initiative spectrum (the red and green areas include the parts of the behavioral health system where public health is often best positioned to provide impact: prevention-focused services, community coordination, and critical social factors that impact health such as housing, transportation, and employment.

Utilizing our public health system to address what is arguably the state's biggest public health challenge, in this context, seems like low-hanging fruit for state policymakers and local elected leaders. Failure to invest in this work (the red and green sections of the HEART Initiative spectrum) seems likely to perpetuate the ever-growing resources needed to address rising need for crisis services, inpatient beds, correctional facilities, and school-based special education services.

The edges of the spectrum in Figure 4 are where local and tribal public health agencies work every day to prevent and limit the spread of disease, to promote healthy behaviors, to coordinate community assessment and engagement, and to address social and economic factors that impact behavioral health. While the HEART Initiative is not a perfect reflection of the Social-Ecological Model, its purpose is similar: to provide a framework to help address a complex system using a broad array of approaches that work on the problem at different levels in a way that is planned and intentional.

Section summary

- Mental health exists on a spectrum and people can be in motion within this spectrum between states of flourishing and languishing, with most people likely somewhere in the middle experiencing moderate mental health. One important goal of any programing should be to support those who begin to languish and orient them towards flourishing.
- Resilience, among individuals and communities, can help mitigate the risk of negative mental health outcomes. Promoting resilience can result in positive outcomes similarly across residents at high and low risk in your community. Supporting community wide assets (education, access to care, etc.) available to all residents can foster resilience.
- Positive psychology or positive emotions can enhance an individual's ability to manage adversity. Additionally, positive emotions can have a positive impact on quality of life, physical health, and employment, while simultaneously reducing criminality and drug and alcohol abuse. Community-wide programming can support positive emotions.
- Applying the understanding that everyone in a community has their own personal level of risk for mental health or substance abuse outcomes will help practitioners use strategies that support residents across the risk spectrum. Shifting upstream from a focus on problems to identifying the process leading to behavioral health issues and programs that can address them will cultivate a more resilient community.
- Conceptual frameworks, such as the Social-Ecological Model, can be useful in helping organizations and communities address complex problems (such as improving our behavioral health system) in intentional ways that work on the problem at multiple social levels.

Part Two: An Examination of Montana's Prevention Programs and Efforts

Once we acknowledge and understand the concepts of prevention-based work as a foundational value and capacity of public health, it is useful to understand how the State of Montana works to provide prevention-based behavioral health services.

Prevention programming in Montana is funded through a series of federal grants as well as the allocation of state tax dollars. Montana-specific revenue sources exist at both the state and county levels.

As in many other states, the core funding for prevention-based behavioral health services in Montana are a mix of federal grants, most notably **Substance Abuse Prevention & Treatment Block Grant (SABG)**, now known as the **Substance Use Prevention, Treatment and Recovery Systems (SUPTRS) Block Grant**. These funds, paired with funds from the **Strategic Prevention Framework (SPF) – Partnership for Success** grant, are administered by the Behavioral Health and Developmental Disabilities Division (BHDD) of DPHHS. These funding streams are the core support for BHDD-funded efforts to fund prevention specialists through regional organizations, and to implement a select number of evidence-based programs, including Communities that Care and the PAX Good Behavior Game (explored in more detail on page 24). Due to the outsized importance of these funding streams, a more thorough discussion is included later in this document.

While the federal grants discussed above are foundational, a number of other funding sources also play a role in Montana's ongoing prevention efforts:

- **The HEART Fund/ Medicaid/ Cannabis Taxes:** One relatively new, but somewhat uncertain, potential funding source is the Healing and Ending Addiction through Recovery and Treatment (HEART Fund) referenced above. The HEART Fund is comprised of revenues from taxes on cannabis sales, an investment which state officials hope will result in matching funds derived from the federal Medicaid program through an application for 1115 Medicaid waiver. If the waiver is approved by federal officials, the HEART Fund would provide roughly $25 million per year for behavioral health services. To date, this funding has been used for substance use treatment services and some prevention-based programs, including expansion of the PAX Good Behavior Game in Montana schools and 17 additional community Prevention Specialists

employed by regional organizations to pursue implementation of primary prevention of youth substance misuse. To date, however, there continues to be uncertainty about how those funds will be allocated in the future and who will make those decisions. For further details about programmatic efforts by DPHHS to support prevention programs, review the interim reports they provide to the state legislature (2022 interim committee report here).

- **Alcohol Tax Dollars:** A portion of taxes collected on alcohol sales in Montana are distributed to the 56 counties and can be used to fund state-approved providers of prevention services. County Commissions have the authority to distribute these revenues to DPHHS-approved prevention providers. Once approved, Montana state law allows local agencies to use those funds to hire staff or pursue programs designed "for purposes pertaining to the problems of chemical dependency or related social problems." Local health departments can become an approved provider through a process outlined in a brief summary document created by the Montana Public Health Institute. (This summary document can be found here.)
- **Opioid Overdose Prevention (State Opioid Response (SOR); Overdose Data 2 Action (OD2A):** Overdose Data to Action (OD2A) supports jurisdictions in implementing prevention activities and in collecting accurate, comprehensive, and timely data on both nonfatal and fatal overdoses and in using those data to enhance programmatic and surveillance efforts. OD2A focuses on understanding and tracking the complex and changing nature of the drug overdose crisis by seamlessly integrating data and prevention strategies. In Montana, this work is led by the Public Health and Safety Division (PHSD) of DPHHS. https://www.cdc.gov/drugoverdose/od2a/about.html
- **Tobacco Education and Prevention.** The Montana Tobacco Use Prevention Program (MTUPP) is funded through cooperative agreements with CDC and state revenues from a master settlement agreement with the nation's largest tobacco companies to settle dozens of state lawsuits brought to recover billions of dollars in health care costs associated with treating smoking-related illnesses. In 2022, Montanans voted to designate 32% of Master Settlement revenues toward prevention of commercial tobacco use. Using these funds, DPHHS maintains task orders (contracts) with local health departments to fund prevention-focused and community-driven approaches to preventing and reducing use of commercial tobacco. Prevention Specialists funded by this work are employed by local health departments throughout the state to pursue work supported by DPHHS. This program could function as a valuable model, or vehicle, through which to provide similar prevention-focused services in behavioral health.

- **Opioid Settlement Fund.** This resource is funded by a multi-state legal settlement with a number of pharmaceutical companies that sell opioid medications in ways that helped fuel the opioid epidemic. The settlement will generate at least $80 million in revenue for the State of Montana, including 15% sent directly to counties, according to the Montana Association of Counties (MaCO). In order to receive these funds, each county must establish its account through the National Opioid Settlement Portal. A MaCO-sponsored discussion of use of these funds can be found here. The Montana Department of Justice (DOJ) is responsible for overseeing these funds. DOJ directs questions about the funds to Rusty Gackle at 406-444-2026.

Other non-government funding sources are also available to address behavioral health in Montana. A few of these include trusts like the Montana Mental Health Trust and foundations like the Montana Healthcare Foundation, Headwaters Foundation and the Montana Community Foundation. While some of the organizations may have very specific topics to address, some like the Montana Healthcare Foundation have broader applicability across a range of behavioral health topics. These funding sources often are time-limited and require applicants to show how the dollars will be used to improve health outcomes and how services will be sustained once funding ends, often a challenging proposition for staffing at local and tribal health departments.

Silos

In discussing the federal- and state-funded programs discussed above, one seemingly universal challenge identified by state and local stakeholders is the complexity of using funds from multiple federal agencies through several distinct grants and contracts. The federal Substance Abuse and Mental Health Services Administration (SAMSHA) funds this work through at least three separate grant programs: Substance Use Prevention Block Grant; Partnership for Success; and the State Opioid Response Grant. The CDC, meanwhile, provides funding through a number of separate and distinct contracts with DPHHS: Overdose Data 2 Action (OD2A); Drug Free Communities; and the National Tobacco Control Program.

DPHHS staff report that blending or braiding these funding sources is a complicated, fraught endeavor. Each funding source typically comes with its own contract, payment system, allowable/unallowable uses, approved interventions, and deliverables with varying degrees of specificity and prescriptiveness. This problem is magnified in Montana because any single funding stream rarely, if ever, has enough dollars to support meaningful prevention staffing and expertise in all 56 counties and reservations.

As a result, this siloing at the federal level is projected down to the state, and ultimately, into local communities. Funding that does make it to local agencies and organizations is often too little to support meaningful staffing, forcing locals to use part-time staff or load the work into other positions that are forced to administer multiple contracts, grants, and funding sources. Often, the various funding sources land in different agencies, organizations, or coalitions, which can lead to duplication of work and lack of coordination.

To be clear, these challenges are neither new nor revelatory to those working in the field. There does seem to be interest and willingness from state staff to address these issues. In May of 2023, DPHHS convened a group of stakeholders, in part, to discuss and plan to address the inherent challenges of this fragmented and complex funding landscape. Some themes that emerged during that session included:

- Prevention work is often most effective when led and executed by local individuals, organizations, and coalitions from the communities being served;
- Current funding practices have led to a fragmented, confusing patchwork of funding streams and programs and local leaders are worn down by prescriptive grant deliverables that come with relatively small amounts of funding;
- Montana counties and communities have widely varying readiness to implement behavioral health prevention services. Some communities will require assistance and resources for capacity building. Others have fairly well-developed capacity (often involving local public health agencies) and would be best served by simplified funding resources to allow locals to choose from a slate of evidence-based interventions based on the needs, readiness, and willingness within their communities;
- There are large potential benefits to blending and braiding funding sources, especially if this can be done at the state level in a way that concentrates and simplifies funding sent to local communities;
- Local health departments that deliver a variety of other prevention services are often involved in local behavioral health efforts but rarely, if ever, funded directly to sustain dedicated personnel and expertise to help lead and strengthen community efforts related to prevention work in behavioral health.

Core Funding – A Closer Look

In many ways, the backbone of the state's behavioral health prevention funding and programming has been derived through a mix of grants awarded to DPHHS by federal agencies. One major component of this funding is the Substance Abuse Prevention & Treatment Block Grant (SABG), now known as the Substance Use Prevention, Treatment and Recovery Systems (SUPTRS) Block Grant. SUPTRS funding is a primary source of funding for the state's contracts with state-approved treatment providers and regional organizations that are contracted to hire and employ prevention specialists in many Montana counties. Due to anticipated funding reductions, and uncertainty about the prospect of using HEART Fund dollars to sustain this work, DPHHS is currently preparing for a potential re-design and reallocation of these programs in 2024.

Due to the outsized importance of the SUPTRS Block Grant to prevention funding, the following section provides a more in-depth examination of this work and funding.

Background

MTPHI contracted with a consultant to interview organizations funded directly by the SUPTRS Block Grant, including the regional contractors and the technical assistance provider, as well as 14 local and tribal health officers or senior leaders, prevention organizations and others familiar with the block grant program. Interviews were conducted remotely in May and July, 2023. Information has not been attributed directly to individual interviewees so that they could speak freely about challenges if any were noted. Not all organizations receiving block grant funding across the state were contacted (or available) for inclusion.

Summary of Interview Information

All of the local and tribal public health organizations interviewed listed behavioral health and SUD as consistently being at the top of their communities' health priority lists established through community health assessments (CHAs). Suicide (both adult and youth), alcohol misuse, drug overdoses, depression and anxiety coupled with lack of access to care, all are prevalent in Montana communities large and small. No county is immune and most reported that the COVID-19 pandemic exacerbated underlying problems. One frontier county health officer categorized the breadth of the behavioral health problem as "a gigantic need" topping everything else on her plate, yet she felt largely impotent to address it. "This is

foundational public health work, even if it doesn't traditionally line up with what we are used to in local health departments. Our communities are looking at us to help solve it," she said.

Each local and tribal health department varies in its approach to addressing behavioral health and SUD in each respective county. All reported some indirect prevention efforts through traditional public health programs such as home visitors interacting with clients and providing referrals. In some other counties, health departments either lead or provide staff to community coalitions playing the convener role by bringing local partners to the table. Still others reported sponsoring training such as mental health first aid for first responders or schools. One frontier county health department has a licensed therapist on staff to conduct free, stopgap limited counseling sessions to county residents looking to connect with a community therapist. In another county, elected leaders have asked the local health department to help organize therapeutic services through treatment providers, while also directly providing support services to connect clients to social and economic supports such as housing and food security.

Local officials report pursuing this work to respond to clear needs in their communities, but doing so in widely varying ways. These departments have assessed the needs in their communities and either brought willing partners to the table to create interventions or have decided to directly engage around the issue because no one else is doing so. The solutions created are as unique as the counties themselves and impacted by capacity, political will, and competing demands/programs. What might work in the Flathead looks different than what works in Billings.

READ THE FULL STORY

Project Venture – All Nations Health Center
Summary Points:

- Look at what works in one community and determine if, with some tweaking, it could produce similar results in your community.
- Inventory your community for both usual and unusual partners. Sometimes different entities just need to be asked and they will step up – especially for kids.
- Don't feel like the health department has to do it all. Public health can be a coordinator and communicator, but don't be afraid to depend on people with passion. Sometimes, public health's best path is to support, convene and connect.

All but one local and tribal health leader interviewed said they would be interested in direct funding from the state to either spearhead new efforts or augment current work around behavioral health and SUD prevention. The majority of leaders expressed that the regional approach has not worked for their counties for a number of reasons. A chief concern among many was that prevention specialists hired and managed by distant regional organizations often lack the local support and relationships necessary to be effective. A few reported good relationships with prevention specialists assigned to their counties, but concern about turnover in those who hold the positions. Local and tribal health department leaders stressed that it is critical that this work is done by trusted, local community members with strong relationships and extensive understanding of their community.

Many health leaders said they had not met and could not name the outside prevention specialists assigned to their county, and, in the post-pandemic world, some of these positions have gone either unfilled or have turned over multiple times as organizations have struggled to keep staff. Health leaders acknowledged that if another organization has solid programs and staff in place and already are working in the community with established roots, they can be successful and the health department is happy to be a willing partner in these efforts. An example of this approach exists in Cascade County with the health department playing a supportive role to the local prevention organization. In Teton County, likewise, the local health department for several years has been directly engaged with the county's prevention specialist in ongoing work that includes youth-focused wellness training and services, first responder training, and maternal and child focused health promotion.

Behavioral Health Coalition – Teton County

READ THE FULL STORY

Summary Points:

- Do an inventory of coalitions and partners working to address behavioral health and reach out to them. Consider bringing similar work under one coalition to avoid duplication of both people and resources.
- Feel-good ideas are low-hanging fruit. Work to convince others that evidence-based programs are the best long-term solutions.
- Don't feel like the health department has to do it all. Public health can be a coordinator and communicator, but don't be afraid to depend on people with passion. Sometimes, public health's best path is to support, convene and connect.

Other departments have succeeded in creating their own solutions by using other public or private funding, such as the health mill levy in Yellowstone County or a foundation grant awarded to Mineral County.

Even so, in interviews across the state, more common feedback from local health officials were examples of local health departments feeling disconnected with prevention work that seemed sporadic and lacking access to the community capacity needed to be effective. In a more rural county in southwest Montana, the leader of a respected community-based organization that works to improve behavioral health services said their work seems "disconnected" from the state-funded prevention programs run by an organization located two counties to the west. "We feel forgotten," the leader said. One large county health officer described being "frustrated by the regional framework because their regional partner is not well integrated into the community which causes friction and confusion.

Interviews with the regional organizations revealed significant differences in how these services are being delivered. One agency, Butte Cares, reported that they hire, manage, and assign county prevention specialists funded by federal block grant dollars for a large territory that includes Helena, Bozeman, and Livingston. In Billings, the South Central Regional Mental Health Center that receives prevention-focused block grant funding reported that their prevention specialists work primarily with law enforcement agencies and schools rather than public health partners. Another provider, Western Montana Mental Health Center, did not make staff available for an interview.

One regional organization, Alliance for Youth, reported that they contract directly through local health departments to engage and lead this work in their communities. The work described above in Teton County, for instance, is pursued through Alliance for Youth. Staff said each county working with Alliance for Youth is working on a logic model to help connect grass-roots efforts to broader strategy efforts.

Farther east, the Eastern Montana Community Mental Health Center (EMCMHC), is tasked with providing prevention services to a vast swath of the state's most sparsely-populated territory -17 counties from the Canadian border to the Wyoming state line. EMCMHC reported workforce challenges and uses its own staff and a limited number of contracts with other agencies to pursue community assessment, parenting classes, and youth-focused services such as PAX Good Behavior Game. Staff expressed appreciation for the prevention resources, while also acknowledging the enormous challenges of serving such a large territory, one that includes dozens of frontier communities, three American Indian reservations, and episodic migration to and from oil and coal fields.

Back at the local level, all local health department leaders interviewed believed that state funding directed to local organizations using tools to blend funding and reduce red tape would be an enormous help to sustain effective prevention work. They said current state funding often does not utilize local health departments to help tailor and design prevention efforts for diverse communities. "It just doesn't work for smaller counties - we can get overlooked," according to one frontier county health officer. Another large county health officer summed up the thoughts of many interviewees: "There is unlikely to be a one-size fits all approach. The state needs to look to the locals to solve the problems."

Funding Background

Montana DPHHS, through its Prevention Section, receives about $6.9 million in SUPTRS Block Grant funding from SAMSHA. The funding is intended to help plan, implement, and evaluate activities that prevent and treat substance abuse. SAMHSA's Center for Substance Abuse Treatment's (CSAT) Performance Partnership Branch, in collaboration with the Center for Substance Abuse Prevention's (CSAP) Division of State Programs, administers the SUPTRS at the federal level. SAMHSA requires that grantees spend no less than 20% of their SUPTRS allotment on substance abuse primary prevention strategies. These strategies are directed at individuals not identified to be in need of treatment.

Funding has been stable for the past five years and DPHHS leveraged two supplemental SUPTRS COVID grants that have allowed for expansion of services and increased the amount to $4 million. The first round of SUPTRS Coronavirus Response and Relief Supplemental Appropriations Act funding ends March 14, 2024 and the ARPA funds end September 30, 2025. DPHHS currently allocates between 40-50% (roughly $3.5 million per year) of the SUPTRS block grant to primary prevention, but there may be changes with the current reorganization of the division at DPHHS. These expansion funds have allowed the regional contractors (listed below) to expand prevention specialists to all 56 counties, sometimes sharing an FTE across two or more sparsely-populated counties when needed.

Prevention Specialist Regional Locations

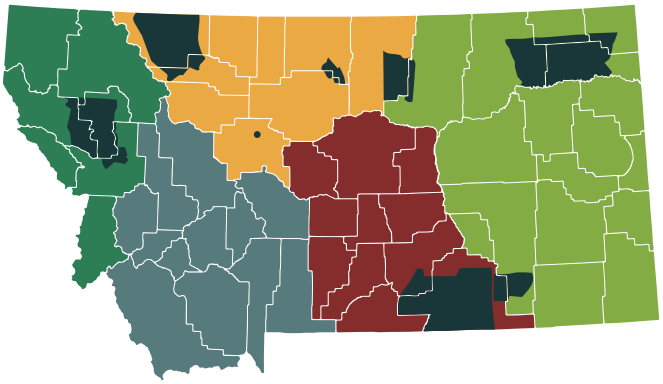


Figure 5. Prevention Specialist Regional Locations

DPHHS currently funds the health planning regions by using regional organizations (Butte Cares, Eastern Montana Mental Health Center, Alliance for Youth, South Central Mental Health Center and Western Montana Mental Health Center) which cover all 56 counties. Other funds are allocated to four tribes: CSKT, Blackfeet, Rocky Boy and Fort Belknap (see Figure 5). Youth Connections holds the statewide training and technical assistance contract that supports the regional contractors. The regional contractors can use up to 17% of their allotment for administrative and indirect costs while remaining funds go toward prevention specialist salaries and other mandated activities. This is the fifth year of funding for most of the regional contractors. MTPHI was able to obtain contractual information reported by come providers, though DPHHS declined to share contracts.

We Interviewed four of the five regional organizations (Western Montana Mental Health declined to make staff available). Based on those conversations, the regional contractors assigned to each health planning region for this work reported that the contracts with DPHHS include about $380,000 in base funding and $300,000 - $700,000 in expansion funding made available through the use of pandemic recovery funds. Overall, the three regional providers that provided information reported contract amounts of between $750,000 and $1 million for the current fiscal year. The organizations used those funding to support 10 to 14 FTE per region to pursue primary prevention work.

A separate organization, Youth Connections, holds the technical assistance (TA) contract under the block grant program. They have responsibility to connect with the five regional contractors to support their work with training, capacity-building, and assisting in preparing prevention specialists for certification among other deliverables. They will receive $810,000 this year, an amount that has been bumped up twice with pandemic expansion dollars. This funding supports 10 staff to provide TA work to the regional contractors

In pursuing this work, BHDD staff have sought to support and fund two evidence-based approaches to work in communities: Communities that Care (CTC) and the PAX Good Behavior Game. While communities do pursue a wide array of other approaches, a closer look at CTC and PAX are warranted.

Communities That Care

Communities that Care (CTC) is a community engagement framework developed by the University of Washington and used in communities across the nation. CTC utilizes the Social Development Model (also referred to as the Social Development Strategy) as a vehicle to engage, organize, assess, and help communities take specific actions to prevent problems before they develop. Proponents cite scientific evidence that CTC is associated with reductions in levels of youth alcohol & tobacco use and crime & violence. The CTC framework includes a youth survey to identify a community's risks and strengths. Based on community data, CTC is designed to guide communities in selecting and implementing effective prevention programs and policies.
CTC also relies on sustained participation and commitment by a wide array of community leaders and stakeholders over a number of years. This requires a community coalition and a leadership committee to be sustained over a long period of time, with strong staff leadership to guide community assets and needs assessment and to help develop and execute a community plan of action.

To succeed, CTC requires strong and sustained leadership by someone who has earned trust from community leaders and who is able to motivate a community-wide coalition to work together for a number of years. BHDD has embraced CTC as an intervention, providing funds to the regional providers and other organizations to implement the model. DPHHS reports that CTC committees have been funded in 18 communities across Montana, including four tribal communities. Organizations employing CTC coordinators in those communities include a number of regional organizations mentioned above, as well as two local health departments funded through a recent call for proposals by BHDD. BHDD provides technical assistance through Youth Connection for CTC sites.

Among local public health leaders, there are mixed reviews on the success of the Communities That Care model in Montana. They note successful implementation requires extensive work, earned trust, and enough time to engage community leaders, build and sustain a coalition, conduct a community assessment, and design and execute an action plan. They say these factors have been a barrier to success in some communities, especially where prevention specialists leading the work are not connected to a known and trusted local organization. Some also reported that this work is foundering because a CTC coordinator has not been hired or has experienced staff turnover. Additional interviewee feedback included:

- The regional contractors often hire and manage a CTC coordinator detailed to a county in their health planning region. These positions can be difficult to hire for and sometimes duplicate what other prevention specialists or

existing coalition coordinators in those counties might already be doing.

- Some counties with a state-funded Prevention Specialist have also been assigned a CTC coordinator, which has created confusion in some communities about the roles of each position.
- Many counties, especially the smaller ones, already have some kind of existing coalition (DUI Task Force, Local Advisory Council on Mental Health, etc.) that may be doing some of the work a CTC coalition would encompass. Because these counties have limited capacity, especially in terms of people at the table, forming another coalition can seem duplicative and may not always be seen as helpful.
- Some of the CTC coalition building and setup requirements can be daunting and can scare communities off from initiating the process
- Often the success of CTC coalitions is tied to either the coordinator hired or a county/community's readiness and willingness to attempt the work, or both. If a coordinator is motivated and well-connected within the community they are serving, their efforts may be more successful.

PAX Good Behavior Game (GBG)

The PAX Good Behavior Game is an evidence-based intervention implemented in classrooms to improve children's self-regulation. This approach relies on research-based strategies with origins in behavioral science, neuroscience, and cultural wisdom to develop strategies to help children to succeed in school. The approach stresses tasks such as getting students' attention, selecting students for tasks, transitioning from one task to the next, working as part of a team, limiting problematic behavior, and reinforcing pro-social behavior. Proponents say PAX GBG helps to build children's self-regulation, resulting in improved focus and attention, improved test scores and other academic outcomes, reduced alcohol and other drug use, reduced psychiatric disorders, and reduced suicide.

Among those interviewed for this analysis, the PAX GBG was found to have nearly universal support. While its deployment across the state was noted to be school-district dependent, the program receives complementary reviews, especially from classroom teachers who have found the methods to decrease classroom behavior problems, interruptions, and other barriers to learning. Having funds available through the prevention specialists to implement the program in any sized school was noted to be a benefit for school districts.

DPHHS reports that 214 schools had participated in PAX activities as of June 30, 2023, with just over 2800 teachers trained in the approach.
It should also be noted that PAX GBG is not a framework for community engagement, but rather a specific intervention designed for schools, educators, and parents. PAX is an approach that could be implemented through a wider community-driven framework such as Communities that Care or the SAMSHA Strategic Prevention Framework.

A Path Forward

Any examination of Montana's current and past efforts around prevention-focused behavioral health work should also be accompanied by ideas to guide a path into the future. Naming the challenges we face fails to be useful without serious consideration of possible solutions.

As noted, this document's focus is on ways to use Montana's local and tribal public health system to help address what is arguably the state's most pressing public health challenge. Utilizing an existing system of public health agencies and professionals that operate in all 56 counties clearly seems to be low-hanging fruit for state policymakers. Below, we offer some ideas to help achieve that goal:

1. Fund and support capable public health agencies to help lead and coordinate community-driven and prevention-focused behavioral health work in the communities they serve. By funding and supporting local agencies, DPHHS could tap into an existing statewide network of local health departments to: assess community needs and capacity; engage local leaders, energy, and talent; coordinate existing stakeholder groups (such as Local Mental Health Advisory Councils); and support and evaluate chosen interventions with established frameworks, such as SAMSHA's Strategic Prevention Framework. Formal relationships with these local agencies could be accomplished in a number of ways, including:

    - Utilize existing master contracts that DPHHS has with every county health department to create task orders (legal agreements that fall under the existing master contract) to fund staff and expertise for prevention-focused behavioral health work. Through this approach, BHDD could fund staff (Prevention Specialists) to pursue deliverables established by DPHHS. This approach would be consistent with the way that DPHHS Public Health and Safety Division pursues prevention-focused work around tobacco use, cancer mortality, healthy lifestyles, and maternal and child health.

- Distribute funding through a competitive RFP process open to local organizations. This approach requires large commitments of staff time and effort to navigate the formal RFP process. And in the past, the process has required agencies to serve very large health planning regions, which is impractical or impossible for county-run health agencies. Future RFP processes should be open to specific counties and smaller collaborations between counties in order to effectively engage local public health agencies.

2. Focus efforts of regional and statewide organizations on providing technical assistance, training, and capacity building, especially in counties and tribal communities with emerging capacity. Regional organizations may also be needed to staff prevention positions in some frontier communities, especially in eastern Montana. But whenever possible, channeling the capacity of regional organizations to train and provide technical support to local organizations that operate within the communities they serve offers a clear path to building local capacity that can be effective in community engagement and assessment, local coalition building, and sustained coordination of local efforts. A companion resource to this document entitled, **Applying a Public Health Lens to Behavioral Health: A Toolkit for Montana's Local and Tribal Health Departments**, was designed to help build local capacity through local health departments.

3. Develop a working group that operates across DPHHS divisions to identify ways that prevention-focused work and funding can be used more effectively and efficiently to promote emotional wellness and resilience and support Montanans living with mental illness or addiction. DPHHS' various divisions operate an array of public health programs, often funded through federal contracts. The Early Childhood & Family Support Division (ECFSD), for instance, funds public health home visitation programs in communities across Montana through local public health agencies. Efforts by ECFSD to address substance use and mental wellness in families served by public health home visitation could benefit from expertise and resources that live within the Behavioral Health and Developmental Disabilities Division (BHDD). Likewise, BHDD might find ready-made pathways to engage local communities by working with and through ECFSD or the Public Health and Safety Division.

The recommendations above consider the mechanisms and actions through which we can more effectively support and use our local and tribal public health system to address behavioral health needs of Montanans. Think of these as the tactics

to gather the low-hanging fruit offered by our existing public health system. A reasonable next question is how those local agencies, once engaged in a systematic way, could be used to build a more complete behavioral system, worthy of the vision shared by Gov. Gianforte's HEART Initiative. The companion resource to this document - entitled, *Applying a Public Health Lens to Behavioral Health: A Toolkit for Montana's Local and Tribal Health Departments* – explores these possibilities in greater detail in a way intended to assist and guide local health officials to operationalize these broad ideas.

But for statewide leaders, a wider angle view of these ideas may be helpful and motivating. Below is a higher-level summary of this work intended to help statewide leaders conceptualize the potential of our currently underutilized local and tribal health agencies.

Assessment

A foundational capacity of any high-performing public health agency is assessment of community health status and capacity. Nearly all local public health organizations conduct a regular community health assessment (CHA) and work with their community to write a community health improvement plan (CHIP) intended to summarize and help organize community-driven work to address a community's most pressing health issues.

Most community health assessments conducted in Montana in recent years have identified behavioral health as a high-priority public health issue. The process of engaging community stakeholders to identify community needs and assets often also leads to coordinated discussions about what to do about those issues. One useful way to organize and push forward on those priorities is through a community health improvement plan. Each CHIP ideally includes specific, actionable, and resonant goals and strategies for community action.

For statewide leaders seeking to improve Montana's behavioral health system, local and tribal health departments offer an existing network of agencies (operating in every county and tribal community) to systematically assess and understand communities' needs and assets. By tapping into this network we could create a two-way health assessment feedback loop, with locals gathering and sharing community-level data and input and state officials compiling, analyzing, and sharing state-level behavioral health data and information.

In other contexts, health departments do this type of work every day in every Montana county. In communicable disease surveillance and response, for instance, local health departments regularly report disease data to the state health department, which in turn compiles, analyzes and shares statewide trends and guidance for local response. This creates an ongoing feedback loop through which the state works with local agencies.

This sort of system, while entirely possible, does not exist within the realm of behavioral health in Montana. If it did, data and community feedback on local behavioral health services and needs could be more readily compiled, shared and used by local public health agencies and their state counterparts.
Through this sort of work, DPHHS could work with locals to bring consistency to data collection and assessment activities, while also creating space for local leaders to do this work in ways that are culturally-appropriate and effective. This work will look different in Billings than it does in Rocky Boy or Dillon but by engaging locals, state leaders can better account for these differences while also providing consistency and support to strengthen work happening in communities.

Planning, Preparing and Coordinating

Likewise, public health emergency preparedness (PHEP) coordinators in nearly every Montana health department (funded through state contracts) use data gathered in the community and by the state to assess community threats and work within coalitions to plan, practice and prepare. This network of PHEP coordinators gives DPHHS a statewide network of trained staff working within local health departments to train, plan and prepare for emergency events.

The PHEP model provides a window through which one might glimpse the possibilities of similar work pointed toward planning, preparing and coordinating behavioral health work.

The task orders (contracts) through which DPHHS funds PHEP coordinators in local health departments include deliverables that address key needs and goals. For instance, through these task orders, local public health agencies are required to facilitate local planning committees that include public health, medical providers, law enforcement, elected officials, and medical first responders. Through these local committees, local agencies work together to build plans, practice through exercises, and plan for future events. DPHHS maintains similar contracts and work relationships with locals to address a variety of important public health priorities: tobacco education, cancer mortality, maternal and child health, and nutrition/ physical activity.

These sorts of systems, while entirely possible, do not currently exist within the realm of behavioral health in Montana. If they did, DPHHS could utilize a similar network of local coordinators to help support and convene (when necessary) key stakeholders to work together. This sort of system, for instance, could be used to bring consistency and support to Mental Health Local Advisory Committees, which operate in most Montana communities but with highly variable methods and results.

The potential for this type of public health work can be glimpsed in Lewis & Clark County, where Lewis & Clark Public Health has created a community-driven response team to support families who are surviving the loss of someone who has committed suicide. Lewis & Clark's LOSS Team (an acronym for Local Outreach to Suicide Survivors) is focused on helping survivors connect to coping resources. The sooner a survivor receives help, the better the chances they won't consider suicide and can begin the recovery process more rapidly. Lewis & Clark's team, made up of both survivors and mental health professionals, boasts 25 volunteers and has been up and running for more than a year.

READ THE FULL STORY

LOSS Team – Lewis & Clark County
Summary Points:

- Everyone in Montana plays a role to prevent suicide because it is such a pervasive public health issue. Each community has resources; oftentimes they just need to be asked.
- Engage stakeholders from at-risk populations and direct resources to these groups.
- Don't feel like the health department has to do it all. Public health can be a coordinator and communicator, but don't be afraid to depend on people with passion. Sometimes, public health's best path is to support, convene and connect.

Again, this work should look different from one community to the next. But by engaging Montana's existing network of health departments, state leaders can help communities learn from one another while also working to build consistency to how these efforts are evaluated and supported. Some communities may gravitate toward Communities that Care as a framework to engage youth, while other communities may wish to focus on outreach to military veterans or seniors. Tribal communities may wish to focus on cultural tradition and connection to the land. Local and tribal health departments can be a backbone for the selection and

support of these community decisions and state coordination. They can also serve an important partner for BHDD in pursuing this work using consistent and evidence-based approaches, such as those endorsed by the Center for Substance Use Prevention (CSAP).

Community Engagement - Moving from Crisis to Collaboration

The public health work described above - assessment, planning, practicing and coordinating - provides the foundational building blocks from which communities can respond to exigent events more effectively and with a greater shared understanding.

In the example from Lewis & Clark County, shared understanding and concern about the tragic impact of suicide on individuals and a community led to a planned response informed by science and, hopefully, understood by the community. In this example, local leaders have a clear and specific response to community concern during a crisis event. Through this work, community stress and energy can be channeled into planned and lasting action.

This is a familiar pattern in both public health and emergency preparedness: assess, plan, practice, and respond. It is the process we use to respond to unplanned events, from wildfires to communicable disease outbreaks. For some public health efforts (tobacco education, for instance), the response has become so routine and ingrained for so long that it no longer attracts attention (prohibitions against smoking in indoor public spaces, for instance). At a more local level, prevention specialists funded by DPHHS and employed by health departments throughout the state work to educate young people to the risks of tobacco use. Year by year and decade by decade, this work has led to declining rates of tobacco use and cancer mortality.

This sort of statewide partnership between state and local public health agencies, while entirely possible, does not currently exist within the realm of behavioral health in Montana. If they did, DPHHS could utilize a similar network of local prevention specialists and community coordinators to help reduce stigma and build community-wide support (protective factors) for people living with addiction or mental illness.

The good news is that local public health agencies are eager for this work and, in many cases, prepared to build these prevention-focused systems beside existing efforts to address communicable and chronic diseases, natural or man-made disasters, and child and maternal health. The system exists and is ready to be used.

Conclusion

The foundation of Montana's public health system is the constellation of county and tribal health departments that serve all 56 counties, seven American Indian Reservations and 12 recognized tribes. These health agencies provide a statewide network of organizations and public health professionals who are embedded in their communities and grounded in the principles of public health, providing prevention-focused and community-driven services in every corner of the state. This system of local public health agencies provides a reservoir of untapped potential to help address the state's most prominent public health challenge: building a better behavioral health system.

Many local health departments have been working in behavioral health for years, often because the needs in their communities are so evident, so consequential, and so urgent. Too often, local public health leaders are doing this work without reliable funding to support needed expertise and staffing. Local health leaders interviewed are asking for reliable funding to hire local staff to work within a coordinated statewide effort to build mental wellness, community resilience, and protective factors. These local leaders express eagerness to align this work with prevention-focused work in chronic disease prevention, maternal and child health, and community emergency preparedness.

Local health leaders also acknowledge that Montana's local and tribal health departments have varying degrees of readiness to do this work. Some already are deeply involved in the work and engaged with community partners. Other departments will need training and internal capacity building to engage most effectively. State and regional organizations could play a critical role, as some already do, in providing technical assistance, training, and (in some cases) staffing to help departments and communities build local capacity.

Acknowledgments

In pursuing this work, we seek to emphasize and imagine ways to tap into the potential of local and tribal health departments to address behavioral health. But our focus on our local public health system should not be confused with an effort to marginalize other types of behavioral health organizations. Treatment providers, non-profit organizations, elected leaders, law enforcement, and health care organizations all have a role to play in providing a more cohesive and effective public mental health system. We acknowledge the need to work collectively. We also wish to thank the Montana Healthcare Foundation for their financial support for this work. We have also benefited from the work of a number of partner organizations: JG Research & Evaluation, Stellar Group, and BMT Consulting.

We acknowledge that American Indian tribes and tribal people and their ancestors have lived on the lands now called Montana for thousands of years prior to the arrival of European settlers. We offer unambiguous acknowledgment of the sovereignty of Montana's Tribal nations and clear recognition that tribal people are the indispensable leaders of any work to improve their health and quality of life. Our work here also acknowledges that ongoing work is necessary to understand and support tribal behavioral health systems and to learn from traditional tribal practices.

Finally, we wish to thank these staff and leaders of local and tribal health departments, mental health care organizations, and other organizations working to improve mental health and wellness in Montana. Their ongoing hard work and collaboration will be essential to creating a better system.

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Appendix A

Project Venture – All Nations Health Center, Missoula (Faith Price, Community Prevention Coordinator)

Building Resiliency and Cultural Connection in Native Youth by Getting Outdoors

After having lived in Missoula for more than 20 years, Jessie Scalpcane, a member of the Blackfeet Nation, and her husband, who is Northern Cheyenne, have felt quite distanced from the cultural aspects of their former reservation life. When she noticed a flyer during a provider visit at All Nations Health Center advertising a new after-school program aimed at engaging middle school youth, Jessie thought it could be a perfect opportunity for her 12-year-old daughter, Asher, a sixth-grader.

"I liked that they get these students from different schools all together," Scalpcane said. "Some knew each other, and some didn't, but the program connected native kids for discussions and activities so they could get to know each other."

The program, Project Venture, currently is hosting its second cohort of 13-15 students that meet once per week within a 27-week curriculum that also includes one outdoor activity each month that could range from disc golf to archery to cross-country skiing. Faith Price, the community prevention coordinator for All Nations Health Center, spearheaded the program in Missoula as a strategy to promote healthy relationships and prevent substance use in middle school aged native kids. The curriculum was developed by a native researcher and is one of the first evidence-based prevention strategies targeting native youth. It has been used in both the US and Canada and has been adapted to non-native kids as well.

"It can be challenging to be away from other tribal members and these kids might be the only native students in their classes," Price explained. "Project Venture allows Native youth to share similar experiences while learning more about their culture and building in some fun as well."

Price and her fellow facilitators plan outdoor activities that connect participants to nature and use games to teach both life and social skills. Learning about indigenous healthy foods, building fires and identifying trees or plants while kids are cross-country skiing through the woods has been successful in keeping

kids engaged while emphasizing cultural values such as realizing that no matter what their tribal affiliation may be, they all are connected and must take care of their communities together.

All Nations engaged Missoula area schools and signed memoranda of understanding (MOU) agreements to help build connections to the schools. While the program originally was designed to be implemented within schools, Price said her team liked the after-school model better. After partnering with the schools, Price went into the community and was thrilled by how businesses stepped up to offer gear donations like skis and snowshoes as most of this equipment would be cost-prohibitive to participant families.

Project Venture's curriculum can be tailored to individual communities. Asked if she thought the program could be used successfully in smaller towns or on the reservations, Price said with a bit of creativity and commitment, it most certainly could be. She encouraged health leaders to consider starting with small things that don't cost a lot and to use resources and experts that already exist nearby.

"Disc golf courses are cheap and tribal lands are perfect for outdoor activities like hiking and discovering nature," Price said. "Our native culture derives everything from the land so doing what we can to get kids excited about it is one of the most important parts of this program."

Price uses the health center to get word out about the program through social media, postcards, open houses and word of mouth. As kids hear about it from their peers, they want to join too. She sees hope spreading among families and her participants gaining confidence in outdoor recreational activities that they also can bring home to engage parents and siblings in healthy pursuits. In a survey of participating families conducted last year, parents mentioned the program offers alternatives to video games and social media and connects kids to real life issues and emotions, while the kids overwhelmingly picked the monthly outings as the best part of the program.

Price vividly recalled two interactions from the last cohort that made her feel the program was achieving success. One occurred after a snowshoe outing and while waiting for parents to pick up their kids, she saw two boys from different schools talking. She overheard one ask the other if he had a best friend at school and the boy replied that he didn't. Then they talked about movies for awhile before giving each other a hug as they left. Price knew they had created a buddy group.

"On that same snowshoe trip, we went up Marshall Mountain and it was tough uphill work and the kids were getting worn out," Price recalled. "But when we finally reached the top and we had this gorgeous view over our valley, one girl turned to me and confided that she was really proud of herself for making it to the top. It reminded me that we are building strength and resilience in these kids

which could not be more important."

When asked what Jessie Scalpcone thinks her daughter Asher has gained from Project Venture, she was reflective and noted that middle school is tough for any kid, though being a Native girl can be especially difficult. Having a program that emphasizes both cultural education combined with healthy choices also has brought her closer to her daughter.

"After their trip to Marshall Mountain, Asher wanted our family to do some of this outdoor stuff and she wanted to show me some cool trees and a special stump," Scalpcone said. "She has learned about some native connections to astrology and I could bond with her telling her about what I knew about the stars from growing up. We both really liked that."

Appendix B

Behavioral Health Coalition – Teton County (Melissa Moyer, MPH, Health Officer)

Build It and They Will Come

In six years as health officer of rural Teton County, Melissa Moyer has had to wear many hats. With a staff of just seven to manage all the essential public health functions, there is not much disposable time or dollars for taking on additional work. However, when data from the community health needs assessment and community health improvement plan (CHIP) in 2017 pointed to substance use and behavioral health as major local concerns, Moyer knew her department had to act even though it had relatively little experience in either of those areas.

"When I started at the Health Department, the attitude at the time was that mental health did not belong in public health and there was more local appetite to discuss substance use because it was less scary than anxiety, depression and suicide," Moyer said. "But it made sense for the Health Department to step in and lead on this because public health is a good fit for that role. Like any other illness, behavioral health is a public health issue because it impacts many people in very broad ways. It impacts everyone."

Moyer's plan was to gather partners to talk about what could be done in their county of 6,000 people. In its infancy, the Teton County Behavioral Health Coalition had few members and no money. A local resident had offered a $5,000 seed gift but it was tied to his very specific ideas about how to combat substance use. Moyer knew that one of her largest challenges would be to convince community members that any interventions would have to be evidence-based and not just feel-good Band-Aids. To draw diversity into the coalition's membership, Moyer cast a wide net into the community looking for partnership in EMS, faith-based, law enforcement and school organizations to name a few, and she was thrilled when they all showed up to the table.

"Being a part of this coalition, I see now how partner organizations view the Health Department," Moyer said. "Behavioral health was important to the community and we showed up. It made me realize that we have social capital and that is important to gather partners to the table."

Being in a small community, Moyer realized that having multiple task forces or coalitions working on similar issues, often using the same partners, did not make sense. She worked with the Local Advisory Council on Mental Health (LAC) to

merge efforts so that all programs and their funding requests could funnel through the same organization. Using this approach, the Teton County Behavioral Health Coalition has brought multiple new interventions to the community including the PAX Good Behavior Games as well as both Youth and Teen Mental Health First Aid in several schools. In addition, the coalition has helped to bring QPR and CIT training to first responders and Love and Logic parenting classes in a hybrid model using a Health Department nurse and school counselor. And because there was demand in the community, the coalition listened and has embarked on a Mothers and Babies postpartum depression class as well.

Six years into its formation, the Coalition meets twice per month and all member organizations were asked to sign memorandum of understanding (MOUs) agreements to solidify their participation and partnership. Moyer said it has helped to demonstrate their commitment to the cause.

"Local health departments have the flexibility to work on a variety of community-minded efforts," Moyer explained when asked why her health department has been successful in being the convener of the Behavioral Health Coalition. "Our EMS and Sheriff's Office came to us recently and said there was no adequate crisis response system in the county and asked if the Health Department could help with this challenging problem. In the past, I'm not sure that would have happened."

Keith Van Setten has been sheriff in Teton County for 15 years and knows that calls for service to his department that have a behavioral health component are challenging for his deputies and everyone involved. He explained that a recent call involving a suicidal individual with a gun in his hand was the closest his deputies have come to having to use lethal force. Luckily this person surrendered the weapon and voluntarily agreed to evaluation by behavioral health professionals.

"Our county, like all counties, has a mental health issue," Van Setten said. "But thanks to our coalition, what we have now is wonderful. It has brought much-needed public awareness to the issue and now everyone is very aware. We had a training recently on opioids and three times as many people showed up as I would have expected."

More than ever before, especially post COVID-19, school districts across Montana and the country are having to lean on their community partners to help deliver programming to both staff and students in order to address many new complexities that kids today are facing. Ann Verploegen, a psychologist that works in the Teton County Schools, notes that eating disorders, anxiety, depression, cutting and suicidal ideation now are commonplace among students in schools of all sizes. Having access to evidence-based programming, like Love & Logic parenting classes and Youth Mental Health First Aid, thanks to the work of the Coalition, has been life-saving.

Moyer notes that every community in Montana, regardless of size, has resources even if they might not be traditional partners with public health. Community members want action around issues, especially when there may be a high-profile event, and sometimes they might perceive a leadership vacuum. In Teton County, all roads lead to the Behavioral Health Coalition because the proof has been in the pudding that the organization has the credibility to bring in programs that both work and provide funding to match.

"It can be hard to leverage to get the ball rolling," Moyer said, "and it can be intimidating thinking that this issue may not be important to everyone or there may be resistance. That has not been our experience. People want to talk about this stuff."

Summary Points:

- Do an inventory of coalitions and partners working to address behavioral health and reach out to them. Consider bringing similar work under one coalition to avoid duplication of both people and resources.
- Feel-good ideas are low-hanging fruit. Work to convince others that evidence-based programs are the best long-term solutions.
- Don't feel like the health department has to do it all. Public health can be a coordinator and communicator, but don't be afraid to depend on people with passion. Sometimes, public health's best path is to support, convene and connect.

Appendix C

LOSS Team - Lewis & Clark Public Health (Jess Hegstrom, Suicide Prevention Coordinator)

Blazing the Trail: Lewis & Clark Public Health's LOSS Team - a first in Montana

One of the first things anyone who talks to Jess Hegstrom about suicide realizes is that she is overwhelmingly passionate about the issue. The Lewis & Clark Public Health's suicide prevention coordinator doesn't want another human to have to follow her journey of survivorship after losing her father to suicide when she was 20 years old.

"When I lost my dad, I struggled with my own mental health while taking care of my mom and brother and having no time to grieve," Jess explained. "Our family never addressed it or looked for resources and it has taken us 17 years to fully comprehend how suicide affected us all."

Survivors of suicide are statistically more likely to attempt suicide themselves, especially if they lack the resources and coping skills to deal with their loss. Stigma permeates suicide and compounds the isolation many survivors feel, while they often believe there is no one to talk to who will understand what they are going through. That's where Lewis & Clark Public Health's LOSS team comes in.

The LOSS team, or Local Outreach to Suicide Survivors, is focused on postvention, which data suggest reduces the time survivors take to seek out coping resources from an average of 4.5 years to 39 days. The sooner a survivor can receive help, the better the chances they won't consider suicide and can begin the recovery process more rapidly. Lewis & Clark's team, made up of both survivors and mental health professionals, boasts 25 volunteers and has been up and running for more than a year. Volunteers are on call 24/7/365 and work in pairs consisting of one survivor and one counselor who will make contact with those most directly connected to someone who has completed suicide. They are summoned using a partnership with the Lewis & Clark County Sheriff's Office Coroner Division to any confirmed suicide in the county and they bring both a packet of resources as well as the credibility of being a survivor themselves.

"Until now, survivors only receive resources from a hospital, but often they never go to the hospital, so we have missed the boat," Hegstrom noted. "The LOSS

team delivers the resources to their doorstep and we will keep being there for them even if initially they are not ready for it."

Ali Mullen, a volunteer on the LOSS team, lost her husband to suicide two years ago and, between her shifts with the team, is raising three children outside of Helena. When she walked into her first LOSS Team training one year ago, she said it literally took her breath away.

"Losing someone to suicide, when it happens, you feel very alone," Mullen said. "Through this program, I've met other survivors, which has helped me significantly. When you meet other survivors, you're instantly able to talk to someone."

Thus far into her tenure with the LOSS team Mullen has yet to be called out, but the team's volunteers regularly train for when that call comes. She knows it will be difficult, however, she is bolstered knowing that what she can provide will help others heal. Bill Wheeler, another team member who lost his son to suicide nine years ago, volunteers with his wife to do phone follow up. The team conducts regular check-in intervals with survivors for up to a year after the passing of their loved one. Wheeler explained that sometimes just leaving a voicemail is enough to show someone that others understand what they are going through and stand ready to support them.

"Grief is so deep," Wheeler said. "After the funeral is over, folks think life goes back to normal and it doesn't. The LOSS team lets survivors know there is someone out there who truly cares."

Hegstrom explained there are about 40 LOSS teams nationwide but none in Montana until now. The team can be thought of as existing for survivors by survivors, though it adds a second dimension by incorporating mental health counselors too. She has worked diligently to recruit these professionals by offering them grief training while also helping to pay for a new state licensing requirement that dictates each counselor must complete two hours of suicide prevention training annually. In addition, the team also has secured a grant to pay for two free counseling sessions for any suicide survivor served by the team's volunteers. Hegstrom suggested that communities looking to start a similar model should first check in with Karl Rosston, the Montana DPHHS suicide prevention coordinator, as he has best practice programs to offer. From there she suggested finding the community stakeholders, and most importantly, the survivors because they have personal missions to prevent what happened to them from happening to others. Finally, make sure to find representatives from at-risk populations like youth, seniors, Indian Country and those who identify as LGBTQ.

The LOSS team is one prevention program within a larger framework that Lewis & Clark Public Health has developed under Hegstrom's leadership. Some others include working with firearms dealers to recognize suicide warning signs in

their buyers as well as educating the pharmaceutical industry about risk-reduction strategies in packaging medications like using harder to open blister packs to prevent someone from consuming a whole bottle at once.

"No one wants anyone to die from suicide, but unfortunately suicide is part of the human condition, so we will never get to zero," Hegstrom said. "In public health, we're a convener, but it takes a village to have a comprehensive suicide prevention program. It's regular people who are going to prevent suicide because it's everybody's business. Everybody."

The Lewis & Clark Public Health's suicide prevention website is: LCSuicidePrevention.org.

Summary Points:

- Everyone in Montana plays a role to prevent suicide because it is such a pervasive public health issue. Each community has resources; oftentimes they just need to be asked.
- Engage stakeholders from at-risk populations and direct resources to these groups.
- Don't feel like the health department has to do it all. Public health can be a coordinator and communicator, but don't be afraid to depend on people with passion. Sometimes, public health's best path is to support, convene and connect.