

ABSTRACT

The Montana Office of Public Instruction’s NITT-Project AWARE-SEA project will address the mental health needs of children, youth, families/caregivers, and communities by coordinating and integrating the services of 13 State agencies, three Safe Schools/Healthy Students grantees, and three high-need LEAs and their partners and will train nine state-level Youth Mental Health First Aid (YMHFA) trainers, 45 LEA trainers, 75 regional trainers, and 5,000 First Aiders.

The project will serve the entire state of Montana with YMHFA training. The entire state also will benefit from the Project Management Team’s intentional system transformation to be achieved through *Leading by Convening* and *Community of Practice* frameworks.

The LEAs participating in the project are the Browning, Butte, and Kalispell school districts. **The Browning School District**, located on the Blackfeet Indian Reservation, serves approximately 2,000 students (80% Free/Reduced Lunch; 90% Native American). More than 440 students are homeless. At least 300 students are persistently absent. Many students live with friends or noncustodial relatives, making it impossible to secure Medicaid services for them. **The Butte School District** serves about 3,850 students (5.2% Hispanic/Latino; 3.7% Native American; 45% Free/Reduced Lunch). The Butte community has been reeling from the suicides of five students since Christmas 2013. A tough, self-reliant mentality left over from Butte’s mining history contributes to a stigma about seeking mental health assistance. **The Kalispell School District** serves 5,778 students (46% Free/Reduced Lunch). Elementary enrollment has increased 18% over the past five years resulting in crowded classrooms and stretched support services. This is a highly mobile community with an estimated 30% transient rate at the schools (50% at the two highest poverty schools). These LEA communities will be served by strategies specifically selected to respond to their greatest needs, including provider coalitions, crisis center, suicide prevention programs, multi-tiered positive behavioral and support systems, and coordinated referral.

The project goals are to **1)** build/expand state and local capacity to make schools safer and improve school climate; **2)** increase awareness of mental health issues; and **3)** connect children and youth with mental, emotional, and behavioral health issues with needed services. Our key objectives and strategies are to 1) promote positive school climate, prosocial behaviors and violence prevention, including bullying and electronic bullying, primarily through the Montana Behavioral Initiative; 2) prevent suicide, primarily through ASIST and QPR training; 3) increase understanding about mental health issues, warning signs, and early childhood/ historical trauma, primarily through YMHFA and informal education; 4) create a continuum of behavioral health care, primarily through collaboration and tier 2/3 training; and 5) improve access to screening, counseling, and treatment, primarily through screening provider allotments, and systems integration. The project will serve more than 12,600 people per year, and more than 63,000 total.

TABLE OF CONTENTS

Abstract..... 1

Table of Contents..... 2

Project Narrative.....3-32

Budget Justification.....33-48

File Attachment 1

- Section E: Literature Citations.....49-55
- Section F: Biographical Sketches and Job Descriptions.....56-82
- Section G: Confidentiality and SAMHSA Participant Protection/Human Subjects.....83-91

File Attachment 2

- Attachment 1: Letters of Commitment.....92-110
- Attachment 2: Data Collection Instruments and Interview Protocols.....111-170
- Attachment 3: Sample Consent Forms.....171-181
- Indicator Data.....182-184
- Attachment 5: Logic Model.....185-188

PROJECT NARRATIVE

SECTION A: STATEMENT OF NEED (15 POINTS)

Captivated by Montana’s big sky, endless horizons, and distance from cosmopolitan distractions, writer A.B. Guthrie described Montana as having “elbow room for the mind.” While undeniably romantic, that same geographic isolation and remoteness can have a debilitating effect on mental health and the safe and healthy development of children and youth. It compounds the risks of alcoholism, violence, and suicide. Geographic remoteness and social isolation also contribute to a rugged self-reliance, restricted and romanticized world view, and limited self-expectations that often manifest themselves in risky or self-destructive behaviors. (Berkman, Glass, Brissette, and Seeman, 2000)

In this state spanning the extent from Washington D.C. to Chicago, distances are vast. With an average of 6.1 people (1.09 public school students) per square mile, and with more cattle than people, Montana is beyond rural. Because of its low population density, low income, and distance from resources and services, Montana has been designated a *frontier state* by the U.S. Department of Health and Human Services. Forty seven of Montana’s 56 counties (83.9 percent) meet the U.S. Department of Health and Human Services’ *frontier* classification of six or fewer people per square mile. About 54 percent of the state’s population resides in these frontier counties; about half lives in the seven largest towns or cities. Billings, our largest city, has just 107,000 residents; Kalispell, the seventh largest city, has 20,487.

Montana is not only one of the least-populous states, it is also one of the poorest. Montana’s 2012 *per capita* income of \$39,049 is 8% below the U.S. average (\$42,693), 31st in the nation (BBER, 2013). The median household income is \$45,456 (US Census, 2012). Our poverty rate is more than 15 percent; 36.3 percent for Native Americans. More than 33% of our children aged 5-17 live in families in poverty, 13th highest in the nation (US Census, 2012). Prior to implementation of the Affordable Care Act, slightly more than 16% of the population did not have health insurance (CEIC, 2010b). While income is low, the cost of living is not. Montana ranks 31st in affordability on the CNBC ranking scale.

Montana is home to seven Indian reservations and 12 Tribal Nations. American Indians make up the largest minority group in the state (6.2%). Enrollment data for the 2012-13 school year indicate that approximately 143,000 students are served in 824 schools located in 417 districts. 34.8% of our elementary students are eligible for free/reduced lunch; 31.9% of middle-school students, and 28.6% of all students.

Risk Factors: Statewide, in 2012, of students completing the Montana Prevention Needs Assessment (MPNA)¹, 46% of eighth-graders, 50% of 10th graders, and 51% of 12th graders were identified as *high risk*—all well above the national norm. Key *risk factors* of concern include: **Community Domain** – laws and norms favorable to drug use; perceived availability of drugs and handguns; **Family Domain** - parent attitudes favorable toward antisocial behavior and drug use; **School Domain** – low commitment to school; **Peer-individual Domain** – attitudes favorable to drug use; perceived risk of drug use; intention to use drugs; sensation seeking; and rewards for antisocial behavior. A further examination of MPNA and Youth Risk Behavior Survey

¹ Student risk and protective factors (Hawkins and Catalano, 1992, 1999, 2000, 2002) are identified in the *Montana Prevention Needs Assessment (MPNA)*, which is coordinated statewide by the Montana Department of Public Health and Human Services and administered in even-numbered years to all students in grades 8, 10, and 12 in participating schools. Because Montana is a local control state, schools and districts cannot be compelled to participate. Participating LEAs Browning and Butte use the MPNA.

(YRBS)² cross-tabulations disaggregated by gender, ethnicity, and students with disabilities revealed that Native American and students with disabilities engaged in antisocial, violent, and self-harmful behaviors in every category at approximately twice the rate of the general student population; and that females, students with disabilities, and Native American students were most likely to suffer depressive symptoms and engage in suicide ideation, planning, and attempts.

Participating LEAs: The Montana Office of Public Instruction (OPI) selected the three participating eligible high-need LEAs to reflect the varied nature of our state while being fairly easily geographically accessible to OPI and other State resources throughout the grant period.

The Browning School District, located on the Blackfeet Indian Reservation 175 miles north of the state capital of Helena, serves approximately 2,000 students per year through five elementary schools, one middle school, two K-8 schools located on Hutterite colonies, and one high school. 40% of families live below the federal poverty level, and 80% of students are eligible for the Federal Free and Reduced Lunch Program. More than 90% of the population is Native American. The median age is 31; 31.5% of the population is under age 18; 39.2% of households have children under age 18 living with them. The average per capita income is \$9,769.

Persistent unemployment (72%, BIA Labor Force Statistics) and lack of education (37% of tribal members between ages 18 and 25 do not have a high-school diploma) significantly affect the health and well-being of Browning students and their families. More than one fifth of students—at least 440 children and youth who meet the McKinney Vento definition of “homeless”—face an enormous challenge to be present in school each day. Often these students go without a good night’s sleep, shower, clean clothes, food, and a place to go after school. At least 300 students are persistently absent for a variety of reasons ranging from disengagement with school to family participation in rodeos and pow-wows. Many students live with friends or noncustodial relatives, making it impossible to secure Medicaid services for them.

In 2012, 78% of students in grade 8; 51% of students in grade 10; and 54% of students in grade 12 were identified as *high risk*. Key risk factors of concern include: **Community Domain**—all factors; **Family Domain**—parent attitudes favorable to antisocial behavior and drug use; **School Domain**—academic failure; **Peer-individual Domain**—early initiation of antisocial behavior; early initiation of drug use; perceived risk of drug use; intention to use drugs; friends’ use of drugs; and depressive symptoms. Students at grade 8 also are at risk because of poor family management; attitudes favorable to antisocial behavior and drug use; interaction with antisocial peers; sensation seeking; and rewards for antisocial behavior. The most serious absence of protective factors is in the community domain. The political atmosphere is especially tense because of a serious rift in the tribal government, which has deteriorated service delivery and jeopardized coordination, cooperation, and collaboration internally and throughout the community. However, tribal mental health providers remain committed to finding ways to deliver services. In fact, the community has many resources in place, but needs to coordinate, centralize, and organize those supports for students and families.

The Butte School District, located 65 miles south of Helena, serves about 3,850 students each year through six elementary schools, one middle school, and one high school. The largest student minorities are Hispanic/Latino (5.2%) and Native American (3.7%). 41% of students are economically disadvantaged and 45% qualify for the Federal Free and Reduced Lunch Program.

² The Youth Risk Behavior Survey is coordinated statewide by the Montana Office of Public Instruction and administered in odd-numbered years to a selected sampling of about 100 students at each participating middle school and high school. Because Montana is a local control state, schools and districts cannot be compelled to participate. All three participating LEAs use the YRBS.

Butte is Montana’s sixth largest city with a population of 33,730. 21% percent of the population is under age 18. 16.6 percent of the population lives below the poverty level. Butte School District has identified 67 homeless students in grades k-12, but does not receive McKinney-Vento grant funds.

In 2012, 50% of students in grade 8, 65% of students in grade 10, and 54% of students in grade 12 were identified as *high risk*. *Key risk factors* of concern include: **Community Domain** –perceived availability of drugs; **Family Domain** – parental attitudes favorable to antisocial behavior and drug use; **School Domain** – low commitment to school; **Peer-individual Domain** – attitudes favorable to antisocial behavior; friends’ use of drugs; sensation seeking. Students in grade 10 face risks across the entire community domain and individual domain risks of rebelliousness, intention to use drugs, rewards for antisocial behavior, and depressive symptoms.

The Butte community has been reeling from the suicides of five students since Christmas 2013. Local mental health providers believe that a tough, self-reliant mentality left over from Butte’s mining history contributes to a stigma about seeking mental health assistance.

The Kalispell School District, located about 200 miles northwest of Helena, west of Continental Divide, serves 5,778 students through five elementary schools, one middle school, and two high schools. 24% of Kalispell families live below the poverty line. 46% of K-12 students qualify for free/reduced lunch; two elementary sites report more than 60%. The median age is 34.5; 31% of the population is under age 18. The average per capita income is \$22,679. The two homeless shelters in the county house approximately 1,650 people. Kalispell Public Schools has identified 175 homeless students in grades Pk-12 with an additional 19 students identified in Evergreen Elementary District, a feeder district.

Elementary enrollment has increased 18% over the past five years resulting in crowded classrooms and stretched support services. This is a highly mobile community with an estimated 30% transient rate at the schools (50% at the two highest poverty schools). Comprehensive School and Community Treatment (CSCT) services are consistently full; principals indicate a need for twice the services, but there is no physical space for additional programs in schools. The district’s 13 K-8 feeder schools do not have comparable mental health programs in place, resulting in additional challenges for students, especially in the critical transition from 8th to 9th grade, from a small rural school to a larger ‘town’ school. The community has wide resources but also a need to coordinate, centralize, and organize those supports for students and families.

Goal-related Gaps and Resources: In early 2014, the LEAs and OPI convened advisory groups of individuals knowledgeable about healthy student development and student mental health issues and resources to identify gaps and needs as well as available resources, systems, and programs. This local knowledge was augmented by an examination of current literature, student surveys (Youth Risk Behavior Survey, Montana Prevention Needs Assessment, My Voice), and adult surveys (Adverse Childhood Experiences Study, Behavioral Risk Factor Surveillance System) for trends and indicators of concern. These gaps and needs were then related to the goals and objectives of NITT-Project AWARE-SEA, as illustrated below and in the project logic model (Other Attachment File #2).

Goal #1: Build and/or expand capacity at the state and local levels to make schools safer and improve school climate

Gap 1: Lack of implementation of school-system and community-wide, evidence-based, proven programming and strategies promoting positive school climate, prosocial behaviors, and violence prevention, including bullying and electronic bullying

Positive school climate is critical to effective risk prevention (Berkowitz & Bier, 2006; Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2002; Greenberg et al., 2003) and health promotion efforts (Cohen, 2001; Najaka, Gottfredson, & Wilson, 2002; Rand Corporation, 2004; Wang, Haertel, & Walberg, 1993). The five essential areas of positive school climate are safety (e.g. rules and norms; physical safety; social-emotional safety); relationships (e.g. respect for diversity; school connectedness/ engagement; social support; leadership); teaching and learning (e.g. social, emotional, ethical and civic learning; support for academic learning; support for professional relationships); institutional environment (e.g. physical surrounding) and; school climate, the processes of school improvement. (Clifford, Menon, Condon, & Hornung; 2012; Gangi, 2010; Haggerty, Elgin, & Woodley, 2010).

According to the *Youth Risk Behavior Survey*, the percentage of students who missed high school because they did not feel safe has increased steadily since 1993, more than doubling between 2011 and 2013. The MPNA indicates that attitudes favorable to antisocial behavior were high among students and parents and that there were rewards for anti-social behavior. While most of the indicators appear to be declining, thanks primarily to the Montana Behavioral Initiative (Montana’s Positive Behavior Intervention and Supports system – PBIS) and Safe Schools/Healthy Students grants in Helena, Missoula, and Ronan, they remain higher than the national norms. (See Indicator Data Tables in Other Attachment File 2.)

Across Montana, some individual schools and classrooms offer research-based programming that promotes prosocial behaviors and reduces violent behavior, but because the programming is *ad hoc* and lacks follow-up, even where it does exist it may not be implemented with fidelity.

Available resources, systems, and programs

Statewide: Project AWARE Leadership Team including a broad spectrum of state intra- and interagency representation; Montana Behavior Initiative; Systematic Screening for Behavioral Disorders tool implemented as part of Multi-Tiered Systems of Support (MTSS); OPI Neglected/Delinquent and Homeless Specialist; Graduation Matters Montana drop-out prevention Initiative; experience of prior Safe Schools/Healthy Students grantees in Helena, Missoula, and Ronan; Leading By Convening; Interagency Coordinating Council for State Prevention; a cadre of dedicated School Resource Officers.

Browning: OLWEUS Bullying Prevention; Graduation Matters Montana drop-out prevention initiative; Drop-out Prevention Specialist training for 15 school district employees offering training in all k-12 buildings; Homeless Grant; Domestic Violence Prevention Advocates; BIA Victim Specialist; Teen Parent/Pregnancy Coalition; Bureau of Indian Affairs Law Enforcement and Justice Service; Blackfeet Tribal Law Enforcement; Interquest Detection Canines drug/weapon detection service in schools; Reconnecting Youth curriculum; Remember the Child Conference (Blackfeet Family Services); Blackfeet Community College Behavioral Health K-12 Endorsement; Nurturing Center; Boarding Dorm; Youth Dynamics; Underage Youth Drinking Prevention Initiative, Blackfeet Tobacco Prevention Program

Butte: The Butte School District offers mental health programs in all schools. In addition, the North American Indian Alliance offers Native American Heritage Day for all students; Butte/Silver Bow Health Department teaches 3rd and 5th grade students about the dangers and effects of drugs and alcohol; Family Services teaches middle-school students about personal responsibility, including teen pregnancy and STDs; Big Brothers Big Sisters teaches grades 4-6 about respecting boundaries; Butte Cares teaches students the importance and qualities of leadership; TASC assists students with the transition from elementary to middle school. Healthy Citizens Curriculum Committee including 15 local agencies promotes all around healthy

individuals; Butte Community Coordinated Child Care provides academic screenings for students entering Butte Public Schools.

Kalispell: The district collaborates with the Kalispell Regional Medical Center to provide CSCT teams (including a therapist and a behavioral specialist) in all schools. Six schools are involved in MBI, OLWEUS Bullying Prevention, and Rachel’s Challenge. SROs in both high school and middle school; Homeless Grant; Social Responsibility Training at Flathead High School and the Attendance Transition Center (part of the Alternative High School)

Gap 2: Lack of implementation of school-system and community-wide, evidence-based, proven programming and strategies to prevent suicide

Rurality and remoteness are significantly associated with greater suicide rates for both adults and adolescents (Goldcamp, Hendricks, & Myers, 2004; Gunderson et al., 1993; Peek-Asa, Zwerling, & Stallones, 2004; Pratt, 1990; Saftlass, Blair, Cantor, Hanrahan, & Anderson, 1987; Singh & Siahpush, 2002; Stallones & Cook, 1992). A lack of available services, excess driving time to appointments, nonexistent long-distance public transportation, and the requirements and culture of rural life may make it difficult or undesirable to seek out assistance in rural or frontier areas (Ciarlo et al., 1996). In addition, frequent appointments for therapy and access to crisis intervention services may be both inconvenient and impractical (Kelleher et al., 1992); and, the outpatient therapeutic model effective in urban areas (e.g., a weekly, hour-long appointment) may not be workable for rural areas (Mulder & Chang, 1997).

For 30 years, Montana has ranked in the top five states for suicide rates for all age groups. (Rosston, 2014). Montana’s Suicide Injury Deaths and Rates per 100,000 (ages 10-18) are nearly three times the national rate of 3.61, and the rate for Native American youth is more than 20; our Suicide Firearm Deaths and Rates per 100,000 (ages 10-18) is three times the national rate of 1.55. (CDC, 2013) The percentage of youths who have seriously considered attempting suicide increased 52% from 2009 to 2013. (See Indicator Data Tables in Other Attachment File 2.)

Available resources, systems, and programs

Statewide: Montana Prevention Resource Center; ASIST training through the Addictive and Mental Disorders Division of the Montana Department of Public Health and Human Services; experience of prior Safe Schools/Healthy Students grantees in Helena, Missoula, and Ronan

Browning: American Indian Life Skills suicide prevention curriculum; Question, Persuade, Refer (QPR) Suicide Prevention; Blackfeet Honor Your Life Program; Indian Health Service Behavioral Health program; National Suicide Prevention Lifeline (1-800-273-TALK)

Butte: QPR Suicide Prevention Training (Question, Persuade, Refer) for all Butte School District personnel, all school-based mental health personnel, and members of the community including many parents; Signs of Suicide, an evidenced based program, in 8th and 10th grade physical education/health classrooms; ASIST (Applied Suicide Intervention Skills Training) workshops for all health/p.e. teachers, counselors, and nurses

Kalispell: The Youth Suicide Prevention Project makes Applied Suicide Intervention Skills Training (ASIST) available to staff; counselors and mental health providers have training in intervention. KMRC/ Pathways Treatment Center partners for mental health evaluations and crisis intervention.

Gap 3: Lack of fully coordinated support infrastructures and referral process within schools and between schools and community

According to the National Institute of Mental Health, 10% of children need mental health services (New Freedom Commission on Mental Health, 2003), and 4 of every 5 children with mental illnesses are undiagnosed. (Kataoka, S., et al.,2002) Many students find themselves in

serious trouble with the law or are expelled because they are a danger to others or as a result of substance abuse issues. Some do not act out in an overt fashion, but rather “act in”: while they are showing signs of risk, they remain unnoticed, tuning out well-intentioned interventions and slipping out of the system.

Even if students have been identified, research shows they often are not connected with someone who is able to perform further evaluations and/or provide services. An estimated two-thirds of all young people with mental health problems are not receiving the help they need. (Merikangas K.R., et al., 2011) Similarly, among the 8.5% of the population aged 12 to 17 who need substance use treatment, approximately 92% did not receive it. (Han, B., et al., 2011) Even when students are connected with services, a small proportion actually completes them.

The SEA, LEAs, and partnering agencies involved in this grant have struggled with many of the patterns noted above. The lack of a coordinated, streamlined referral process influences if/when students are identified and referred and the extent to which such referrals result in appropriate, effective, and seamless services. For example, students who may need behavioral or mental health services are being referred to law enforcement/probation, which may lead to worsening of problem behavior, even though it may be the ONLY way to get some sort of help.

Many school districts have poor, varied, or nonexistent infrastructures for identifying, referring, following up, coordinating, and monitoring services for students showing signs of behavioral, emotional, or academic risk (Bridgeland, Balfanz, and Fox, 2011). Common barriers include 1) identification and referral based on single risk dimensions (e.g., academics only) rather than multiple behavioral, social/emotional, and academic risk factors; 2) referrals to programs/services via a few or single individuals and based on relationships rather than need; 3) complicated and time-consuming paperwork, referral, and communication processes; 4) lack of awareness of available resources, services, and programs; 5) lack of faith that anything ever occurs if referrals are made, and lack of feedback/communication resulting in a lack of faith in that anything will occur even if a referral is made; 6) lack of monitoring regarding service impact; and 7) stigma, confidentiality concerns, or fear of consequences,.

Available resources, systems, and programs

Statewide: Montana Behavioral Initiative tiered supports; Leading by Convening; experience of prior Safe Schools/Healthy Students grantees in Helena, Missoula, and Ronan

Browning: “wraparound” services meetings with Indian Health Services and other providers (tier 3)

Butte: Student Assistance Team team-based referrals for school- or community-based mental health services

Kalispell: Montana Behavioral Initiative tiered supports; RtI tiered supports; many community-based support systems for students and families.

Goal #2: Increase awareness of mental health issues

Gap 1: Lack of understanding among students, families, educators, other support staff, and community providers about mental health issues, warning signs, and role of early childhood/historical trauma

Mental illness in children can be hard for adults to identify. As a result, many children who could benefit from treatment don't get the help they need. Children can experience a range of mental health conditions, including anxiety disorders, attention-deficit/hyperactivity disorder (ADHD), autism, eating disorders, mood disorders, and schizophrenia. (Mayo Clinic, 2014)

Childhood stressors such as abuse can lead to a variety of negative health outcomes and behaviors (Anda et al., 2005). A notable recent series of research studies on this topic has linked

adverse childhood experiences (ACEs) to abnormal brain development and a range of mental health outcomes well into adulthood (Chapman et al., 2004; Dube et al., 2001).

Historical trauma is the collective emotional and psychological injury both over the life span and across generations, resulting from a cataclysmic history that occurs as a result of genocide and other significant abuses. Powerlessness and hopelessness are associated with historical trauma that likely contributes to high rates of alcoholism, substance abuse, suicide, and other health issues. (Yellow Horse Brave Heart, M. and Fong, R., & Furuto, S. Eds., 2001.) In a 2010 study (Running Wolf, P., et al., 2011) of 64 Browning seventh-grade students 78.1% were above criterion on Violence Exposure, 57.8% were above criterion on Child Traumatic Stress Symptoms; and 73.4% listed a lifetime loss.

The MPNA indicates a higher percentage of students at high risk for depressive symptoms than the national norm and shows that more than a quarter of Montana students exhibit depressive symptoms. (See Indicator Data Tables in Other Attachment File 2.)

Available resources, systems, and programs

Statewide: Statewide Best Beginnings Advisory Council; county- and tribal-level Early Childhood Councils; Montana Infant Early Childhood Home Visiting program; Montana Behavioral Initiative Youth Days; Peer-to-Peer Model; scattered MHFA/YMHFA trainers; experience of prior Safe Schools/Healthy Students grantees in Helena, Missoula, and Ronan; Montana Chapter of the National Alliance on Mental Illness; Childwise Institute ACE Master Training Program

Browning: “Students Trauma and Resiliency” (STAR) training for two health teachers and two school counselors who implemented Tier 1 STAR curriculum in middle school; The National Native Children’s Trauma Center Cognitive Behavioral Intervention for Trauma in Schools (CBITS) screening and groups; Honor Your Life weekly warning signs ads; Lifeline program on local television; Behavioral Health Aides; Days of the Blackfeet Health Fair; Remember the Child conference; Blackfeet Community College Disabilities Conference; Head Start Disabilities Conference

Butte: mental health programs in all schools; Butte Silver Bow Health Department Home Visiting to families with children age 0 -8 that includes information about mental health and childhood trauma

Kalispell: mental health programs in all schools; The Nurturing Center provides training in mental health awareness to childcare providers; Flathead Best Beginnings Council facilitates communication about early childhood care, including normalizing asking for help.

Goal #3: Connect children and youth with behavioral and mental health issues with needed services

Gap 1: Lack of continuum of behavioral health care for all kids

SAMHSA’s *Behavioral Health Continuum of Care Model* and the *Mental Health Intervention Spectrum* include *promotion* to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges and to reinforce the entire continuum of services; *prevention* to prevent or reduce the risk of developing a problem; *treatment* for people diagnosed with a disorder; and *recovery* to support individuals’ compliance with long-term treatment and aftercare.

Montana offers a range and variety of behavioral and mental health services; however, they are more piecemeal than integrated and systematic. Many students are referred directly from universal tier 1 approaches to tier 3 individual therapy. An effective identification, referral, and tracking system needs to be developed to ensure an appropriate continuum of care.

Available resources, systems, and programs

Statewide: Comprehensive School and Community Treatment (CSCT), an intensive multi-level intervention, in 352 schools; OPI Neglected/Delinquent and Homeless Specialist

Browning: CSCT in some school buildings; Northern Winds Recovery Center; Crystal Creek Lodge Treatment Center

Butte: The Butte School District works closely with a variety of mental health providers that could help design and implement a comprehensive continuum, including Acadia, AWARE, Community Health Center, Intermountain Family Based Services, Life Management Associates, Shodair, Western Montana Mental Health Center, Youth Dynamics, and Rocky Mountain Clinic.

Kalispell: Kalispell Schools partners with Turtle Bay Partial Hospitalization Program, acute care hospital unit, Crossroads, Shodair, Youth Dynamics, Intermountain Family Based Services, KRMC, AWARE, Sinopah, House, Stillwater Therapeutic Services, Sunburst, Flathead Youth Home, the Flathead Juvenile Justice System, NW Head Start, CDC, CPS, Summit Independent Living, the Community Action Partnership, and CARE to provide needed mental health services and interventions to students and families.

Gap 2: Lack of access to behavioral, mental health, and co-occurring substance abuse screening, counseling, and treatment for students and families

The barriers preventing access to mental health care in rural populations have been exhaustively identified in the literature by the Center for Mental Health Services (CMHS), the Frontier Mental Health Services Resource Network (FMHSRN), the National Rural Health Association (NRHA), National Association for Rural Mental Health (NARMH), Roberts, et al. (1999), and Spoth (1997). Several challenges and ethical dilemmas affect provision and access to effective mental health services in rural areas. These include limited access to qualified providers and services; co-occurring substance abuse with mental illness; geographical isolation; conflicting roles among care-providers, patients, and families; protection of patient confidentiality; and cultural philosophy regarding mental health care.

Stigma and lack of financial/insurance resources also create barriers to accessing services. (Schwarz, S. W., 2009) Mental illness is permeated with negative connotations in rural areas. A recent study (Sirey, 2001) indicated stigma not only dissuades people from seeking mental health services, but may also impede progress once people are engaged in treatment. The effects of this stigma are magnified among rural Americans. (Esters, Cooker, and Ittenbach, 1998) “Rural communities have been likened to fish bowls. Comings and goings at the mental health clinic are observed and people listen carefully to comments of clinic staff members.” (Roberts et al., 1999) The close scrutiny common in rural communities combined with the pervasive tendency to stereotype mental health services creates a barrier for those who need services.

In examining the perceptions that rural parents have regarding attaining mental health services for their children, Starr et al. (2002) found that parents expressed a long list of obstacles to accessing services, yet the same respondents said they would feel good taking their child to see a mental health professional; that mental health professionals were needed for their children; that a mental health professional would find out what was wrong with their child; and that taking their child to a mental health professional would help her/him grow up healthy. This points to the need to educate people about the therapeutic process and alleviate the negative viewpoints.

According to the 2012 Behavioral Risk Factor Surveillance System, 18.8% of adults had no health coverage, compared to 14.5% nationally. Approximately 11% of Montana adults reported that they needed to see a doctor but were unable to afford care. Taking this into account, it is likely that some of our students who need services do not have the insurance or financial

resources to access services independently.

Available resources, systems, and programs

Statewide: Medicaid, Comprehensive School and Community Treatment (CSCT) in 352 schools; OPI Neglected/Delinquent and Homeless Specialist; National Alliance on Mental Illness; SSHS grant recipient community of Helena social marketing products. Financial resources include Children’s Health Insurance Program, insurance through the Affordable Care Act, Prevention Incentive Funds, and scattered providers offering sliding-scale fees.

Browning: Indian Health Service has two licensed mental health therapists; drug screening for middle- and high-school students participating in extracurricular activities; Shodair; Youth Dynamics; Family Services via Indian Health Services.

Butte: Acadia; AWARE; Community Health Center; Intermountain Family Based Services; Life Management Associates; Shodair; Western Montana Mental Health Center; Youth Dynamics; Rocky Mountain Clinic, Screening Brief Intervention Referral to Treatment (SBIRTT)

Kalispell: Same providers as listed in Goal 2, Gap #1 above. SBIRTT. Pathways provides substance screening; high schools use a basic substance screening tool; Flathead Valley Chemical Dependency Clinic and a few private practitioners do substance screening on request.

SECTION B: PROPOSED APPROACH (40 POINTS)

Goals and Objectives: The purpose of Montana’s NITT-AWARE-SEA project is to build and expand the capacity of the Montana Office of Public Instruction (OPI) to increase awareness of mental health issues among school-aged youth, provide training for school personnel and other adults who interact youth to detect and respond to mental health issues in children and young adults, and connect children, youth, and families who may have behavioral health issues with appropriate services. Our goals link to the federal objectives in section 2.1 as follows:

Goal 1: Build and/or expand capacity at the state and local levels to make schools safer and improve school climate

Objectives:

- a) Increase access to school- and community-based mental health services including improved coordination of state and local policies and resources
- b) Link planning and implementation of NITT-AWARE-SEA grant initiatives with efforts to coordinate planning across state and local education, mental health, juvenile justice, and other child serving systems
- c) Implement youth violence prevention strategies
- d) Build the capacity and leadership to sustain community-based mental health promotion, illness prevention, early identification, and treatment services and initiatives
- e) Ensure that the mental health services delivered are culturally specific and developmentally appropriate
- f) Encourage the implementation and expansion of the multi-tiered behavioral framework (e.g., Montana Behavioral Initiative (MBI))

Goal 2: Increase awareness of mental health issues

Objectives:

- a) Increase outreach, awareness, and engagement of youth and families on mental health issues to promote mental health.
- b) Increase mental health literacy of school personnel and other adults who come into contact with school-aged youth via YMHFA training

Goal 3: Connect children and youth with mental, emotional, and behavioral health issues with needed services

Objectives:

- a) Connect families, schools, and communities to increase engagement in planning and implementing programs
- b) Develop and implement systems for early identification of signs and symptoms that are linked to existing services
- c) Implement effective behavioral health promotion and mental illness prevention strategies, including universal, selected, and indicated approaches
- d) Access existing funding systems to support the provision of mental health services to school-aged children and youth

Achieving these goals will increase our system capacity to support effective mental health services by increasing the number of mental health first aiders and trainers available throughout the state, particularly in the three participating LEAs; creating deep stakeholder engagement and effective partnerships among youth-serving agencies; enhancing school and community based mental health provider awareness of services, funding sources, and eligibility/application processes; and streamlining and coordinating the case management and referral systems.

Project Activities

Goal 1: Build and/or expand capacity at the state and local levels to make schools safer and improve school climate

1. OPI will expand the research-based Montana Behavioral Initiative³ (MBI) to sub-recipient schools not currently implementing MBI with fidelity at LEAs and integrate MBI with school-based mental health activities. See page 22, *Violence Prevention Strategies*, for a description of MBI. (This activity reflects objectives b, c, and f above, and responds to gaps 1 and 3 in Section A and Goal 3 objectives a, b, c, and d and gaps 1 and 2.)

LEAs will use the Interconnected System Framework (ISF) to integrate MBI with school-based mental health activities. ISF connects Positive Behavioral Intervention and Supports (PBIS) and School Mental Health (SMH) systems to improve educational outcomes for all students, especially those with or at risk of developing mental health challenges. ISF is based on a multi-tiered framework addressing critical gaps currently in schools, school districts, and states. Through this multi-tiered systems integration between PBIS and SMH, the possibility of catching children and youth on a spectrum from early identification at tier 1 to rigorous modified intervention at tier 3 is greatly enhanced. (Barrett, S. et al., 2013)

2. MBI will work with participating LEAs to increase student behavioral screenings via use of a two-gate universal screener such as SSBD (Systematic Screening of Behavioral Disorders) implemented as part of the Multi-Tiered System of Support (MTSS). (This activity reflects objectives a, b, c, d, and f above, and responds to gaps 1, 2 and 3 in Section A.)

Up to 20% of school-age children have a diagnosable emotional disorder that impedes normal functioning (Burns et al., 1995; Merikangas et al., 2010; Shaffer et al., 1996). Yet, students with emotional/behavioral disorders supported in special education represent less than 1% of enrollment (U.S. Department of Education, National Center for Education Statistics, 2011) demonstrating a sizable gap between need and service delivery. Untreated behavioral and mental health problems interfere with learning (Adelman & Taylor, 2002) and are likely to persist without early identification and effective intervention (Walker, Ramsey, and Gresham, 2004).

The two-gate process has teachers consider all students for additional supports based on

³ Montana's name for Positive Behavioral Interventions and Supports

exhibiting any behaviors listed on a standardized checklist. The use of a standardized checklist of behaviors for the initial phase (gate one) of the screening process helps reduce teacher bias. Also, the multi-gate process especially benefits students who never receive discipline referrals. These students may exhibit overly shy or withdrawn behaviors that are risk factors for more serious problems (i.e., school refusal, anxiety and depression).

3. The Project Management Team will examine model schools for effective Comprehensive School and Community Treatment (CSCT) referral processes such as A Team, and offer guidance, support, and models for Tier 2 and 3 support teams through MBI. (This activity reflects objectives a, b, d, and f above and responds to gap 3 in Section A and **Goal 3**, objectives a, b, and c and gaps 1 and 2.)

The A-Team Protocol allows for student referral by any staff member to the building A-team coordinator. Perceptions are gathered from the student’s other teachers, and either immediate action is taken by the coordinator or the referral is discussed by the A-Team. The team reviews the progress of all referred students and determines whether to continue or change interventions.

4. The Project Management Team will lead coordination of dissemination of information on lessons learned/best practices/resources available related to mental health, suicide prevention, violence prevention, bullying, poverty and relation to mental health/substance use issues, etc. among state agencies and participating LEAs via multiple methods, including community of practice, superintendent meetings, and professional conference pre-meetings. (This activity reflects objectives a, b, and d above and responds to gaps 1, 2, and 3 in Section A)

The Project Management team will host semi-annual presentations of lessons learned/best practices/resources available related to mental health, suicide prevention, violence prevention, bullying, poverty, etc. for state agencies and participating LEAs featuring presentations by the LEAs and Montana’s SSHS grantees. It will also implement a Community of Practice for the Project Management Team. A Community of Practice is a group of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly. It has an identity defined by a shared domain of interest, commitment to the domain, and a shared competence that distinguishes members from other people. Members engage in joint activities and discussions, help each other, and share information to build relationships that enable them to learn from one other. (Etienne Wenger, et al., 2002)

5. The Project Management Team will provide training/education on FERPA/ HIPAA/ PPRA/MOUs/release of information compliant policies and procedures for information-sharing between agencies. (This activity reflects objectives a and b above and responds to gap 3 in Section A.)

Schools and mental health professionals are bound by many federal and state regulations, and these regulations change. In order to design and implement a streamlined, coordinated referral process, all participants need an up-to-date understanding of how to uphold the law while making the process more convenient for students and families.

6. The Project Management Team will coordinate with other State councils, agencies, and grants for mental health awareness, resources, and support (e.g., Interagency Coordinating Council, Project Launch, School Climate Transformation Grant-if awarded, etc.) to leverage resources and reduce duplication via the Coordination and Integration Plan. See the Coordination and Integration Plan below. (This activity reflects objectives a, b and d above and responds to gap 3 in Section A.)

7. The Project Management Team will promote interagency collaboration and coordination and provide information to LEAs and community providers regarding resources

available (e.g. funding) for addressing mental health issues, including shared risk factors and co-occurring disorders. (This activity reflects objectives a, b, d, and f above and responds to gap 3 in Section A and Goal 3 objectives a, b, c, and d and gap 2.)

The project will use the *Models for Change toolkit* and *Leading by Convening* to improve collaboration, coordination, and information sharing. *Leading by Convening* is an overarching, guiding framework that includes habits of interaction, elements of interaction, and depth of interaction by coalescing around issues, ensuring relevant participation, and doing work together. The elements of interaction are informed by the work of Heifetz and Linsky (2002) on technical and adaptive change. Depth of interaction progresses from informing, to networking and collaborating, to transforming. (Cashman, et al., 2014).

8. The OPI Health Enhancement Division will review participating LEA school safety plans to ensure that violence prevention activities reflect best practices and will provide specific recommendations for sub-recipients. (This activity reflects objectives b and c above and responds to gap 1 in Section A.)

9. OPI, with particular assistance from Indian Education and ESL, will ensure that proposed activities as determined through the planning process address the mental health inequities among cultural and linguistic groups in Montana and will work with the Project Leadership Team to ensure that the national Culturally and Linguistically Appropriate Services (CLAS) standards are used as a strategy to help eliminate these disparities. (This activity reflects objective e above and responds to gaps 1 and 3 in Section A.)

10. The Project Management Team will review the state continuum of mental health care (from prevention to intensive services) and make recommendations for policy change. (This activity reflects objectives a, b, and d above and responds to gaps 1, 2 and 3 in Section A and Goal 3 objectives a, b and c and gap 2.)

A continuum of mental health care seeks to bridge the separation of promotion of mental health and prevention of mental and behavioral disorders from treatment and recovery. Promotion, prevention, treatment, and recovery are inextricably linked, so adequate attention to the whole continuum of services is essential to Montana’s psychological health.

11. The Project Leadership Team will work with interested School Resource Officers (SRO) to plan for and develop a statewide SRO association that will establish consistent officer expectations and responsibilities, offer training in MHFA/YMHFA, trauma-informed practice, confidentiality, etc., and provide opportunities for networking with peers to bridge the gap between law enforcement and mental health. (This activity reflects objectives b, c, and d above and responds to gaps 1 and 3 in Section A.)

This will address the concern that many Montana schools are increasingly relying on local law enforcement to handle disciplinary issues that traditionally have been strictly the responsibility of teachers and administrators. By having police officers facilitate school discipline, schools move students directly into the juvenile justice system rather than allowing them an opportunity to correct their behavior before creating a court record. (Catherine Kim, et al., 2010)

12. The Project Management Team will develop plans for addressing alternatives to justice system placement. (This activity reflects objectives a and b above and responds to gap 3 in Section A.)

Goal 2: Increase awareness of mental health issues

1. The Project Leadership Team and LEAs will provide opportunities to parents/families (preK-12) to learn about and understand mental health issues and warning signs through

YMHFA and informal education such as mini-workshops and lunch-and-learn sessions. (This activity reflects objective a above and responds to gap 1 in Section A.)

Informal education opportunities are not meant to replace YMHFA, but rather to increase awareness of and interest in mental health issues and inspire participants to become YMHFA First Aiders or trainers.

2. The Project Leadership Team will provide mental health awareness to students through YMHFA as described in the YMHFA plan below and through MBI Youth Days. (This activity reflects objective a above and responds to gap 1 in Section A.)

Each year MBI offers a two-day youth leadership conference in five locations around Montana to help youth incorporate the “8 Conditions” that need to be in place if they are to strive for and fulfill their academic, personal, and social promise. The content for the next five years will include mental health issues and YMHFA.

3. Youth Dynamics, Inc. will hire a YMHFA Coordinator to oversee and coordinate statewide YMHFA training for various stakeholders as described in the YMHFA plan below and will ensure adherence to the LEA training plans. (This activity reflects objective b above and responds to gap 1 in Section A.)

4. The Project Management Team will provide professional development to educators and school staff on how to provide behavioral supports to students through the University of Maryland Center for School Mental Health continuing education modules. (This activity reflects objective b above and responds to gap 1 in Section A.)

The Center for School Mental Health offers 7 modules to help educators and school-based staff identify, refer, and provide other needed support to youth with mental health needs. The curriculum recognizes the interconnectedness of mental health and school achievement and the value of educators, school-based staff, and families in promoting youth success.

5. The Browning LEA will implement the SAMHSA-endorsed Reconnecting Youth program in middle school and high school. This activity reflects objective a above and responds to gap 1 in Section A.

6. The Browning LEA and Blackfeet Community College will establish a dual-credit course in Peer Assistance Leadership for high-school students. This activity reflects objective a above and responds to gap 1 in Section A.

Goal 3: Connect children and youth with mental, emotional, or behavioral health issues with needed services

1. The Browning and Butte LEAs will provide financial allotments for school- or community-based services for those not eligible for Medicaid. (This activity reflects objectives a and b above and responds to gaps 1 and 2 in Section A.)

2. The Browning LEA will partner with tribal and community-based behavioral and mental health providers to establish a provider coalition; the Kalispell LEA will reestablish the Youth Services Network. (This activity reflects objectives a-d above and responds to gaps 1 and 2 in Section A.)

3. The Browning LEA will partner with tribal and community-based behavioral and mental health providers and Blackfeet Community College to create a Community Crisis Center. (This activity reflects objectives a-d above and responds to gaps 1 and 2 in Section A.)

The Center will serve students from 8 a.m. to 4 p.m. with in-school therapy in the afternoons. From 4 p.m. to 8 p.m., the Center will conduct group and family interventions and provide a safe after-school destination for homeless students and others. A helpline will be staffed around the

clock. The Center also will develop local provider capacity by providing required clinical supervision hours for licensable practitioners.

4. All three LEAs will hire or contract with school-based mental health therapists (This activity reflects objectives a and b above and responds to gaps 1 and 2 in Section A.)

5. The Project Management Team will require all service providers providing services under this grant to demonstrate training in trauma-informed care, as well as implementation of evidence-based services. (This activity reflects objectives a, b, and c above and responds to gaps 1 and 2 in Section A.)

Early childhood and historical trauma are shrouded in secrecy and denial and are often ignored. When providers don’t ask about trauma in behavioral healthcare, harm can be done or abuse unintentionally recreated. There are many evidence-based models and promising practices designed for specific populations, types of trauma, and behavioral health manifestations. (National Council for Behavioral Health, 2014) In the best interest of our students, we will require all service providers under this grant to demonstrate training in trauma-informed care. Montana’s Childwise Institute is developing a certification process for training in early-childhood trauma; and Blackfeet Community College is developing a certification process for training in historical trauma. MBI will provide teacher training in trauma-informed classroom practices.

6. The Project Management Team will engage early childhood providers in improving the process of referrals to services (and funding sources) for young children and families and educating them about YMHFA training (see Goal #2) (This activity reflects objectives a and d above and responds to gaps 1 and 2 in Section A.)

The participating LEAs noted that many of the behaviors and mental health issues they observe in students have their roots at home and in early childhood. While this grant is restricted to serving school-aged youth, the parents of many school-aged youth also have young children, and can best be reached through early childhood providers. By helping early childhood providers understand referral options and funding sources, we help the families they serve. Again, because they are in contact with families who also have (or who will soon have) school-aged children, we are including them in our YMHFA audience.

Each of Montana’s 22 judicial districts offers Prevention Incentive Funds that can be used for a wide range of programming and services. Many schools are not aware of the funds or of the many possible uses. (This activity reflects objectives a, c, and d above and responds to gaps 1 and 2 in Section A.)

Sometimes students with behavioral or mental health needs are placed in the justice system simply because there is no funding to serve them in appropriate settings.

Timeline (See *YMHFA Plan* below for YMHFA schedule)

Activity	Target Date/Milestones	Responsibility
Update the Needs Assessment and Environmental Scan Data	Year 1, 1 st quarter	State and Local Project Management Teams
Update the Coordination and Integration Plan	Year 1, 2 nd quarter	Project Management Team
Prepare a plan to align NITT-AWARE-SEA and ED SEA School Climate Transformation grants	Month 1 and ongoing	Project Management Team
Conduct Project Management Team meetings	Monthly years 1-2	Project Director
Collect and report GPRA data	Quarterly, every year	Evaluators and LEAs

Attend joint grantee meeting	Years 1,3,5	Project Director and representative team
Hire state, local, and YMHFA coordinators	Year 1, 2 nd quarter	OPI/YDI, LEAs
Conduct site visit to LEAs	Year 1, 2 nd quarter and quarterly thereafter	SEA Project Coordinator
Expand MBI to LEA schools not currently implementing or not implementing with fidelity	Year 1/Application and team training; Year 2/Tier 1 training; Years 3 -5/Tier 2 and 3 training	MBI Coordinator and MBI coaches
Integrate MBI with school-based mental health activities	Years 1 and 2/align with new Montana CSCT rules	State Management Team/Erin Butts
Conduct student behavioral screenings	Years 1-5 in Butte and Kalispell Years 2 -5 in Browning	LEA teachers
Examine model schools for effective CSCT referral processes	Year 1, 1 st quarter	Project Management Team
Reestablish the Youth Services Network	Year 1, 1 st quarter	Kalispell LEA
Offer guidance, support, and models for Tier 2 and 3 support teams at LEAs	Years 3-5	Tim Lewis, National PBIS Center
Conduct Community of Practice	Years 1-5, twice annually	Dr. Kristine Jolivette, PBIS Network and State Project Coordinator, Erin Butts
Present lessons learned/best practices/resources available to all school superintendents	Years 1-5, annually	Project Coordinator, Project Management Team
Present lessons learned/best practices/resources available to mental health professionals and other providers	Years 1-5, annually	Erin Butts
Provide training on FERPA/HIPAA/PPRA/MOU/Release of Information compliant policies and procedures	Years 2-5, annually	State Project Coordinator
Implement Leading by Convening	Begin year 1, month 1, monthly thereafter	Frank Podobnik
Implement the Interconnected System Framework	Year 1 and ongoing	Erin Butts
Review LEA school safety plans for violence prevention best practices	Year 1, 1 st quarter and annually	Health Enhancement Division
Recommend violence prevention strategies for LEAs	Year 1, 2 nd quarter and annually	Health Enhancement Division
Review proposed activities for adherence to CLAS standards	Year 1, 3 rd quarter and ongoing	Donnie Wetzel
Review the state continuum of mental health care	Year 1 and ongoing	Erin Butts
Recommend policy changes to the state continuum of mental health care	Year 1 and ongoing	Erin Butts
Contract with a nonprofit specialist to work with SROs to develop a statewide SRO association	Year 1, 2 nd quarter and annually	State Project Coordinator
Conduct mini-workshops on MHFA	Year 1, 4 th quarter and 4 times per year thereafter	State Project Coordinator
Participate in MBI Youth Days	Year 2 and annually, timing varies by community	Representative teams from LEAs
Provide professional development to educators and school staff	Years 1 -5, annually	State Management Team

Institute financial allotments for school- or community-based services for Medicaid borderline kids/families	Years 2 - 5	Browning and Butte LEAs
Hire mental health therapists	Year 1, 1 st quarter	All three LEAs
Develop a process to assure training in trauma-informed care and provision of evidence-based services	Year 2	Project Management Team
Work with early childhood providers to improve referrals to services	Year 1, 1 st quarter and ongoing	Project Management Team
Develop a streamlined, coordinated referral process	Year 2	LEA school MBI teams, LEA Project Teams
Identify replicable, high-quality programs funded by Prevention Incentive Funds	Year 1, 3 rd quarter and annually	State Management Team, led by Bob Peake
Develop alternatives to justice system placement	Year 3/achieve “integration” status with Leading by Convening Year 5/complete task	Project Management Team
Institute Reconnecting Youth at middle schools and high schools	Year 2, 1 st quarter	Browning LEA
Develop dual-credit course for Peer Assistance Leadership	Year 2, 1 st quarter	Browning LEA
Establish a provider coalition	Year 1	Browning LEA
Create a community crisis center	Years 1 and 2/develop MOUs; develop processes and policies; hiring and training Years 3 – 5 roll out	Browning LEA
Work to reform Medicaid policy to serve school-age children who do not reside with custodial parents	All years	Project Management Team

Project Participants

Montana Office of Public Instruction: Superintendent’s Office/Department of Education Services: serve on Project Management Team, inform the Superintendent, coordinate within OPI and across systems, provide data. **Health Enhancement Division:** administer grant, serve on Project Management Team, review school safety plans, provide recommendations for evidence-based violence prevention programs and anti-bullying policies, provide data. **Special Education Division:** serve on Project Management Team, coordinate MBI activities, link to Leading by Convening, provide data. **Educational Opportunity and Equity Division:** serve on Project Management Team, coordinate within department, link to Title I services. **Neglected/Delinquent and Homeless Specialist:** serve on Project Management Team, link to homeless and other Title I services. **Indian Education Division:** serve on Project Management Team, review adherence to CLAS, support relationships between the Blackfeet Tribe and the Browning LEA. **Montana Supreme Court, Youth Court Services Division, Juvenile Probation:** serve on Project Management team, coordinate within the division and across systems, link to Prevention Incentive Funds, link to Systems of Care statutory committee. **Montana Department of Public Health and Human Services: Medicaid and Health Services Branch:** serve on the Project Management Team, link to Medicaid services. **Children’s Mental Health Bureau:** serve on Project Management Team, coordinate within the department and across systems. **Addictive and Mental Disorders Division, Suicide Prevention Specialist:** serve on Project Management Team, link to AMDD, provide expertise on suicide prevention, provide data. **Early Childhood Services:** serve on Project Management Team, link to statewide Best Beginnings Advisory Council, Montana Infant and Early Care Home Visiting, and community childcare coalitions. **Child**

Protective Services: serve on Project Management Team, link to CPS services. **Prevention Resource Center:** serve on the Project Management Team, link to PRC resources and Interagency Coordinating Council, including the Montana Governor’s Office. **Youth Dynamics, Inc.:** Hire YMHFA Coordinator, coordinate YMHFA plan, serve on Project Management Team, link to school- and community-based mental health providers, provide data. **Browning School District:** fulfill expectations of LEA participant, serve on Project Management Team, provide data. **Blackfeet Community College:** collaborate with Browning LEA and Youth Dynamics to implement the Coordination and Integration Plan and YMHFA plan, provide data. **The Blackfeet Tribe:** collaborate with Browning LEA to implement the Coordination and Integration Plan and integrate with the Blackfeet Tribal NITT grant if awarded (The Montana Codes require LEAs to connect with the local tribes in near proximity). **Butte School District:** fulfill expectations of LEA participant, serve on Project Management Team, provide data. **Kalispell School District:** fulfill expectations of LEA participant, serve on Project Management Team, provide data. **Helena Safe Schools Healthy Students Grant Management Team:** serve on Project Management Team, share experience with best practices, lessons learned, referral system. **Missoula Safe Schools Healthy Students Grant and Mental Health Grant Management Team:** serve on Project Management Team, share experience with best practices, lessons learned, referral system. **Ronan Safe Schools Healthy Students Grant Management Team:** serve on Project Management Team, share experience with best practices, lessons learned, referral system.

LEA Readiness and Willingness: As indicated in their letters of commitment, the Browning, Butte, and Kalispell School Districts are ready and willing to participate fully in this grant and the Coordination and Integration Plan. They have identified the mental health need priorities of their children and youth, and they have the capacity to work with other sectors of their community to implement an intervention, strategy, or approach that addresses the mental health needs of school-aged children or creates safe and respectful school climates.

Working with LEAs to improve collaboration and improve access to services: OPI will work with the three LEAs to improve collaboration across all child, youth, and family serving organizations by including them as essential members of the Project Management Team where they will meet and develop relationships with representatives of statewide providers; by including them in the evidence-based collaboration-building processes of Leading by Convening and Community of Practice; and by helping them implement local Interconnected Systems Frameworks and streamlined, coordinated referral processes.

OPI will help them improve access to services by identifying and connecting them with various sources of services and funding that they may not yet be familiar with; by offering professional development for school counselors and other professionals; and by exposing them to best practices and lessons from the field, in particular the Safe Schools Healthy Community Grantees in Helena, Missoula, and Ronan.

YMHFA Selection Process: After reviewing the LEA environmental scans and the project gaps and needs, the Project Management Team reviewed the descriptions of MHFA and YMHFA provided with the RFA and discussed our needs with the National Council for Behavioral Health. Youth Dynamics, Inc., which will house our YMHFA Coordinator, provides MHFA and YMHFA training throughout Montana. Their experience also guided us to YMHFA. Montana has the capacity to build from existing YMHFA infrastructure, and YMHFA will provide training for youth age 16 and over to serve other teens.

Involvement of School-Aged Youth and Families: School-aged youth were involved in the assessment process through their participation in the Youth Risk Behavior Survey, the Montana

Prevention Needs Assessment, and the My Voice Survey that helped identify mental health, emotional, and behavioral needs and gaps statewide and in the LEAs. Individual school-aged youth and families also were involved in the local environmental scans that helped pinpoint needs and resources. Youth and families were involved in planning the grant activities through the participation of Northwinds Recovery Center/Blackfeet Family Wellness, a youth and family mental health treatment and advocacy organization, which also will participate on the Project Management Team and help implement activities. Youth over age 16 also will be trained as first aiders, implementing mental health supports in their communities.

Coordination and Integration Plan: Montana will coordinate and integrate multiple service systems including education, behavioral health, criminal/juvenile justice, law enforcement, child welfare, and early childhood by including decision-making representatives of these systems on our Project Management Team and facilitating meaningful collaboration through Leading by Convening and Community of Practice (described above).

LEA/Public Mental Health Partnership: Browning Public Schools will partner with Blackfeet Community College (BCC) through a universal prevention collaboration during which BPS teaching assistants will participate in the BCC behavioral health teaching assistant endorsement program, which Youth Mental Health First Aid training. BCC will provide one trainer for the project who is already certified in Youth Mental Health First Aid. Because these teaching assistants will be taking this training while they are employed by BPS, they will be able to implement the strategies learned directly into schools. BPS also will collaborate with BCC to instruct Browning High School students in Historical Trauma during their required Blackfeet Native American Studies classes and present Reconnecting Youth training through their advisory periods. BCC will offer students who complete these components dual credit with the college under Peer Assistance Leadership.

BPS will expand its collaborative relationships with Indian Health Service by strengthening the existing wraparound services and consultations through the increased awareness of mental health issues by the staff in both agencies. As part of our proposed training plan, numerous BPS staff members and HIS workers will be trained in the Youth Mental Health First Aid program.

Finally, collaboration for early and intensive interventions among numerous community organizations and BPS will take place through the new Crisis Center to be located on BPS property. As a result of this grant, BPS will be able to train numerous staff members and volunteers in the ASIST suicide recognition and referral process. A partial list of partners includes: Blackfeet Community College, Indian Health Services, IHS Family services Unit, Blackfeet Law Enforcement, CSCT, and Community Mental Health Services.

Butte will address intervention on all three levels primarily through the school district’s community provider collaborative, the Healthy Citizens Committee. Kalispell will address intervention on all three levels primarily through revitalization of the Youth Services Network.

LEA Referral Process: Currently, in the three LEAs, school- and community-based referral processes take place within the school student assistance teams. The LEA Project Coordinators will facilitate meetings of school and community mental health providers to develop streamlined, coordinated referral processes that meet the needs of their communities. This will be refined with guidance from the SSHS grantees.

Developing the Capacity of LEAs to leverage funding to support school-based mental health services: The Project Management Team identified the following sources of state and local funding available to LEAs and will secure and share eligibility and application information with LEAs: *Judicial District Prevention Incentive Funds*: available for at-risk students through

the district juvenile probation officer; *Medicaid*: for students in families who qualify; *CSCT*: some dollars are available to youth who need immediate attention out of a classroom, but are not Medicaid eligible; *Healthy Montana Kids*: the State’s insurance program for children and youth, which has more liberal eligibility than Medicaid; *Private insurance*: train service providers to ask about it and encourage participation under the Affordable Care Act. The Project Management Team will help the LEA coordinators become expert in mental health funding.

LEA collaboration with juvenile justice/law enforcement agencies: Members of the Blackfeet Law Enforcement and Glacier County Sheriff’s Office will be represented on the local Project Management Team. The Browning LEA will offer YMHFA and ASIST training to their officers and staff members and to those centers to which youth from Browning are placed for juvenile violations. The district recently learned about Juvenile Justice Prevention Incentive Funds and will work with the local probation officer to apply for funds to support Project AWARE activities.

Butte Silver Bow County’s local justice/law enforcement participate on the district’s Health Citizens Committee and will be included on the local Project Management Team. This collaboration led to use of Juvenile Justice Prevention Incentive Funds for school activities; the district will continue to apply for funds to support Project AWARE activities. The Butte LEA also collaborates with local law enforcement on the county Youth Suicide Prevention Committee.

Kalispell’s local justice/law enforcement will participate in the Youth Services Network and will be included on the local Project Management Team. Kalispell has used Juvenile Justice Prevention Incentive Funds for school activities; the district will continue to apply for funds to support Project AWARE activities.

Policies and procedures to ensure enhanced communication and information-sharing across service systems: The Montana Systems of Care Statutory Committee has already identified, and continues to identify, policies and procedures that interfere with beneficial information-sharing across systems, and will provide the Project Management Team with lists of Montana codes that get in the way. Project Management Team members also are serving on a subgroup of the National Center for State Courts specifically addressing this topic and will share information and recommendations with the rest of the team. Under *Models for Change*, Montana has already taken on this task with child-serving agencies, using MOUs among agencies to share information dependent upon a release form from parents.

Reviewing and developing state policies to improve access to mental health services: We will use the existing structures of the Mental Health Oversight and Advisory Council and Systems of Care committees to review policy gaps and policies needing revision. The Project Management Team will encourage all public employees who work with families to get MHFA/YMHFA training and/or become trainers.

State policies to collect LEA-level disaggregated data: Because Montana is a local control state, we cannot implement state policies to collect LEA-level data. However, we will execute MOUs with the participating LEAs to secure available disaggregated data from the school discipline data system, YRBS, MPNA, and My Voice surveys.

Developing an infrastructure to increase capacity to implement, sustain, and improve services when federal funding ends: Montana is leveraging an infrastructure that is already in place, building on existing relationships, and focusing efforts to provide more effective and efficient mental health promotion, illness prevention, and treatment services. Leading by Convening and Community of Practice will further strengthen the existing relationships. We will have substantially increased the number of YMHFA trainers and first aiders across the state, and

Youth Dynamics will continue to offer this training and include YMHFA as part of its continuum of care. Participants will continue to seek and secure funds from third party billing, Medicaid, and private funders. State-level conferences such as the School Mental Health Conference, School Counselor Conference, School Nurse Conference, Juvenile Probation Officer Conference, Board of Crime Control Conference, and Montana Behavioral Initiative Summer Institute will continue to provide a platform to communicate issues and best practices beyond the grant. The Browning School District will also work during the grant period to help Indian Health Services build capacity to provide local day treatment centers.

Linking Project AWARE with existing cross-system activities to enhance state prevention infrastructure: Our primary method of linking cross-system activities is by including decision-makers on our Project Management Team. The Project AWARE Management Team also will serve as the Project Management Team for the School Climate Transformation project if we receive that grant. We also will infuse the MHFA/YMHFA training in other activities such as training hours and CEUs for educators, Licensed Clinical Professional Counselors, Masters of Social Work, Health Aides, and others. Blackfeet Community College is expanding its Behavioral Health Aide training to provide specialized mental health training, requiring YMHFA as part of *Introduction to Counseling*, and developing curriculum specific to school district needs.

Engaging youth and families in promoting awareness of mental health: We will engage youth and families in promoting mental health through mini-workshops, school open houses, school family night, kindergarten roundups, basketball half-time events, mental health fairs, and YMHFA first aid training. Youth will participate in MBI Youth Days. We also will work through organizations that have a focus on youth and mental health such as the National Alliance on Mental Illness, Kiwanis, Key Clubs, Big Brothers Big Sisters, Mariah’s Challenge, Honor Your Life, and the North American Indian Alliance.

Youth Violence Prevention Strategies: Our primary youth violence prevention strategy is the improvement of school climate through the Montana Behavioral Initiative (MBI). MBI is a proactive approach for creating behavioral supports and a social culture that establishes social, emotional, and academic success for all students using the Response to Intervention model, a 3-tiered system of support and a problem solving process to help schools meet the needs of and effectively educate all students. MBI/PBIS has proven its effectiveness and efficiency as an Evidence-Based Practice (Sugai and Horner, 2007) LEAs will implement My Voice follow-up focus groups and OLWEUS Bullying Prevention. In addition, accreditation standards require all districts to submit a bullying-prevention policy to OPI. The Health Enhancement Division will ensure that the policies reflect best practices.

YMHFA Training Plan

OPI will contract with Youth Dynamics, Inc. to lead, manage, and oversee all parts of the YMHFA Training Plan. Youth Dynamics employs the only two YMHFA Certified Trainers in Montana. Immediately upon notification of the grant award, Youth Dynamics will advertise and hire a Project Coordinator. The Project Coordinator will be trained within 60 days of award/hire.

Training Goal 1: Train nine state level trainers, at least six of whom will be trained in Year 1.

Training Goal 2: Coordinate with LEA Project Coordinators to train 3 Trainers and 125 Youth Mental Health “First Aiders” annually in Butte, Kalispell, and Browning (45 total LEA trainers and 1,875 LEA YMH First Aiders by the end of the project).

Training Goal 3: Saturate Montana by training 3 Trainers and 125 “First Aiders” in YMHFA annually in each of 5 identified areas: 1) Great Falls, Shelby, Havre; 2) Wolf Point, Malta,

Glasgow; 3) Miles City, Glendive, Colstrip, Billings; 4) Bozeman, Livingston; 5) Missoula, Hamilton. YMHFA training will be provided to any community members including, but not limited to, adults serving youth such as teachers, counselors, other school personnel, emergency responders, parents, coaches, and caregivers. (75 total trainers and 3,125 YMH First Aiders by the end of the project.)

Schedule: Year 1, 1st quarter: Coordinate and facilitate monthly YMHFA Leadership Meetings; generate and disseminate public service announcements and convene public meetings regarding the grant award in each of the identified 5 areas plus 3 LEAs to outline the goals and objectives of the grant, and to begin generating awareness and interest; identify and select 9 state level trainers, 3 trainers from each LEA, and 7 new YMHFA trainers from the 5 areas representing multiple agencies that will receive training in year 1, complete YMHFA Train the Trainer training.

Year 1, 2^{nd-4th} quarters: Coordinate and facilitate monthly YMHFA Leadership Meetings; Conduct a minimum of 5 trainings, 25 participants each in YMHFA, in the 5 identified areas and each of the three identified LEAs; Add a page to the Youth Dynamics website to provide information on YMHFA, provide information on risk factors and warning signs for mental health and addiction concerns, and connections to agencies providing MH and/or intervention services.

Annually, Years 2 – 5: Coordinate and facilitate monthly YMHFA Leadership Meetings; identify and select 3 new YMHFA trainers representing multiple agencies that will receive training in year 2 of the grant from the 5 areas plus 3 trainers in each of the three LEAs; train 3 new YMHFA trainers in the 5 regions plus 3 new trainers in each of the LEAs; conduct a minimum of 5 trainings, 25 participants each in YMHFA, in the 5 identified areas and each of the 3 LEAs, while extending the training opportunities to more community members; implement strategic plan for moving beyond the training to connecting support services and resources to youth and families.

We have budgeted for necessary materials for trainers and trainees as well as substitutes and other LEA supports. The YMHFA Coordinator will be responsible for ordering materials.

Enhancing and not duplicating other similar activities or programs: Our two major efforts to enhance current activities are 1) to contract with Youth Dynamics, Inc. to coordinate the YMHFA Training Plan because Youth Dynamics, Inc. serves all of Montana and already provides fee-based MHFA/YMHFA training to any interested audiences; and 2) to integrate school-based mental health into Montana’s existing MTTs-PBIS system and implement MBI with fidelity throughout the three LEAs. The Browning School District is working closely with Blackfeet Community College, which already offers MHFA/YMHFA training as part of its course offerings. OPI will collaborate and coordinate grant activities with the SEA School Climate Transformation Grant by employing the same Project Management Team for both grants, including the lead staff for MBI. School Climate Grant trainers Tim Lewis and Dr. Kristine Jolivet will also provide training for Project AWARE leadership.

SECTION C – STAFF, MANAGEMENT, AND RELEVANT EXPERIENCE (25 POINTS)

Applicant Organization Capability and Experience: The Montana OPI is well equipped with resources to support this project and ensure its success. Six OPI divisions will be directly involved in the project and on the management team. OPI’s Special Education Division houses the Montana Behavior Initiative (MBI), our multi-tiered, Positive Behavioral Interventions and Support strategy to improve school climate and safety. We have a large Indian Education Division and a law that mandates working collaboratively with the tribes. OPI collects annual

data from all school districts regarding school staffing and student discipline and obstacles to success that will help identify needs and progress toward project goals. OPI also administers the Youth Risk Behavior Survey (YRBS), conducted since 2001, with a school participation rate between 96 and 100 percent. OPI also is working to expand the My Voice climate survey for students, staff, and community members.

OPI has a long history of collaborating at the state and community level to develop and implement programs while working to leverage maximum benefit from limited resources. OPI representatives sit on the Montana Inter-Agency Coordinating Council, which is charged with helping align state agency substance-use prevention programs designed to strengthen the healthy development, well-being, and safety of at-risk children, families, individuals, and communities. OPI works under an MOU with the Montana Tobacco Use Prevention Program to provide tobacco use prevention education and policy support to 417 Montana school districts and under an MOU with the Department of Public Health and Human Services to provide school districts with nutrition, wellness policy, and comprehensive school physical activity program support. OPI representatives also work with the State and school districts to review and update the rules governing school-based mental health services.

OPI has led many federal grant projects, but perhaps the most similar is the Montana Schools of Promise – School Improvement Grant Initiative, established in 2009 as a partnership among schools, communities, and OPI to improve Montana’s most struggling schools. In communities across Montana, parents, families, and caregivers share the hope that their children will graduate from high school and go on to college or the work force. OPI hired 22 employees to support this unprecedented effort.

Montana’s Superintendent of Public Instruction is a member of the Mandan Tribe and has a personal as well as professional interest in providing culturally appropriate services for all students. She instituted Schools of Promise, pioneered a statewide advisory council of students, and spearheaded Graduation Matters Montana to reduce drop-out rates.

Staff positions: Administrator: (.10 FTE) Karin Olsen Billings is the Administrator of the Health Enhancement Division. She will communicate with other OPI divisions and link to numerous State committees and statewide initiatives. **Program Supervisor:** (.20 FTE) Tracy Moseman, former Safe Schools Health Students Project Director from the 2009 cohort in Helena, Montana, now serves as the Director of Coordinated School Health for OPI’s Health Enhancement and Safety Division. She will supervise the Project Director and the YMHFA Contractor. **Project Director:** OPI will employ a fulltime Project Director responsible for day-to-day project leadership and oversight. The Project Director will be responsible for convening the State Management Team; monitor and coordinate grant activities; serve as the liaison for the three LEA Project Directors and management teams; oversee grant budgets and expenditures; collect data; submit federal reports; and provide support and assistance for successful grant implementation. The Project Director will be housed within the Health Enhancement and Safety Division of OPI and will be supervised by the Director of Coordinated School Health. The position requires a minimum B.A./B.S. in a field relative to education/mental health or equivalent combination of education and experience. **Youth Mental Health First Aid Coordinator:** OPI will contract with Youth Dynamics, Inc., which will hire a 1.0 FTE Youth Mental Health First Aid Coordinator to oversee Youth Mental Health First Aid training throughout the state and monitor and coordinate activities under the YMHFA plan. Minimum qualifications are a B.A./B.S. related to business, marketing, or communications and two years’ experience with outreach, engagement, and services to youth. **MBI Supervisor:** (.1 FTE) MBI

Coordinator Susan Bailey Anderson will work with the LEAs on implementation of MBI. **Indian Education Liaison:** (.25 FTE) American Indian Youth Development Coordinator, Don Wetzel, Jr., will ensure CLAS compliance, support relationships between the Blackfeet Tribe and Browning LEA, conduct ASIST training, and assist with evaluation protocols. **School Mental Health Coordinator:** (.25 FTE) School Based Mental Health Service Coordinator Erin Butts will work with LEAs to implement trauma-informed practices and the Interconnected Systems Framework. **Title I Coordinator:** (.1 FTE) Neglected/Delinquent and Homeless Specialist Heather Denny will connect Project Aware with the homeless liaisons in the LEAs and ensure implementation of the ISF model with the tier 3 homeless population. **YRBS Data Coordinator:** (.1 FTE) Susan Court, YRBS Coordinator will work with the project evaluators to collect and report data. **Administrative Assistant:** (.1 FTE) OPI Administrative Assistant Leona Wetherall will provide administrative support to project staff. **LEA Project Directors:** The Browning LEA will hire a full-time Project Director to monitor and coordinate its plan, convene the local Project Management Team, collect data, and to staff and supervise the Crisis Center. A minimum of a Master’s degree and active license in a mental health is required. Butte and Kalispell LEAs each will hire a full-time Project Director to oversee implementation and manage day-to-day activities, convene the local Project Management Team, collect data, and serve as the community point of contact. The position will require a minimum B.A./B.S. in a field relative to education/mental health or equivalent combination of education and experience. **LEA Therapists:** Each LEA will add full-time therapists to assist students with mental health issues and crisis interventions. Minimum qualifications are a Masters degree and license. **LEA Administrative Assistant:** The Kalispell LEA will hire a .5 FTE Administrative Assistant to support the Project Director. Minimum qualifications are a high-school diploma and three years’ experience. **LEA Medicaid Clerk:** The Browning LEA will hire a full-time Medicaid Clerk to bill Medicaid and add financial infrastructure to sustain beyond the grant period. Minimum qualifications are a high-school diploma and three years of experience.

Key staff experience and qualifications to develop the infrastructure for services: **Tracy Moseman**, Project Supervisor, served as Project Director for Helena’ Safe Schools Healthy Students Initiative. She has experience working across education, criminal justice, and mental health systems and has worked top change local policies to allow for better information sharing and earlier identification and referral for children who could benefit from services. **Frank Podobnik**, Special Education Division Administrator, agency representative on the Project Management Team, has successfully used Leading by Convening in two statewide projects, the School-Based Mental Health Community of Practice and the Response to Intervention Leadership Council, a joint venture between OPI and the School Administrators of Montana. Podobnik is a board member and president-elect of the National Association of State Directors of Special Education (NASDSE) where he helped create the blueprint for implementing Leading by Convening. He will lead and facilitate this model in Montana. **Susan Bailey Anderson** serves as the MBI program director and Director of Multi-tiered Systems of Support. She has been recognized nationally for her work implementing comprehensive tiered behavior support programs within many Montana schools. **Erin Butts** coordinates school mental health programs. She co-authored the Interconnected Systems Framework (ISF) state chapter in the *Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide Positive Behavior Support* monograph; authored *Advancing School Mental Health in Montana: A Report on Changes to Administrative Rules for Comprehensive School and Community Treatment* and is actively involved in the National School Behavioral Health Community of Practice. She will lead

efforts to integrate the behavioral and mental health continuums, review and enhance the state mental health continuum; implement the Interconnected System Framework; and coordinate the lessons learned/best practices/resources available outreach to mental health professionals and other providers. **Donnie Wetzel, Jr.**, is the American Indian Youth Development Coordinator. He will lead the effort to ensure culturally and linguistically appropriate services and help create connections between the Browning LEA and the Blackfeet Tribe. He worked 10 tribal reservations at the Montana-Wyoming Tribal Leaders Council for 13 years, doing advocacy work, and was the Seeds of Hope Suicide Prevention Director.

State Management Team and ability to support components 1 and 2: In addition to the key staff above, who will also serve on the State Management Team: **Steve York, OPI Assistant Superintendent for Education**, will keep the superintendent informed and coordinate activities within the agency and across systems, and provide data; **Karin Olsen Billings, Director of the OPI Health Enhancement Division**, will supervise the grant supervisor, oversee the review of school safety plans and recommendations for evidence-based violence prevention programs and anti-bullying policies, and provide data; **Heather Denny, OPI Neglected/Delinquent and Homeless Specialist**, whose Homeless Education Program received a commendation from the US Department of Education in 2014, will connect to homeless and other Title I services as well as an extensive network of collaborative partners in state governments, school districts, and local agencies that serve homeless children and families; **Bob Peake, Director of the Montana Supreme Court, Youth Court Services Division** provides experience in implementing Models of Change and will connect to the Office of Court Administration, Prevention Incentive Funds, and the Systems of Care policy review committee; **Patty Butler, Bureau Chief, DPHHS Early Childhood Services** will connect to the statewide Best Beginnings Council, Montana Infant and Early Care Home Visiting, and county/tribal level childcare coalitions; **Mary Dalton, State Medicaid Director** and **Zoe Barnard, Bureau Chief, DPHHS Children’s Mental Health Bureau**, will connect to Medicaid services; **Sarah Pierce, SIG Advocate Specialist**, will connect to the resources and lessons learned from the School Improvement Grant. **Karl Rosston, DPHHS Addictive and Mental Disorders Division, Suicide Prevention Specialist**, will connect to AMDD, provide expertise on suicide prevention, and provide data; **Sarah Corbally, Administrator of DPHHS Child and Family Services Division** will connect to Child Protective Services and other CFS services; **John Rouse, Superintendent of the Browning School District**, **Jim O’Neill, Curriculum Specialist for the Butte School District**, and **Cissy Klein, ESEA Coordinator for the Kalispell School District** will connect their Project Directors with local and state resources for components 1 and 2; **Peter Degel, Chief Executive Officer of Youth Dynamics, Inc.**—a CARF-accredited service provider—will hire and supervise the YMHFA Coordinator and connect to YDI’s 17 Montana offices and its vast network of mental/behavioral health providers and resources statewide. **Dr. Crystal Evans, Executive Director of the North Winds Recovery Center** will connect to families and youth through her organization and via her contacts with other providers. **Vicky Turner, NPN, Director of the Prevention Resources Center**, will connect to the resources of the National Prevention Network, the PRC, and the Interagency Coordinating Council.

SECTION D: DATA COLLECTION AND PERFORMANCE MEASUREMENT (20 POINTS)

Evaluation Goals & Questions: The evaluation of the NITT-AWARE-SEA Initiative will consist of both formative and summative components, using a range of quantitative and

qualitative methods to: inform project implementation on an ongoing basis; and ascertain the degree to which activities are making progress toward established performance measures. While data will be systematically gathered on all articulated outcomes (GPRA and additional process and outcome measures included in the logic model), the range of data collection methods employed will allow enough flexibility to detect unintended effects as well as contextual factors and barriers influencing implementation. Specific goals of the evaluation include:

- 1) provide timely, useful information to program staff to inform their planning, implementation and delivery structure on an ongoing basis, thereby promoting the likelihood that the grant will achieve its intended effects;
- 2) evaluate the effects of the activities, programs, and services that constitute the Coordination and Integration Plan;
- 3) efficiently⁴ collect all data necessary to address: 1) the federal reporting requirements, 2) the needs of the National Multi-Site Evaluation, and 3) process/outcome measures included as part of the developed program logic models;
- 4) develop a data and reporting infrastructure that will provide key stakeholders with timely information to inform program status, planning, and activities on an ongoing basis;
- 5) provide ongoing technical assistance on all aspects of the evaluation and implementation issues encountered, including a focus on the use and dissemination of evaluation data and strategically using evaluation and other resources to address needs; and
- 6) promote the ongoing sustainability and effectiveness of the initiative(s), in part, by helping build internal evaluation capacity and embedding referral and monitoring infrastructures to promote ongoing seamless, coordinated service integration.

The Montana Office of Public Instruction, grant partners, and LEAs all comply with federal reporting requirements of performance measures (GPRA Modernization Act of 2010) as part of all federal grants awarded and will continue to do so under NITT-AWARE-SEA. In addition to the demonstrated capacity of the SEA and partners to fully meet federal reporting requirements in a timely manner, the evaluation team⁵ assembled for this project has been principal evaluators on numerous federal, state, and local grants, including multiple Safe Schools/Healthy Students (SSHS) grants. Spanning the content areas of education, social services, mental health, substance use, and criminal justice, their evaluation experience includes employing culturally-sensitive research approaches (e.g., involvement of community representatives, use of Native speaker(s) to review all measures, etc.) with Native American populations. They are highly experienced with fully addressing federal accountability and reporting requirements associated with such grants, as well as working with national evaluation efforts.

The evaluation will address the following outcome and process questions at both the state and local level, which are directly linked to those listed in section 2.5.2 of the RFA.

Process Questions

1. How has Montana implemented the NITT-AWARE-SEA?
 - a. How closely did implementation match the comprehensive plan at the state and community levels and, if changes were made, why and what type of changes were made?

⁴ The term “efficiently,” as used in this context refers to collecting data that is useful, meaningful, non-redundant, and for a clear purpose. Such an approach also includes embedding streamlined and efficient mechanisms for collecting such data so as to minimize the burden on program staff and grant partners.

⁵ PRES Associates Inc. has over twenty years of experience evaluating complex, multi-faceted initiatives involving multiple stakeholders, partners and agencies.

- b. What factors and policies facilitate or hinder development and implementation of the comprehensive plan at the state and local level?
 - c. How did collaborative decision making with the state partnership and LEA, and local community partnerships support or hinder implementation of the comprehensive plan?
 - d. Who provided (program staff) what training (modality, type, intensity, duration), to whom (individual characteristics & total served), in what context (system, community), and at what cost (facilities, personnel, dollars)?
 - e. How did the project engage families and youth?
 - f. To what extent have programs, services, and activities undertaken been implemented with fidelity and in a manner that contributes to producing the intended effects?
2. How has capacity increased, particularly in the area of mental health? Specifically, to what extent has state and LEAs:
- a. Followed the YMHFA training plan, and if changes made why?
 - b. Made changes to address behavioral health disparities, including the use of CLAS standards, and best practices for cultural / linguistic competence, and how?
 - c. Implemented activities that support coordinated services and programs among partners to improve outcomes for the school and community, and how?

Outcome Questions

3. What was the effect of the strategic planning process and implementation of selected intervention(s) on the key outcomes identified by the SEA and three LEAs?
 - a. Are programs and activities associated with other anticipated and unanticipated outcomes?
4. What factors, such as program/cultural/contextual and student/family demographics, are related to SEA, LEA, and local community outcomes?
5. How effectively did the project reach populations at high risk for mental, emotional, and behavioral health disorders and violence?
6. What were the barriers to interagency collaboration, partnership development, and shared decision-making and how were they addressed?

Evaluation Design: Planning, Data Collection, Analyses, Measures: To promote both the quality and ongoing use of evaluation findings, the evaluation team will employ a participatory approach that involves active involvement from key stakeholders throughout the evaluation process. During the planning phase, evaluators will work closely with the SMT and key stakeholders on logic model development to ensure full alignment between the Coordination and Integration Plan, identified needs, goals and objectives, activities, and process and outcome measures. Baseline data collection and identification of target performance objectives will occur during this phase. Annual targets will serve as a measure of ongoing progress and will be based upon baseline data and trends; review of the literature and activities being undertaken to determine the amount of change that can be expected; and talking to experienced service providers and developers of interventions to obtain information on what can be expected over the course of implementation.

Based upon the information gathered during planning meetings and the logic model development phase, the evaluation team will develop a comprehensive evaluation plan for approval by the State PD. This evaluation plan will include, but not be limited to: Goals, Objectives, Activities, Outcome/Process Measures, Collection of Information (who will collect data, timing of data collection, target population), and Analysis. With the caveat that this will be expanded upon during the planning phase, what follows is an overview of the evaluation

methodology to be employed, including data collection methods, measures aligned to the activities described in this proposal, and details on how all federal and state reporting requirements (GPRAs) will be fully addressed.

Data Collection: The evaluation will collect rigorous data over time on both the intended and unintended effects of the project on students, families, schools and the community. The nature of changes that may occur because of the project necessitates that, in addition to quantitative measures more open-ended, in-depth, qualitative methods will need to be utilized in order to accurately capture what is truly occurring and why. Data will be collected on students, families, schools, communities, and partnering agencies as well as on program implementation and service delivery.

GPRAs Measures: All parties identified as part of the data collection process will be required to report according to the evaluation plan. As required, the state will report quarterly, via the TRAC system, on the following GPRA performance measures: 1) the number of individuals who have received training in prevention or mental health promotion; 2) the number of people in mental health and related workforce who are trained in mental health related practices and activities that are consistent with the goals of the grant; and 3) the number of individuals referred to mental health or other related services. GPRA #1 and #2 will be collected by the YMHFA Coordinators at the state and LEA levels, and GPRA #3 will be collected via a comprehensive referral and service tracking and monitoring system, with data entered by program-level staff. Furthermore, the LEAs will report semi-annually on the following GPRA performance measures to evaluators and SMT for program monitoring purposes, and report to SAMHSA annually per federal grant reporting requirements: 1) the total number of school-aged youth served as a result of implementing strategies identified in the SEA coordination plan; 2) the total number of school-aged youth who received school-based mental health services; and 3) the percentage of mental health service referrals for school-aged youth that resulted in mental health services being provided in the community. LEA GPRA measure 1 will be collected by community level partners and the LEAs for each of the proposed activities directly serving students (e.g., MBI, YMHFA, school-based mental health services, etc.) via existing data infrastructures employed by partners and the LEAs (e.g., school records, training sign-in sheets, referral and service tracking system, etc.). LEA level GPRA measures 2 and 3 will be collected by community level mental health partners and school-based mental health workers via the aforementioned referral and service tracking and monitoring system. It should be noted that the State Project Supervisor and evaluator have experience in the development and deployment of a referral, tracking, and management system through their work on the Helena Safe Schools Healthy Students Grant. Through this work, a system was developed that was used to: a) make referrals; b) promote effective and timely service delivery; c) provide program staff and partnering agencies with an efficient communication mechanism to inform their grant-related activities on an ongoing basis; d) generate interactive online reports to monitor implementation, utilization, and service delivery; and e) gather data necessary for the evaluation of the grant and other district goals. Data for GPRA measures will be quality checked and aggregated by the evaluator for reporting.

Other Measures: Additional measures beyond the six GPRA are proposed to measure other outcomes that may occur as a result of proposed activities. This includes gathering data on existing surveys administered to schools and students in Montana such as the Youth Risk Behavior Survey (YRBS) and Montana Prevention Needs Assessment (MPNA), and using instruments that are program/activity specific (e.g., instruments used by the Montana Behavioral Initiative, YMHFA and other training feedback surveys, universal screener, etc.). For those

surveys not administered annually (YRBS/MPNA), performance data will be collected via a supplemental survey as needed that contains the same items and employs the same sampling frame as those used during the regular administration window. Original survey development may also be necessary if existing measures are non-existent, deemed insufficient, or unreliable. We propose to collect more in-depth qualitative data from key stakeholders via interviews and site visits to gain a stronger contextual understanding of the project’s outcomes (e.g., barriers, changes made, collaborative activities, etc.). Additional data collection activities include document reviews, archival school and partner records, and a Collaboration and Capacity Survey. For the latter, the evaluator will design a survey to identify partnership and capacity strengths and weaknesses, which will help evaluators explore the relationships between community capacity, fidelity of implementation, and success in achieving desired outcomes. Such information will be shared with LEAs and Project Management Team. Based on the gaps, goals, and objectives noted in Section A, the following table presents the proposed activities along with aligned measures and methods.

Analysis and Reporting: Quantitative and qualitative data analyses will be performed to address all of the evaluation questions, and data will be compiled for purposes of completing federal reports as well as completing state project status reports and presentations. Given the continuum of outcomes that may be expected as a result of the program, we anticipate that the following data analysis techniques will be utilized: 1) descriptive outcome and repeated measures analysis to examine the extent to which changes are observed over time in outcomes; 2) qualitative analysis on data from interviews and site visits to expand on the results and explain how and why changes may have occurred; and 3) descriptive analysis on implementation and contextual/program/ demographic data to describe implementation and sample, and determine the relationship(s) between observable factors and outcomes.

Evaluators will function as an integral member of the project team and communicate regularly with state and local project directors and key stakeholders. This will include but not be limited to formal quarterly updates sharing progress to date, noting any problems encountered or anticipated, and disseminating implementation and outcome feedback as it becomes available.

In addition, annual reports will be prepared to meet federal grant requirements, as well as local programmatic feedback. These reports will summarize process and outcome information on the NITT-AWARE-SEA initiative. The evaluator will also generate *ad hoc* reports and presentations, as requested by the SEA and will meet any data/reporting requests by the national multi-site evaluator. Reporting and presentations will be geared towards multiple types of stakeholders. Data and results will be presented via user-friendly graphs and discussion which will facilitate the use of the findings and make evaluation results accessible to a wide variety of audiences. Evaluation findings will be translated into specific program recommendations that can be used to make adjustments in activities and/or program delivery to improve implementation and outcomes.

Proposed Activities, Measures and Methods

Activities	Proposed Measures	Proposed Methods
<p><i>GOAL 1: Build and/or expand capacity at the state and local levels to make schools safer and improve school climate</i></p> <p><u>MBI-Related Strategies</u></p> <p>a. Expand the research-based Montana Behavioral Initiative (MBI) to sub-recipient schools not currently implementing MBI with fidelity at</p>	<p><u>Process Measures (State and LEA)</u></p> <p>1. Number of LEAs that have integrated MBI with school-based mental health and incorporated universal screeners; types of student screenings (Activities: a, b, c)</p> <p>2. Percent of schools administering MBI</p>	<ul style="list-style-type: none"> • Document review (e.g., state/LEA/partner reports, policies/recommendations, comprehensive plan, YMHFA training)

<p>LEAs and integrate MBI with school-based mental health activities.</p> <p>b. Increase student behavioral screenings via usage of universal screener such as SSBT (Systematic Screening of Behavior Tool) as part of MTSS work.</p> <p>c. Examine model schools for CSCT referral process (e.g., A Team) – and offer guidance/ support/model for Tier 2/3 support teams through MBI.</p>	<p>measures of implementation (a, c)</p> <p>3. Number of training and technical assistance activities provided and satisfaction with such trainings (d, e, l, o, w) →Who, what, to whom, in what context, and at what cost</p> <p>4. Description of partnerships established and collaborative/integrative activities that took place and among what agencies/groups (f, g, k, n, t, w)</p>	<p>plans, logic models, etc.) (<i>Measures</i>: 6, 7, 8, 11)</p> <ul style="list-style-type: none"> • Annual key informant interviews with state & local stakeholders & annual LEA site visits (4, 6, 7, 9, 10, 11)
<p><u>Education/Training Related Strategies</u></p>		
<p>d. State will lead coordination of dissemination of information on lessons learned/best practices/resources available related to mental health, suicide prevention, violence prevention, bullying, poverty and relation to mental health/substance use issues, etc. among state agencies & LEAs via multiple methods, i.e., community of practice, superintendent meetings, professional conference pre-meetings.</p> <p>e. Provide training/education on FERPA/ HIPAA/PPRA compliant policies and procedures for information-sharing between agencies.</p>	<p>5. Number and types of resources developed to promote mental health awareness / knowledge (d, e, l, o, u, w)</p> <p>6. State (policy) recommendations made - # & type (c, h, j, u, v, x)</p> <p>7. Documentation of new activities supported by leveraging of resources (f)</p> <p>8. Number of state-level, LEA, community members, parents and students that received YMHFA training and technical assistance – who, what, when, where (l, m, n)</p>	<ul style="list-style-type: none"> • Documentation of trainings/professional development/ presentations/ workshops, etc., including sign-in sheets, logs, satisfaction surveys, etc. (3, 5, 8, 9, 12, 13, 14, 21)
<p><u>State Policy/Guidance Related Strategies</u></p>		
<p>f. Coordinate with other state councils, agencies, and grants for mental health awareness, resources, and support (e.g., Interagency Coordinating Council, Project Launch, School Climate Transformation Grant-if awarded, etc.) to leverage resources and reduce duplication via Coordination & Integration Plan.</p> <p>g. Promote interagency collaboration and coordination, and provide information to LEAs and community providers of resources available (e.g. funding) for addressing mental health issues, including co-occurring disorders.</p> <p>h. OPI to review school policies for violence prevention (a current statewide practice) against best practices and provide specific recommendations for sub-recipients.</p> <p>i. Proposed activities as determined through the planning process will address the mental health inequities among cultural and linguistic groups in Montana and the CLAS standards will be used as a strategy to help eliminate these disparities.</p> <p>j. Review State continuum of mental health care (from prevention to intensive services) and make recommendations for policy change.</p> <p>k. Plan for and develop a statewide SRO association to establish consistent responsibilities, offer training in YMHFA, trauma-informed practice, confidentiality, etc., and provide opportunities for networking with peers to bridge the gap between law enforcement and mental health.</p>	<p>9. Description of activities undertaken to address mental health disparities (j)</p> <p>10. Description of implementation of mental health services, strategies, and programs in the LEAs and local communities, including service delivery, client & system outcomes (p)</p> <p>11. Description and number of implemented evidence-based programs, policies, and/or practices related to mental health (q)</p> <p>12. Number of providers trained for trauma-informed care (q)</p>	<ul style="list-style-type: none"> • MBI Implementation fidelity measures such as Schoolwide Evaluation Tool (SET), Self-Assessment Survey (SAS), and Individual Student Systems Evaluation Tool (ISSET) and other PBIS tools (1, 2, 21, 32) • Universal screener such as Systematic Screening of Behavior Disorder tool (26) • Collaboration & Capacity Survey (4, 10, 11, 17, 24) • Referral & services tracking system (10, 11, 15, 18, 21, 22, 23, 25) • Partner data systems/ documentation (18, 19, 20, 21, 25) • Student Surveys [e.g., Montana Prevention Needs Assessment (MPNA), Youth Risk Behavior Survey (YRBS), My Voices Survey, and supplemental surveys
<p><i>GOAL 2: Increase awareness of mental health issues</i></p>	<p><u>Outcome Measures</u></p> <p><i>State Level</i></p> <p>13. GPRA: The number of individuals who have received training in prevention or mental health promotion (a, d, i, k, l, m, n, o, u)</p> <p>14. GPRA: The number of people in mental health and related workforce who are trained in mental health related practices and activities that are consistent with the goals of the grant (a, e, i, k, u)</p> <p>15. GPRA: The number of individuals referred to mental health or other related services (a, c, p, q, r, u)</p> <p>16. Percentage increase in community</p>	

<p>l. Provide opportunities to parents/families (preK-12) to learn about and understand mental health issues and warning signs through YMHFA and informal education such as mini-workshops and lunch-and-learn sessions.</p> <p>m. Provide mental health awareness to students through YMHFA and MBI Youth Days.</p> <p>n. Oversee/coordinate statewide YMHFA training for various stakeholders including but not limited to: juniors/seniors aged 16+, SROs, school counselors (required), early childhood providers, post-secondary, hospitals, etc.; and implement the state training plan and ensure adherence of LEA training plans.</p> <p>o. Provide professional development to school counselors on how to provide behavioral supports to students through the UM Center for School Mental Health continuing education modules.</p> <p>GOAL 3: Connect children and youth with mental, emotional, and behavioral health issues with needed services</p> <p>Direct Supports</p> <p>p. Dependent on LEA logic models, provide stipends for those not eligible for Medicaid, and/or pay for school-based MH counselor.</p> <p>q. Require that all service providers providing services under grant demonstrate training in trauma-informed care, as well as implementation of evidence-based services.</p> <p>MBI-Related Strategies – See activities A-C</p> <p>Training / Education Related Strategies</p> <p>r. Engage early childhood in improving the process of referrals to services (and funding sources) for young children and families and educating them about YMHFA training (see Goal #2 also)</p> <p>s. Provide guidance to LEAs for development of identification and referral process so that students may access appropriate school-based and community-based mental health services.</p> <p>State Policy/Guidance Related Strategies</p> <p>t. Review continuum of mental health care (from prevention to intensive services) and make recommendations for policy change.</p> <p>u. Promote interagency collaboration & coordination, and provide information to LEAs and community providers of resources available (e.g. funding) for addressing mental health issues, including co-occurring disorders.</p> <p>v. Review high quality programs funded through Juvenile Justice Prevention Incentive Funds that can be duplicated and develop plan for addressing alternatives to placement.</p>	<p>awareness of mental health issues and resources available (d, e, f, g, k, l, m, n, o, t, u, w)</p> <p>17. Percentage of state partners and key stakeholders that report effective collaborations (f, g, j, k, w)</p> <p>18. Number of schools providing CSCT services, providers, and students served (d, f, t)</p> <p>LEA Level</p> <p>19. GPRA: The total number of school-aged youth served as a result of implementing strategies identified in the SEA comprehensive plan (a, b, c, m, o, p, q, r)</p> <p>20. GPRA: The total number of school-aged youth who received school-based mental health services (a, c, p, q, u)</p> <p>21. GPRA: The percentage of mental health service referrals for school-aged youth which resulted in mental health services being provided in the community (p, q, u)</p> <p>22. Percentage of local partners and key stakeholders that report effective collaborations/partnerships (f, g, j, k, w)</p> <p>23. Percentage of students from cultural, linguistic, and minority or disenfranchised groups receiving mental health services (i, c, p, g, w)</p> <p>24. Number of students screened via universal screener (b)</p> <p>25. Percentage of students with a positive sense of school safety (a, c, d, h, k)</p> <p>26. Percentage of students with feelings of belongingness and engagement (a, c, m)</p> <p>27. Percentage of students who engage in negative behaviors/thoughts such as bullying and disciplinary events (a, c, d, h, k, o, v)</p> <p>28. Percentage of students exhibiting symptoms of depression and suicide ideations (a, b, c, l, m, o, p, q, s)</p> <p>29. Graduation rates (all)</p> <p>30. Pre/post SET/ISSET/SAS scores (a, b, c, o)</p>	<p>for off years in which YRBS/MPNA are not administered] (27, 28, 29, 30)</p> <ul style="list-style-type: none"> • Measures of community awareness such as items within Behavioral Risk Factor Surveillance System (BRFSS) Survey, YMHFA and other trainings’ exit surveys (16) • School records (31, 29)
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