

Strategic Prevention Enhancement (SPE) Planning Document

A Vision for Montana's Future

September 1, 2011 to December 31, 2012



Healthy People. Healthy Communities.

Department of Public Health & Human Services

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Acknowledgements

In keeping with the theme of this planning document, *Prevention is everyone's business and we can do it better together*, there are many people to thank for their contributions to the planning process and the development of the Planning Document.

Firstly, on behalf of the SPE Consortium and staff, I wish to recognize and thank Anna Whiting Sorrell, Director of the Montana Department of Public Health and Human Services, for providing the impetus to apply for this planning grant and believing that together we could develop *A Vision for Montana's Future*.

Secondly, the SPE staff would like to acknowledge the contributions of SPE Consortium members in the planning process. This sixteen month process has been a journey and there were times when we were uncertain about where we were going, how to get there or why we were part of the journey. In the end, however, we were able to determine how to proceed and define the Planning Document that would be produced.

Thirdly, there are those who were major contributors to the planning process and the document. I'd like to recognize their respective efforts.

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Special appreciation goes to the community members from the seven reservations who participated in the focus groups and interviews. Your rich stories, experiences and observations provide the planners with a better understanding of the successes and challenges in promoting emotional health and carrying out prevention activities in Indian County.

Thank you all,



**Prevention is
Everyone's
Business. We
can do better
together.**

Executive Summary

Montana's Vision for Prevention

In September 2011, the Addictive and Mental Disorders Division, within the Department of Public Health and Human Services, was awarded a planning grant to mobilize state agencies and tribal entities to better plan for and coordinate prevention activities to address four specific health areas. The four areas are: 1) to build *emotional health*; 2) to prevent and reduce the *consequences of underage and adult problem drinking*; 3) to reduce *prescription drug misuse and abuse* and 4) to *prevent suicide and attempted suicide* in the general population and populations at-risk including Military families, Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) populations and American Indians.

Twelve state agencies and three tribal entities participated in the 16 month process. Tribal participation in the Consortium fell to four members representing two of the reservations (The Confederated Salish and Kootenai Tribes of the Flathead Reservation and the Rocky Boy's Indian Reservation) and the Montana/Wyoming Tribal Leaders Council. There are current formal relationships between these two reservations. The Tribal Leaders Council represents all of the tribes and provides a means of communication with tribal leadership.

Montana does a good job of planning within individual state agencies, but comprehensive cross-agency planning was new and very challenging. There's also little experience with planning, with the tribal entities, on this scale. The Consortium members struggled to clearly see the connection between the activities they did and how to plan for prevention on this comprehensive scale. As a result, the grant engaged the services of an expert in training government agencies, communities and non-profit agencies in the art of collaboration. Over a course of three Consortium meetings and additional meetings with grant staff, the path to planning became clearer.

The Consortium members agreed that creating a 5-year strategic plan was not a realistic goal at this time. They recognized they were not ready to and did not have the capacity to carry out the Mini-Plan activities that would have provided the structure of the plan.¹ It was also agreed that instead of jumping in and creating a plan, time was needed to raise awareness about the targeted mental health and behavioral health areas and current prevention efforts and to build their capacity to successfully plan.

The outcome of the sixteen month process is a planning document that articulates an enhanced approach to planning and it outlines an action plan. The approach is based on the assumption that joint implementation of prevention plans will produce more effective prevention efforts, better evaluation of prevention outcomes and more efficient use of resources.

What the planning document proposes:

1) It advocates using a *Public Health Model* to address the targeted mental and behavioral health problems. This approach, by definition, recognizes the interconnectedness between the targeted health areas as well as the environmental risk factors that contribute to the development of the health problems and the protective factors that can be used to prevent or reduce the

¹ A progress report of the Mini-Plans is provided in Appendix A.

problems. The outcome is a unified approach that also benefits the respective interests of state agencies and tribes.

2) It recognizes that planning for prevention *is a developmental and long-term process*. The developmental approach follows the basic tenants of the Strategic Prevention Framework (SPF) and shapes the six phases of the planning process. It requires an initial five-year commitment from state agencies to move through the process and reap the rewards. It also involves building relationships with new stakeholders including the LGBTQ community and American Indians.

3) It emphasizes the need for *true collaboration* across state agencies. We're asking state agencies to commit to building a relationship – to move from cooperation and coordination to a more rigorous level – true collaboration. It is committing to mutual outcomes, developing a shared structure and shared responsibility, it is allocating resources, it is reaping the rewards, and changing and improving upon individual agency policies and procedures.

4) It acknowledges the importance of the *Interagency Coordinating Council (ICC) to lead this process*. The ICC has the experience, the political leverage to catalyze agencies, the infrastructure to spearhead the development of the strategic plan and fiscal leverage to support implementation of the plan elements.

5) It includes *valuable resources to support* the long-term planning efforts. For example, epidemiological data have been compiled and analyzed on the respective targeted health areas. There are maps and tables that indicate which of the fifty-six counties and seven reservations are at the very highest risk, highest risk, moderate risk, low risk and lowest risk for the respective health concerns. Interview data from tribal spokespersons provide an overview of the status of prevention efforts on the reservations and the process provided an opportunity for state agency and tribal members to connect and learn from each other. The plan includes an initial assessment of data collection, sharing and reporting of the targeted health behaviors and identifies areas for enhancement. There's also an assessment of planning capacity and recommendations for enhancing that capacity.

The Epidemiological data on the targeted mental and behavioral health problems clearly indicate the severity of the problems for Montana. The county level data on the consequences of the problems, such as the percentage of car crashes involving alcohol, also confirm the pervasiveness of the problems.

Twenty-two (22) of the fifty-six counties (including six of the seven reservations) are ranked as very high risk or high risk across these public health issues. This means that these communities have more than one public health problem. **Fifty-five percent of Montanans live in these 22 counties.**

Over the past few years, there have been some indicators that suggest there's growing public awareness and support for helping Montanan's choose positive and responsible behaviors. For example, in the last legislative session a number of DUI bills were passed making clear the consequences for irresponsible and undesirable behavior. It's the hope of the SPE Consortium and the ICC workgroup that the unified, 5-year strategic plan that will emerge from the continuing planning process will *promote the conditions in which the healthy choice is the default choice*.

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Strategic Prevention Enhancement (SPE) Planning Document

Montana's Vision for Prevention

Planning for Prevention in Montana: The Context

The state of planning efforts in prevention could be summed up by saying, *Montana does good planning within individual state agencies*. Each state agency uses plans and within agencies, divisions and bureaus develop plans. Plans are developed in consultation with professionals and community members, plans include broad goals and measurable objectives, plans contain past and current data showing trends to identify needs, strategies and actions match the needs identified, and plans are updated. For example, within the Montana Department of Public Health and Human Services (DPHHS), there are twelve divisions with innumerable plans currently in use. It would take considerable time and effort to actually quantify how many plans are in use, under revision or under construction.

Another statement that can be made is, state-level *planning efforts take place in highly institutionalized silos*. For example, the state plan and related activities for preventing Prescription Drug misuse and abuse have been primarily driven by the Attorney General's Office. A new Attorney General was recently elected and in 2013 it's uncertain if prevention of Prescription Drugs will remain a priority. As another example, the Montana plan for Suicide Prevention was developed under the auspices of the Suicide Prevention Coordinator, housed in the Addictive and Mental Disorders Division (AMDD) within the Department of Public Health and Human Services. This sole employee is largely responsible for educating the state agencies, tribal entities and local communities about suicide prevention. A final example of this "silo effect" is the numerous state plans that involve efforts to prevent the consequences of underage and adult problem drinking. Plans from the Montana Highway Patrol, Department of Transportation, and the Department of Revenue, which coordinates liquor control and some alcohol education, include environmental strategies to target the various consequences of underage and adult problem drinking. While these different sectors of the government do good work in prevention, their planning and activities are largely carried out by their own agency personnel.

There are examples of cross-agency work in prevention and some of the state agencies have a history of cooperating together through their affiliation with the *Montana Interagency Coordinating Council for State Prevention Programs* (ICC) workgroup. For example, the workgroup regularly shares information about their host agency resources, educational opportunities, and calendar and conference events related to reducing underage drinking efforts in Montana. Many times they coordinate resources and actions around a specific prevention activity such as developing, funding and organizing the Parent Power media campaign. Overall, cross-agency work by the ICC has involved working together on prevention activities rather than planning for prevention. The workgroup has an action plan and established roles, but the authority to carry out spending of resources, both human capital and financial, rests with individual agencies.

It could be said that the SPE planning effort was largely an example of coordination; planning revolved around an activity, i.e., developing a strategic plan. The level required to successfully develop a five-year strategic plan, across multiple state agencies and tribal entities requires *true* collaboration where partners are ready, capable and willing to work on a shared vision and have the authority and resources to implement the vision.

The SPE Planning Process

Montana's Policy Consortium -- Strategic Prevention Enhancement (SPE) Consortium

November 8th, 2011 was the first meeting with eighteen state department/agency staff and two community-based representatives. Those invited to attend represented a cross-section of agencies and authorities involved in the prevention of the targeted health areas. They included:

- ❖ DPHHS: Children's Mental Health
- ❖ DPHHS: Addictive and Mental Disorders Division
- ❖ DPHHS: The Prevention Resource Center
- ❖ DPHHS: Behavioral Health
- ❖ DPHHS: Suicide Prevention Program
- ❖ DPHHS: Chronic Disease Prevention and Health Promotion
- ❖ DUI Task Forces
- ❖ White Sky Hope Lodge, a residential treatment program located on the Rocky Boy's Reservation
- ❖ Montana Army National Guard
- ❖ Montana State University
- ❖ Department of Labor
- ❖ Department of Revenue, Liquor Control Division
- ❖ Department of Justice; Attorney General's Office, Prescription Drug Abuse Awareness Program
- ❖ Montana Kids Count (Epidemiological Group)

This introductory meeting explained the purpose and vision of the SPE grant including the targeted behavioral and mental health areas: 1) *building emotional health*, 2) *preventing and reducing the consequences of underage drinking and adult problem drinking*; 3) *reducing prescription drug misuse and abuse*, and 4) *preventing suicide and attempted suicide*, and invited agencies to join in the planning process.

Over the course of the 16 months, additional state agencies joined the Consortium including:

- ❖ DPPHS: Children's Trust Fund
- ❖ Office of Public Instruction (OPI)
- ❖ Montana Board of Crime Control, Juvenile Justice
- ❖ Department of Transportation
- ❖ Montana Safe Schools Center, The University of Montana
- ❖ Gallatin County Sheriff's Department
- ❖ Lewis and Clark County Sheriff's Department

Eleven of the state agency representatives were also members of the ICC workgroup and had experience in working together; for others it was a new experience.²

The members met eight times during the sixteen months. It's fair to say that for the first five meetings, working together to address the grant goals was a struggle. The mandate to create a unified 5-year strategic plan for prevention, across state agencies, was new to all involved. Members struggled to clearly see the connection between the activities they did and how to plan for prevention on this comprehensive scale.

In-keeping with the goal of empowering the SPE Policy Consortium (**Goal 3**), the grant engaged the services of Karen Ray, President of Karen Ray Associates', an author and expert in training government agencies, communities and non-profit agencies in the art of collaboration.³ Over a course of three Consortium meetings and additional meetings with grant staff, the path to planning became clearer.

The Consortium members agreed that creating a 5-year strategic plan was not a realistic goal at this time. They recognized they were not ready to and did not have the capacity to carry out the Mini-Plan activities that would have provided the structure of the plan. A progress report of the Mini-Plans is provided in Appendix A.

The Consortium agreed that instead of jumping in and creating a plan, time was needed to raise awareness about the targeted mental health and behavioral health areas and current prevention efforts and to build their capacity to successfully plan.

OUTCOMES OF THIS PLANNING PHASE (PHASE I)

- ❖ A planning document that outlines the steps needed to develop a 5-year strategic plan.
- ❖ Resources that can be used to develop the plan, including:
 - 1) an assessment of the severity of the targeted mental and behavioral health problems
 - 2) assessment of current prevention efforts of state agencies
 - 3) assessment of current prevention efforts on the seven reservations
 - 4) assessment of healthcare workforce
 - 5) recommendations to enhance planning capacity.

In essence, this planning document is the revised Mini-Plan as it addresses the four components: 1) Data Collection, Analysis and Reporting; 2) Coordination of Services; 3) TA and Training; 4) Performance/Evaluation; it includes concrete action steps; milestones; timelines; and the responsible parties. It also includes six of the critical components of a strategic prevention plan required by SAMHSA. More importantly it is based on what is achievable, likely to be

² For a complete listing of the ICC workgroup members, please refer to Appendix B.

³ Ray, Karen. (2002). *The Nimble Collaboration. Fine tuning your collaboration for lasting success.* Fieldstone Alliance: NY. Ray, K. & Winer, M. (1994). *Collaboration Handbook: Creating, sustaining, and enjoying the journey.* (1994). Fieldstone Alliance: NY.

implemented and useful for Montana. The planning steps include: Phase I: creating the Planning Document; Phase II focuses on Capacity Building; Phase III involves Planning; Phase IV focuses on Implementing and Evaluating; and Phase V & VI involves Implementation, Evaluation, and Sustainability.

Assumptions of the Planning Document

A number of assumptions guided the development of this planning document. The assumptions are: 1) *true* collaboration is needed in order to effectively plan; 2) planning is recognized as a developmental process; 3) planning will follow the SPF steps and use the Public Health Model; and 4) planning for and implementing prevention is subject to a number of influences including the geographic and demographic, political, social and economic landscapes.

1. *True collaboration is needed*

The planning document that resulted from the meetings and discussions is predicated on the assumption that joint implementation of prevention plans will produce more effective prevention efforts, better evaluation of prevention outcomes, and more efficient use of resources. This is a truly collaborative approach to prevention.

In popular use, collaboration occurs anytime people work together to achieve an outcome. For current purposes, collaboration is more carefully defined. In Montana, while there are many activities being conducted in concert, there is no agreed-upon inter-department or inter-agency effort to braid planning, implementation, outcome evaluation or resource assignment of prevention efforts. At this time a *true* collaborative approach to prevention planning does not exist.

During Phase I, the planning process, the SPE Consortium members came to understand the potential outcomes from adopting a truly collaborative prevention strategy. As a result they used very specific definitions of collaboration, coordination and cooperation in order to clarify the assumptions about their roles and responsibilities. As one member noted at the August 22nd meeting, “We talk about it all the time and assume we’re doing it but then find out we’re really not. When we better understand what’s required, we’re better able to take that on”

"True collaboration is one way of accomplishing strategic planning: it moves an organization from the way business is done now, to a better way to do business."
(Karen Ray, November 2012)

Collaboration is a mutually beneficial and well-defined *relationship* (not a well defined task) entered into by two or more organizations to achieve results they are more likely to achieve together than alone.

Partners agree that each organization has a unique role to play in addressing the issue.

The relationship is among organizations, not individual staff.

The relationship includes a commitment to mutual outcomes; a jointly developed structure and shared responsibility as well as a sharing of resources and rewards.

Partners focus on the way in which the current system can be improved by changing individual organizational policies and procedures.

Coordination is less demanding.

It helps agencies do tasks together. Some kind of formal relationships and an understanding of compatible missions characterize coordination.

Organizations that coordinate are usually completing some task or project. Some planning and division of roles are required, and communication channels are established.

Authority still rests with the individual organizations, but there is some risk to all participants.

Resources are available to participants and rewards are mutually acknowledged.

Cooperation is characterized by informal relationships that exist without any commonly defined mission, structure, or planning effort. Information is shared as needed, and authority is retained by each organization so there is virtually no risk.

Resources are separate, as are rewards.

While cooperating, people meet and talk, but there is rarely any action taken other than the meeting itself.

These definitions make it clear to the partners that collaboration is a very intense way of working together while still retaining the separate identities, autonomy, and decision-making authority of the organizations involved. The beauty of collaboration is the acknowledgment that each partner has a separate and special function; a power that it brings to the joint effort. When the desired results are achieved, organizations have changed their policy or procedures and the changes are institutionalized and the collaboration effort can be concluded.

2. *Planning for prevention is a developmental process*

The plan produced from this process acknowledges Montana's starting point and builds from there. As noted earlier, before a plan could be developed, other steps needed to occur. The developmental approach follows the basic tenants of the Strategic Prevention Framework (SPF) and are reflected in Phases I to VI. The timeline and activities involved in developing the strategic plan are outlined in the section: *Developing Coordinated Prevention: A Vision for Montana* (page 98). By Year 5 Montana will be in a better place; it will be better informed about the targeted health problems and their impact in Montana; and state agencies

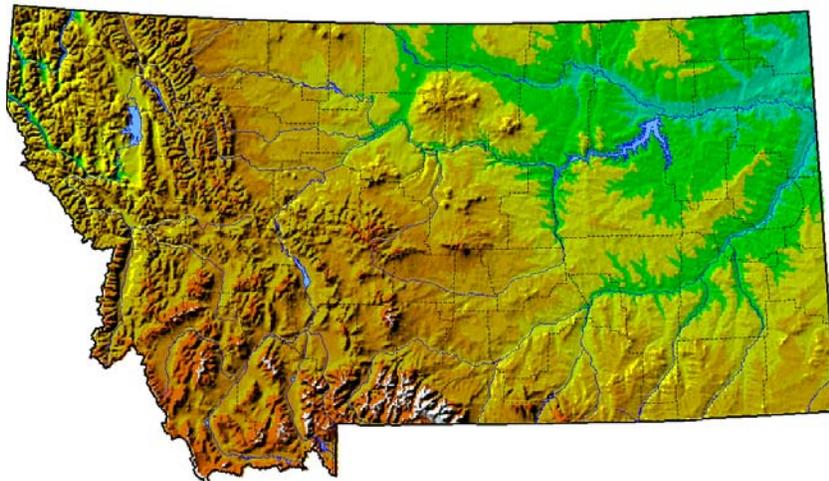
will have built experience with planning for and implementing prevention across agencies in a true collaborative way.

3. *The public health model will be used to address the targeted mental and behavioral health problems.* This approach, by definition, recognizes the interconnectedness between the targeted health areas as well as the conditions that contribute to the development of the health problems and the protective factors that can be used to prevent or reduce the problems. For example, in order to effectively reduce suicide, prevention efforts need to recognize and address the connections between suicide and depression, alcohol abuse and prescription drug misuse/abuse. This approach, by definition, means that agencies, with their respective expertise, would naturally come together to plan and address the interconnections and benefit from the unified approach.
4. *Geographic and demographic, political, social and economic landscapes impact planning for and implementing prevention*

Geographic landscape

Montana is one of the most unique states in the country in terms of its geographic and demographic makeup. Montana has a land area of 147,046 square miles making it the 4th largest state and 7th-least populated in the nation. It has just over a million people, and an average of 6.8 people per square mile. However, 46 of the 56 six counties are defined as *Frontier* with fewer than 6 residents per square mile. If one were to make the trek from the most extreme east to west points (545 miles) it would take at least 9 hours and a minimum of 5 hours (315 miles) from the state's most extreme northern and southern points.

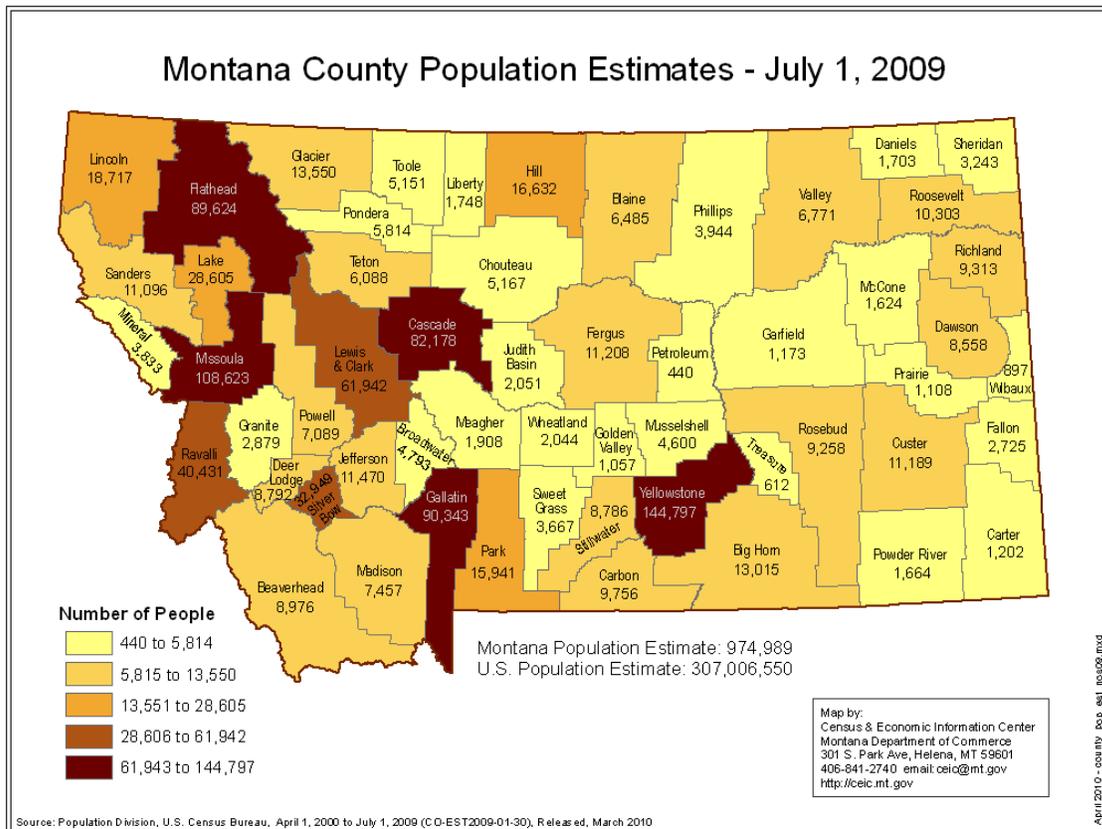
The physical landscape is also diverse; the Rocky Mountains occupy 2/5^{ths} of the western geography and the plains account for 3/5^{ths} of the eastern region. Montana's weather is also quite variable, averaging 28 °F in January and 84°F in July, and is known for long cold, dark winters where freezing temperatures are common from the beginning of November. The combination of extreme geographic and weather conditions can make travel particularly dangerous and time consuming, especially in the winter months.



Population distribution and density

Montana’s population reached 1 million people in 2011. The state has experienced a population growth rate of about 10 percent from 2000-2010, which is average compared to the rest of the country. Most of the population growth occurred in the western third of the state in the more urban counties. Between 2000 and 2010 however, 35 of Montana’s counties (54%) experienced population loss as people moved to the more urban areas for better employment opportunities as a result of Montana’s continuing shift from natural resource extraction based economy to a service economy. This type of out-migration can have a significant impact on the economic and social conditions of these communities that in the past had thrived as a result of logging, coal and gas mining, and drilling for oil.

One of the most important demographic characteristics of Montana is the distribution of the population. As the map below shows, more than half of the population lives in just six counties: Yellowstone, Missoula, Flathead, Gallatin, Cascade, and Lewis and Clark counties. Furthermore, there are 22 counties with fewer than 5,000 residents, such as Sheridan, Fallon, Carter, and Sweet Grass. These counties with the lower populations tend to be in central to eastern regions where agriculture dominates the economy. Consequently the population is not only lower but also spread out over large areas of land and at considerable distances from support services.



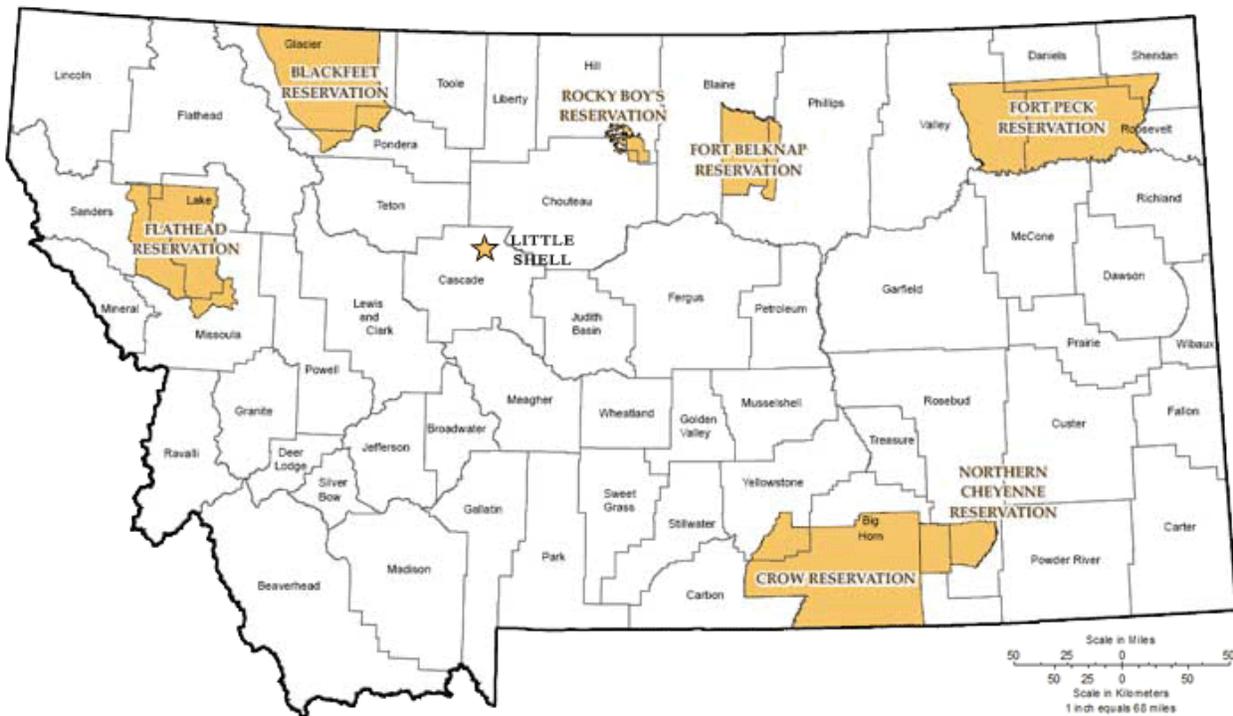
Ethnic distribution

The state is composed of predominately Caucasians, 89.9 %; about 11 percent higher than the national average. The remaining population includes: 6.4% American Indians (5th highest in U.S.) , 3.5% Hispanic and .5% African American (lowest proportion in the U.S.).

Montana is home to seven Indian Reservations, with the majority of the 53,000 American Indian populations living on these reservations. The seven reservations are: the Blackfeet, Crow, Flathead, Fort Belknap, Fort Peck, Northern Cheyenne and Rocky Boy's.⁴ The following map depicts the locations of the reservations.

Tribal nations are diverse. Each tribe has unique cultures, languages, traditions, histories and geographic conditions. The largest tribal organizations in Montana include the Blackfeet Nation, the Crow Tribe, and the Fort Peck Tribes with a total lands covering 13,188 square miles (8,440,147 acres).

One may note that the map recognizes the Little Shell Tribe which is made up of 4,500 members located in Cascade County. The tribe is recognized by the state but not the federal government so they do not receive federal support. The *Little Shell Chippewa Tribe* does not have reserved land and the members of the tribe live throughout the state.



Age distribution:

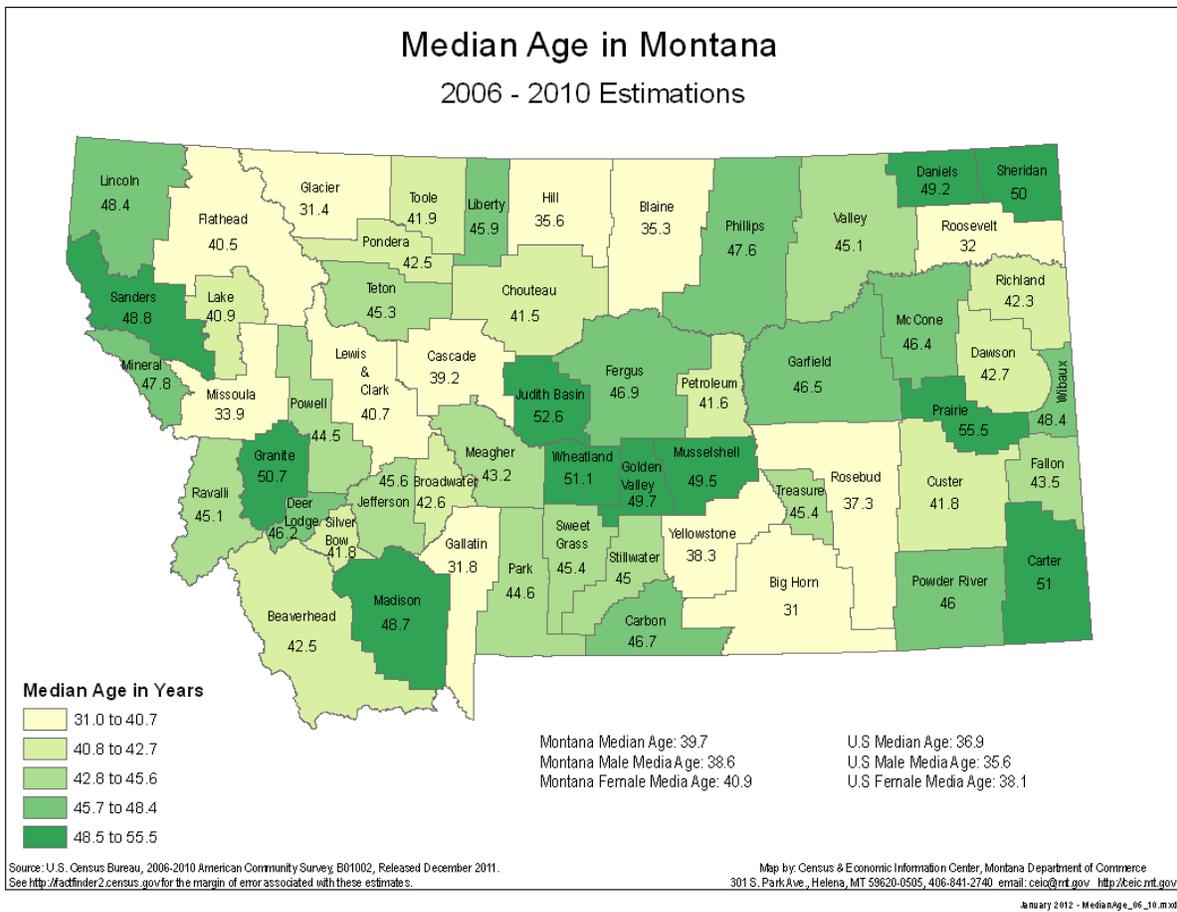
Montana has a higher than average proportion of residents 65 years of age and older than the country as a whole (15.1% vs. 13.3% respectively). It is projected that 25% of Montana's population will be 65 or older by 2020.

⁴ For a more detailed description of the reservations, please refer to Appendix C.

While this aging trend is true for the Caucasian population, a very different trend exists on each of the Indian Reservations in Montana. Reservations that cover the majority of a county, such as Blackfeet Reservation in Glacier County, tend to have higher proportions of people under 25. This is the result of higher birthrates and lower life expectancies on Indian Reservations in Montana. The life expectancy of Caucasians in Montana is approximately 10 years older (78 years of age) than American Indians (68 years of age) in Montana.

The distribution of the younger population is also boosted by enrollment in the colleges and universities located throughout the state. There are two large universities, three public community colleges, seven tribal colleges and three private colleges. Most notably though, is the presence of the University of Montana in Missoula County, with an enrollment of about 15,000 students and Montana State University in Bozeman (Gallatin County) with current enrollment of about 14,000 students.

The following map depicts how different age groups are spread across counties in Montana.



Implications for planning for prevention:

- ❖ *Geographic landscape:* There are only three Metropolitan Statistical Areas in Montana: Billings, Great Falls, and Missoula. Much of Montana is considered Frontier rather than rural; planning must consider the frontier nature and the size of the state. Services are often many miles from residences, are provided on a limited basis, and rely on a small

workforce to cover large areas. The availability of preventative resources for the most frontier counties is not readily accessible to the Eastern 2/3rds of the state, so future planning efforts must explore new ways of reaching these sparsely populated areas.

- ❖ *Population distribution:* Given the population distribution in Montana, a workforce recommendation relates to offering enhanced professional development opportunities for the scattered prevention workforce rather than increasing the workforce. Similarly for the treatment workforce, dual certification in co-occurring substance abuse and mental health would be encouraged.
- ❖ *Ethnic distribution:* Montana is not a very ethnically diverse state, mostly made of white Caucasian. However, Montana does have a significant American Indian population, which makes up about 6.4% of the population, as noted earlier. Higher concentrations of American Indians are residents; generally in and around the seven reservations in Montana. Indian reservations in Montana tend to have lower than average median ages, lower than average wages and negative population growth; factors that can negatively impact the health of the communities.
- ❖ *Age distribution:* The way different age groups are spread across counties in Montana has implications for understanding prevalence or incidence rates of the targeted health behaviors and for designing appropriate prevention efforts. For example, knowing the median age of counties could be useful in understanding the reported suicide rates; suicide rates are highest among the 25-34 age group.

There is an increasing disparity between the aging Caucasian population and the American Indian population which has a higher birthrate. Understanding the prevention and treatment needs of these different communities hinges, in part, on understanding these demographic disparities. There are behaviors which are associated with older populations that are not associated with younger populations. There are multiple factors which may influence these behaviors, but age and developmental stage is an important factor when looking at substance use and abuse or suicide. Also, American Indians are disproportionately represented in the Armed Services of the United States.

The political landscape: Immediately following the conclusion of this initial planning phase, Montana elections will usher in a new state administration due to term limits with the current governor and elected officials. What this means for planning for prevention will unfold over time. At this stage, what is known is that the Governor-elect has experience with promoting public health. For example, in his previous position as Attorney General the Governor-elect was actively involved in prevention initiatives related to prescription drug misuse and abuse. He also promoted changes in Montana's DUI (Driving Under the Influence) statute, providing for frequent testing of DUI offenders and making it easier for law enforcement to obtain a warrant to test for Blood Alcohol Content (BAC).

In the next few months, the Governor will appoint the Director of the Department of Health and Human Services which houses many of the prevention programs related to the targeted mental and behavioral health problems. Other changes that could impact prevention planning include the composition of the Interagency Coordinating Council (ICC). This Council provides much of the leadership behind Montana's prevention efforts. It includes members from twelve state agencies, and two people, appointed by the governor, with prevention program/services experience in the private/non-profit sectors. Two of the state agency leaders

newly elected were: The Superintendent of Public Instruction and the Attorney General. At this stage, it's unclear what support they will bring to prevention. The Superintendent's position is currently subject to a recount and is undecided and the Attorney General is newly elected and his positions on prevention-related issues are evolving.

The impact of the Affordable Care Act (and its moving parts) on planning a 5-year strategic plan is unclear but could be influential in a year or two. We will be watching and waiting to see how the Montana legislature responds to the implementation of the Act. At this time, the intentions of the Act could be viewed as in-keeping with the intents of the SPE grant. For example, to promote a behavioral health care approach whereby mental health and substance abuse are perceived as *health* issues, as important and connected to physical health; to encourage important stakeholders including insurance companies, Medicaid and state funders to adopt this approach and to fund services; and to incentivize coordination of services between primary health care, mental health and substance abuse providers.⁵ These could be influential in reducing the stigma around seeking mental health and substance abuse services by promoting a broader definition of health, health promotion and health care.

The social context within which prevention planning will occur includes an environment where national survey data puts Montana in the spotlight as being #1 in nation for suicide and # 1 for underage drinking⁶. *One has to consider the impact of that type of reputation on the will to change the social norms.* Montanans would tell you that there's a long-time social norm that alcohol consumption is a rite of passage. Is Montana resigned to this destiny?

Another social norm challenge surrounds mental illness. The language used speaks volumes; we talk about mental illness instead of mental health. In the general population, depression can be perceived of as a personal weakness while “there is a generational culture of acceptance of suicide as a viable option to resolve feelings of hopelessness and when one feels they are a burden to others” (SPE member email, 8/22/2012). Ongoing stigma towards seeking mental health services and concerns of maintaining confidentiality in small communities inhibit individuals from seeking needed treatment” is another social reality in Montana (p. 8).⁷

In Montana, there is a perceived culture among youth that a MIP ticket is a badge of honor and a way to fit in. This perception fosters a *pro-social alcohol-use norm amongst youth*. To date the legal system has not addressed MIPs in a systematic manner and MIPs have not been an effective deterrent to counter that pro-social norm. This is a challenge in many states across the nation. A sub-group of the ICC workgroup has been working on addressing this challenge. In-keeping with the public health model of looking at the interconnections between risk factors that contribute to underage drinking, the sub-group has examined: 1) Montana's current Minor in Possession (MIPs) laws in terms of data collection, gaps, inconsistencies, 2) opportunities to improve data collection, and 3) opportunities to intervene with those youth who are on the path to addiction.

⁵Dunn, C.B. *Health care reform and mental health care* (October, 2012). www.heraldsun.com.

⁶*National Survey on Drug Use and Health*, 2012. <https://nsduhweb.rti.org/>

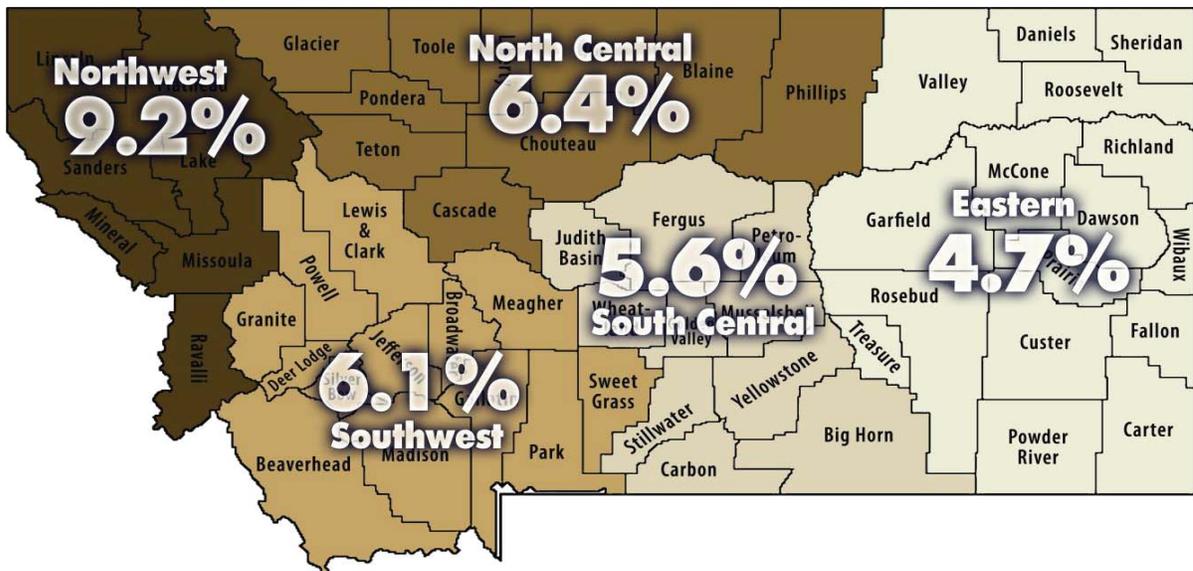
⁷Department of Public Health and Human Services (August, 2012). *Montana Strategic Suicide Prevention Plan - 2013*. Helena, MT. <http://prevention.mt.gov/suicideprevention/index.php>

Based on a survey of nationwide efforts, many states are struggling to address MIPs in an effective way. Twenty-two states responded they are looking to Montana to develop a model that targets the MIP laws as a strategy to reduce the consequences of underage drinking. The MIP law is complex and rendering a reasonable fix is going to take: 1) further buy in, particularly with the courts and more specifically with youth court, and with law enforcement, 2) a universal approach to prevention, and 3) specific recommendations for statute changes. The consequences of this work could be very influential in planning for prevention over the next few years.

Prevention requires a long-term focus; it requires all the stakeholders and funders to understand that change takes a long time and it is a process.

The economic landscape also needs to be considered. As noted earlier, Montana is a diverse state in terms of the types of natural resources, varying population growth, and access to frontier landscapes. This diversity results in significant differences in the regional economies and can affect planning efforts. The assumption is that the economic “health” of a community is correlated with the public health of the counties and reservations.

There are a few different economic measures that tend to be associated with counties at a higher risk for the targeted health problems and/or consequences of the health problems than other counties.⁸ One measure that is closely related to county risk and stress levels is the unemployment rate. The map below indicates the unemployment rate, by regions, during the national recession. The northwest region experienced the highest unemployment rate (9.2%) because of significant job losses in the wood products industry. The unemployment rate is lower in the other regions, with the Eastern and South Central regions having comparatively low unemployment (4.7% and 5.6% respectively) because of continued strength in the energy and agriculture sectors. On the reservations, the unemployment rate ranges from 11% for Fort Peck (Eastern Montana) to 24% on the Crow Reservation (South Central).



⁸ Please see Appendix D for maps and ranking of counties by severity of targeted health areas.

An interesting economic phenomenon to watch over the next five years will be the impact of the oil and gas boom taking place in the eastern portion of the Montana (and into North Dakota); this area is known as the Bakken. Over the last five years, this area of the state has experienced significant economic growth with a large influx of workers, increased wages and low unemployment. These characteristics can be associated with lower risk of the targeted behavioral and mental health problems. However in the current circumstances, the effects are the opposite in north eastern Montana.

The environmental infrastructure of these communities has not kept pace with the sudden demand for services (law enforcement, mental health and addiction services), and the social composition and nature of these frontier communities has undergone rapid change. The counties in this area – Sheridan, Roosevelt and Dawson County -- are already ranked as very high and high risk, based on measures of the targeted health areas used in this planning process. These counties will warrant continued monitoring and will receive attention in the strategic plan. At this time it's unclear how this development could impact the residents of the Fort Peck Reservation, but again they are another community in the region and their rates on the targeted mental and behavioral health measures will be monitored.

Phase I (2012): Needs Assessment Activities and Results

During this initial planning process, numerous needs assessments were carried out in order: 1) to better understand the severity of the targeted mental and behavioral health problems in the counties and on the reservations, 2) to corral the current prevention efforts of state agencies and the tribes, 3) to understand the composition of the current healthcare and prevention workforce, and 4) to assess the capacity and readiness of the agencies to plan for prevention.

Description of Needs Assessment Activities

1. Assessment of the severity of the targeted mental and behavioral health problems

The Montana Epidemiological Workgroup (EPI) was contracted to collect and analyze available data on the targeted health areas drawing on national and state agency data sources. State-level data were used in this assessment as they were deemed more reliable, valid and accessible compared to county-level data. The needs assessment report included: 1) data snapshots of the targeted health areas broken down by age group in order to better understand what's happening for youth, university age and adult populations, 2) data snapshots for suicide by high risk populations including Military families, LGBTQ populations and American Indians, and 3) an overall ranking of the health problems, ranging from the highest priorities areas to medium to the lower priorities. The process used by the EPI workgroup included:⁹

- 1)** Developing a comprehensive list of data sources.
- 2)** Identifying those data sources that met as many of the selection criteria as possible: a) centralized and consistent source; b) state-level and regional breakdowns; c) validity; d) periodic collection; e) sensitivity; f) culturally competent.
- 3)** Evaluating the databases associated with the chosen data sources for relevance to the targeted health behaviors
- 4)** Choosing indicators from 2006/2007 and 2009/2010 to show trends.
- 5)** Developing a SPE database.

- 6)** Ranking the final list of indicators based on equally weighted criteria: a) change in Montana 2006/2007 rate to Montana 2009/2010 rate; b) Montana trend; and c) annual number of persons in Montana.
- 7)** Applying a scoring scheme to each indicator to determine a high priority indicator, medium level priority and low level priority. (It's important to note that some areas of concern had more indicators available than other areas, such as alcohol versus prescription drugs).

- 8)** Developing data snapshots to report the ranking of health problems, including other components, such as mental health data, that are not appropriate for scoring but give a more significant picture of what is going on in Montana.
- 9)** Breaking down the snapshots by age groupings:
 - a) High school/teenagers: 8th-12th graders and under 18's not necessarily in high school.
 - b) Young adults/University students: includes under 25 year olds.
 - c) Adults: 17 years and older; 21-25 year olds; all ages.
- 10)** Breaking down the snapshot for suicide and attempted suicide by:
 - a) Military families
 - b) LGBTQ populations
 - c) American Indians

⁹ Please see Appendix E for a complete description of the background, methodology and data challenges.

A Data Economist, from the Department of Labor, was contracted to collect and analyze county-level data that measured the consequences of suicide, prescription drug misuse/abuse, adult problem drinking and underage drinking. After a thorough review of all the possible county-level measures, the following six were identified as the best possible direct measures or indicators.

Problem Behaviors	Measures/Indicators
Suicide	❖ Suicide rate per 100,000; averaged 2001-2009
Prescription drug misuse/abuse	❖ Prescription drug death per 1,000; averaged 2008-2010 ❖ Drug arrests per 1,000 residents; averaged 2005-2011
Consequences of adult problem drinking	❖ DUIs per 1,000 residents; averaged 2005-2011 ❖ Percent of car crashes involving drugs or alcohol; averaged 2005-2009
Consequences of underage drinking	❖ Liquor law violations per 1,000; averaged 2005-2011 -- the vast majority are MIP (Minor in Possession) violations ❖ Percent of car crashes involving drugs or alcohol; averaged 2005-2009

Note: Some health problems are considered emerging health issues, such as prescription drug misuse/abuse with fewer years of data collection and imperfect measures.

These measures were collected for the fifty-six counties and include the seven reservations that traverse the counties. In addition to knowing the actual numbers/percent of each problem behavior in the respective counties, a composite severity score was calculated for each county.

$$\text{Severity Score by County} = \text{suicide rate} + \text{rate of prescription drug deaths} + \text{drug arrest rate} + \text{DUI rate} + \text{rate of liquor law violations} + \% \text{ of car crashes involving drugs/alcohol}$$

That is, each county was ranked 1 to 56 depending on how high the rate was on each measure in that county. The score was the sum of the rankings on each health problem area. Using the score, counties were categorized as very high risk, high risk, moderate risk, low risk, and lowest risk. By ranking each county on each health problem, it made it easier to compare counties to each other and to understand what multiple public health problems existed within a county.

The Data Economist was also charged with “mapping” pertinent county-level, demographic data. The maps indicate factors that can influence the socio-economic well-being of the counties and the reservations, which in turn can impact the behavioral and emotional health of the residents.

Six maps were generated and are included in Appendix D. The maps include:

- ❖ *Median age, 2006-2010:* this is useful in understanding how different age groups are spread across counties in Montana. This has implications for understanding prevalence or incidence rates of the targeted health problems.
- ❖ *Population density, 2010:* shows that the state population is highly concentrated in a small number of counties and that there are less than 7 persons per square mile compared to the national average of 87.4 persons. These data highlight the possible role that social

isolation can play in understanding counties with higher rates of suicide as well as alcohol and drug abuse, and have implications for planning prevention activities.

- ❖ *Population percent change, 2000-2011*: indicates whether a county and the reservations have been growing or losing residents over time. In Montana, the economic well-being of a county/reservation and the educational and environmental amenities available, often determine growth or decline. One would expect that counties in the very highest risk category would typically have low or negative population growth. The Bakken may challenge that norm as it is an atypical experience and comes with its own unique risk factors. It's well known that high rates of mobility and transition are environmental risk factors, so can rapid population gain. This is because resources are stretched to the breaking point and because of the collusion of strangers who are trying to develop a community.
- ❖ *Average wage per job, 2009*: attempts to measure the average income of those employed in a county. While there are some drawbacks to this measure, it provides an indicator of the "health" of a county and its residents. Lack of economic opportunities and the prevalence of poverty can be stressful for individuals and families and contribute to mental and behavioral health.
- ❖ *Percent American Indian by county, 2009*: shows where the higher concentrations of American Indians are residents; generally in and around the seven reservations. Six of the seven reservations traverse counties that are ranked very high risk and high risk. Fort Belknap is the exception.
- ❖ *Health insurance coverage, 2007*: depicts the proportion of a county's population (under 65 years of age) that lacks health insurance. Seven of the eleven highest risk counties have a higher than average (22%) rate of uninsured people. Access to health insurance can often be a deciding factor in staying healthy and avoiding or delaying onset of disease.

2. *Assessment of current prevention efforts of state agencies*

The status of current prevention efforts of the state agencies, involved in the SPE planning process, was measured through an online survey.

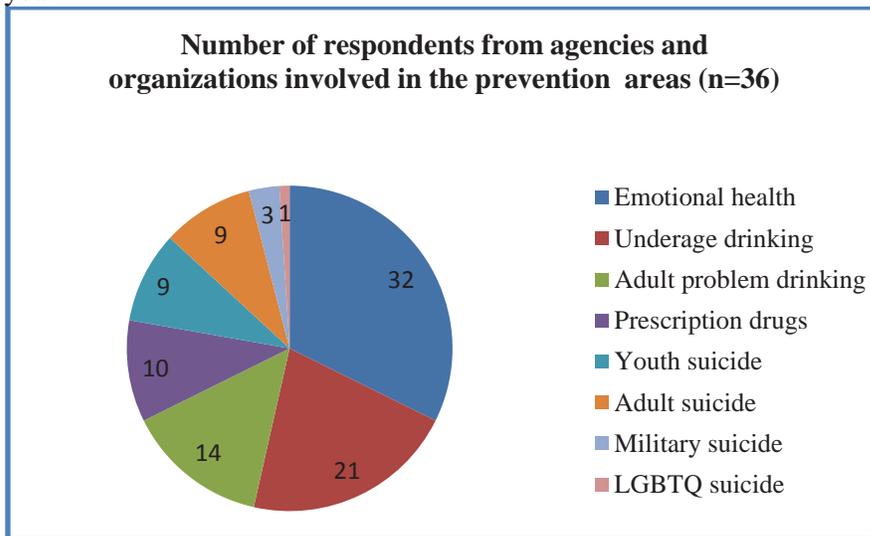
The survey provided data on: 1) the goals of current prevention efforts; 2) county locations of efforts; 3) workforce used; 4) evidence based and other practices used; 5) process and outcome data collected; 6) how data are shared; 7) challenges for implementation; and 8) opportunities that contributed to the success of prevention efforts.

It was completed by fifteen SPE members; state agencies represented:

- ❖ Montana Army National Guard
- ❖ Addictive and Mental Disorders Division
- ❖ Children's Mental Health
- ❖ Youth Community Corrections
- ❖ Chronic Disease Prevention and Health Promotion
- ❖ Office of Public Instruction (OPI)
- ❖ Adult Mental Health
- ❖ Montana Board of Crime Control, Juvenile Justice
- ❖ Children's Trust Fund
- ❖ Attorney General's Office, Prescription Drug Abuse Awareness Program
- ❖ Prevention Resource Center
- ❖ Suicide Prevention Program
- ❖ Montana State University
- ❖ Montana Safe Schools Center, The University of Montana

Other respondents included: 1 county-level agency; 14 non-profit entities; 1 city level organization; 1 private for profit entity; and 1 tribal, residential treatment agency. Sixteen of these respondents are funded with substance abuse prevention block grant dollars from the Addictive and Mental Disorders Division to carry out prevention activities within their communities.

A total of 36 respondents completed the online survey; the majority of respondents reported working in more than one health promotion area. The following graph depicts the number of respondents working on preventing the targeted mental and behavioral health areas, in the last year.



The survey targeted prevention efforts that:

- 1) build emotional health
- 2) prevent/reduce the consequences of underage drinking
- 3) prevent/reduce the consequences of adult problem drinking
- 4) prevent suicide & attempted suicide by American Indian and non-Indian youth
- 5) prevent suicide and attempted suicide by American Indian adults and non-Indian adults
- 6) prevent suicide and attempted suicide by LGBTQ populations
- 7) prevent suicide and attempted suicide by military families
- 8) reduce prescription drug misuse/abuse.

These data translate into the following percentages:

- ❖ 89% reported building emotional health
- ❖ 58% worked on preventing the consequences of underage drinking
- ❖ 39% worked on preventing the consequences of adult problem drinking
- ❖ 28% on reducing prescription drug misuse/abuse
- ❖ 25% preventing suicide and attempted suicide for American Indian and non-Indian adults
- ❖ 25% preventing suicide and attempted suicide for American Indian and non-Indian youth
- ❖ 6% on preventing suicide and attempted suicide by Military families
- ❖ 3% on preventing suicide and attempted suicide by the LGBTQ population.

In addition to the online survey, a number of interviews were conducted with state-level experts in specific targeted health areas. These interviews expanded on what was reported in the online survey or were in lieu of the online survey. Interviews were conducted with: OPI staff in the areas of suicide prevention; the Suicide Prevention Program Coordinator at DPHHS; the Coordinator for the Prescription Drug Abuse Awareness Program; and the planner in Safety Division of the Department of Transportation.

3. *Assessment of current prevention efforts on the seven reservations*

Between March and May 2012, 76 interviews were conducted on all seven reservations. Over 2,000 miles were covered in the course of conducting these interviews that took a month to complete. A broad array of professionals from schools, hospitals, treatment facilities, housing authorities, prevention programs and grants, social services, as well as Elders and leaders in the communities were interviewed. The interviews were compiled into a report that can be used as a resource in the planning phase (2013).¹⁰

The interviews focused on understanding: 1) what prevention efforts, related to the targeted health areas, are occurring in Indian Country across Montana; 2) what efforts worked well; 3) what environmental conditions helped prevent or contributed to the targeted health problems; 4) what resources are used for prevention efforts; and 5) how their prevention work connects to the prevention work carried out at the state-level.

4. *Assessment of workforce data*

The Data Economist, from the Department of Labor, was also contracted to review current workforce data to assess the composition of the prevention and health care workforce. The measures used in the analysis were the online survey administered to the SPE members and county-level measures. These county-level measures included: 1) Quarterly Census on Employment and Wages; 2) Occupational Employment Statistics; 3) Licensure data; and 4) data from the Montana Medical Association Physician Directory.

5. *Assessment of SPE consortium's planning capacity*

Karen Ray, President of Karen Ray Associates', conducted an assessment of the Consortium's capacity to collaboratively plan and provided recommendations for capacity building. Karen Ray carried out the assessment over a three month period while providing technical assistance to the SPE Consortium.

Results of Needs Assessments

Data collection, analysis, reporting and sharing: An Examination

Before discussing the results of the respective needs assessments it's important to recognize the realities that accompany the desire to make data-driven decisions. As a result of this Needs Assessment process, an additional outcome was a better understanding of the issues related to data collection, analysis, reporting and sharing.

That is, not all data are equal, are available, are shared, and are collected in a consistent manner.

1. *Data used in the assessment of the severity of the targeted mental and behavioral health problems.*

The data collection and reporting of behavioral and mental health are largely *siloed*. That is, data are collected on the respective health behaviors by multiple state agencies and tribal entities with little consideration for what are already collected and available, consistency of measuring, consistency of reporting, the desirability of sharing data, and for linking data sets within and

¹⁰ A copy of The Interview Report is found in Appendix F.

across agencies and across tribes. There are multiple data banks housed within state agencies. The Single State Authority, in the Addictive and Mental Disorders Division of DPHHS, does house prevention related data collected from communities and direct services providers, but does not include data from other state agencies. It's probably fair to say that, in part, data are generally collected in this manner so as to meet Federal reporting requirements and are typically driven by those reporting requirements.

Another driver of this data segmentation, among government entities, is that different branches of government tackle public health issues from an array of standpoints. For example, reducing prescription drug misuse/abuse has largely been approached from a legal perspective through the Attorney General's office. The main prevention strategy has been establishing a Prescription Drug Monitoring Program. Alternatively, efforts to prevent suicide and attempted suicide come out of DPHHS with a largely public health approach. Preventing and reducing the consequences of underage drinking and adult problem drinking is tackled from a variety of approaches by innumerable agencies ranging from the Department of Transportation which focuses on DUI and alcohol related car crashes; to the Department of Revenue, Liquor Control Division which is responsible for alcohol beverage control laws, to the Department of Justice which enforces DUI laws.

While this multifaceted approach is beneficial in that multiple approaches are better than just one narrowly defined approach, these very different state agencies could benefit from enhanced coordination of services and sharing of data sets. At times it is not so much that data are difficult to locate, rather the issue is that agencies are unaware of what data are being collected.

Accessing data is subject to the vagaries of data sharing policies, human resources and capacity, financial resources and capacity, and confidentiality policies. Additionally, access to data on suicide and attempted suicide for Military families, LGBTQ populations and American Indians is even more challenging. For example, the EPI workgroup reported that only national data were available on the LGBTQ youth. The confidentiality policy of the DPHHS prohibits the release of data if the frequencies of the cell sizes are less than five or calculation rates were based on fewer than 20 events.¹¹ In a state with just over a million people scattered across 56 counties, small cell sizes are common enough and this means that mental and behavioral health problems are likely to be under-reported.

Assessing the severity of prescription drug abuse/misuse is also problematic. This is an emerging health problem in Montana and the data collection systems are trying to catch up with the demand for action.

County-level data come with their own challenges. As part of the process to understand which counties in Montana have been most negatively affected by the consequences of underage drinking, adult problem drinking, and suicide and prescription drug misuse/abuse, county-level measures were collected and presented to the SPE Consortium. Conversations about the data sources highlighted some of the limitations of the data.

For example, data on suicide are particularly unreliable for a number of reasons including: social pressure on Coroners in small communities to not list "suicide" on the death certificate, most

¹¹ The Epidemiological Workgroup (April 20120). Montana's Strategic Prevention Enhancement Grant – Needs Assessment. *Background and Methodology*.

Coroners are not MDs, and the lack of reporting mechanisms in ERs to record suicide attempts.¹² Under-reporting and stigma are also associated with rates of suicide and attempted suicide for Military families. Montana is home to 102,000 veterans which means there are a large number of Military families in the communities. Understanding suicide in Military families is confounded by the *code of silence*. According to a SPE member, the Department of Defense states that 75% of “suicides” are still under investigation and the data cited by the CDC is not current; it’s from 2009. The stigma associated with labeling deaths as suicide is pervasive in the military and civilian worlds.

State and county-level data used in the Needs Assessments are not necessarily perfect measures of the targeted behavioral and mental health areas, but they represent the best available measures at this time.

One of the steps in developing the strategic plan will be to conduct an assessment of the current data collection systems. In Phase II (2013), the EPI Workgroup will spearhead and report on these assessments; consulting with health content experts as to data concerns, identifying missing data and making recommendations for enhancement.

2. *Data used in the assessment of workforce.*

Not only do the four county-level data sets, used in this assessment, come with their own unique challenges and benefits but there’s a common data challenge in Montana – *it is difficult to collect and/or publish data at the county-level*. Montana has 56 counties, 24 of these counties have fewer than 5,000 residents. The large number of low populated counties makes data retrieval a lower priority in less densely populated areas, and when data are collected, more often than not disclosure rules within various agencies (e.g., DPHHS and the Department of Labor) restrict access to those data in order to prevent the possibility of linking the data back to an individual business or person.

The following describes the benefits and idiosyncrasies of each workforce data set.

Licensure: One way that the workforce can be measured is through licensure data. Most health occupations require some type of license that is renewed every year or two years. An important benefit of these data is that they are recorded at the county-level; this is extremely important when identifying geographic shortages in certain labor markets.

Licensure data comes from a “live” database. For example, this means that the number of Montana Addiction Counselor licenses on one day may not be the same as a few days later. People can renew their license during a month long window or any time of year; therefore the number of licensees changes frequently. Further complicating this picture is that different professions have different renewal dates.

Another complication is that licensure counts, by county, are the number of licenses held by people who live in that county; this does not mean they work in that county. Therefore, county-level licensure data can misrepresent the number employed in a particular county when individuals commute across county lines; this is fairly common especially in the healthcare industry and in frontier communities.

¹² August 22nd SPE Consortium Minutes.

<http://prevention.mt.gov/strategicprevention/strategicprevention.php>

Licensure data also includes all those who hold a license, not all those who are employed in their respective field. For example, licensure data for registered nurses suggests there are 13,000-14,000 RNs licenses, but the actual number employed is more likely to be around 8,000 registered nurses.

Quarterly Census on Employment and Wages (QCEW): The QCEW program gathers information on business establishment's quantity of employees, total wages within the business, and type of business. The primary data source for the QCEW comes from the reports submitted by employers to the Montana Unemployment Insurance program. Employment data represents the number of workers on the payroll during the pay period including the 12th day of the month. Total wages include gross wages and salaries, bonuses, profit sharing, commissions, severance pay, and limited tips.

The benefits of these data are: 1) they are collected on a monthly basis, at the county-level, 2) they include information on wages and 3) they report on semi-specific job-types. However, not all county-level data are available due to enforcement of disclosure rules that prohibit the disclosure of data from low populated counties. For example, after the 2011 collection of *all* Healthcare and Social Assistance employment, data from only half of the counties were published.

Another limitation of these data is best described using an example. The QCEW program reports data on a hospital in Sanders County. It shows monthly employment levels at around 200 employees and total wages in that quarter of around \$2 million, but it does not depict what each of those 200 employees actually do. All we know is that they work at the hospital. They could be surgeons, nurses, physician assistants, or even janitors. These data are limited in their ability to estimate workforce numbers.

Occupational Employment Statistics: The Occupational Employment Statistics (OES) program produces employment and wage estimates for over 800 occupations. These are estimates of the number of people employed in certain occupations and estimates of their wages. Self-employed persons are not included in these data. These estimates are available for the nation as a whole, for individual States, and for metropolitan and nonmetropolitan areas; national occupational estimates for specific industries are also available. Estimates often take into account national labor trends which may or may not be applicable at the individual state-level. This is one reason why the statistics can be over or underestimated.

The benefit of these data is that they identify specific occupations, the amount of education required and the average pay. This allows for a detailed understanding of a particular occupation. While these characteristics of the data are positive, the level of specificity in job titles combined with such low populations in Montana's frontier counties makes little of this information disclosable at the county-level.

Montana Medical Association Physician Directory: The Montana Medical Association (MMA) physician directory compiles information on active and retired members of the MMA at the county-level. These data show a physician's first area of primary practice, business location (town and county), home location (town and county) and their birthdates. Almost all of the data are disclosable because it comes from the MMA.

This information can be extremely useful in comprehending where certain physicians work in designated shortage areas (please see page 83 for discussion). Furthermore, the collection of

birthdates is helpful when estimating the number of retirees and number of future positions that would need to be filled.

With respect to behavioral health however, not many of the job fields, besides psychiatry and psychologists, are represented in the data. Primary care physicians are included and as we know they are often the first line of defense in screening for the targeted mental and behavioral health problems. For example, they are an integral partner in the Montana Suicide Prevention program. However, even these data may be an imperfect measure of the workforce. Anecdotal evidence suggest that physicians often report primary care as their centered area of work, but in actuality some often work as hospitalists or subspecialists and spend less time as primary care physicians.

With these caveats in mind, the following section discusses the results of the various needs assessments.

Assessment of the severity of the targeted mental and behavioral health problems

The results for the respective public health problems are discussed separately. This is due to the fact that little data are cross-tabbed or linked to each other. For example, data on underage drinking is not linked to suicide or mental health data. This makes it difficult to talk about the data from a public health perspective where health problems and their consequences are seen as overlapping and interacting, and the factors that contribute to poor emotional health can also overlap. Instead the following describes: 1) what is known about the severity of each of the targeted mental and behavioral health areas using state and county-level data, and 2) what is known about the prevention efforts of the SPE members.

Reducing Prescription Drug Misuse/Abuse

Severity of prescription drug misuse and abuse in Montana

As noted earlier, the EPI workgroup was charged with collecting data on the severity of prescription drug misuse and abuse in Montana. The reporting of prescription drug misuse and abuse was part of the data snapshots broken down by age groups.

Across all age groups, prescription drug misuse and abuse was *ranked the lowest area of concern compared to the other targeted health problems*. No prescription drug misuse/abuse indicators scored above the 2.99 cut off that would have deemed it a medium level or high priority. The discussion of this result with the Consortium, however, included concerns about the limitations of the available data.

According to the EPI workgroup, “data on prescription drug misuse and abuse is less available using the data source requirements [used in the assessment]. As much as possible, information gleaned from other sources was included in the data snapshots to provide as total a picture as possible”. “The number of people reported in prescription drug consumption or consequence indicators is considerably smaller than the number of people reported in alcohol consumption or consequence indicators. Making this a difference in the scale of the problems.” The EPI workgroup also acknowledged that the low ranking “could be misleading because of recent increasing numbers of prescription drug misuse and abuse”. “They noted that many measures on

prescription drugs have trended upwards compared to alcohol indicators that have remained flat or gone down”¹³.

The EPI workgroup recommended that prescription drug misuse and abuse be considered as “an emerging issue”. At this point it’s probably fair to say that the data collection systems have not caught up with what is being reported anecdotally by law enforcement, the Department of Justice and the medical community.

A county-level measure of the “consequences” of this behavior was: *prescription drug death per 1,000 averaged 2008-2010*. As reported earlier, a county was ranked from 1 to 56 depending how high it rated on this measure, with 1 meaning that county had the highest death rate per 1,000 across the 56 counties. The following table shows the results for the top 30 counties and the reservations. The table also shows the population size of each county, the reservations that traversed these counties and the overall county risk ranking (relative to all the counties in the state across all health problems). A complete listing of counties is provided in Appendix D.

A review of these data indicate some interesting facts to consider from a public health perspective of looking for interrelationships and connections.

- ❖ 10 of the top 12 counties with the highest death rate from prescription drugs have less than 10,000 people residing in those counties.
- ❖ 50% of the top 12 have a composite score that results in their being ranked as very high risk counties. That is, these counties also have high rates for drug arrests, DUIs, car crashes, and liquor law violations.
- ❖ Of the 30 counties reported in the table, 60% are ranked as very high risk or high risk, and 6 of the 7 reservations are included in the top 30 counties.

“With more Montanans dying from overdoses of prescription drugs than in traffic crashes, it’s clear that we must act now. While prescription drug abuse isn’t something we talk about at the dinner table, it’s quietly killing hundreds of Montanans every year and, through addiction it’s destroying the lives of thousands more,” Bullock said. “I’m proud to bring together a group of leaders whose insight and experience will help us tackle this issue head on.” (Bullock Announces Prescription Drug Abuse Advisory Council. Press Release, 9/22/2009)

¹³ Observations and Conclusions of the EPI workgroup are found in Appendix E.

Severity of prescription drug misuse/abuse: Prescription drug death per 1,000 (2008-2010)

Key: the lower the number the higher the risk				
County	Ranked on risk: Prescription drug death per 1,000 average 2008-2010	Population 2010	Reservations	County risk ranking across all health problems
MINERAL	1	4,223		moderate
PETROLEUM	2	494		High
MUSSELSHELL	3	4,538		moderate
BROADWATER	4	5,612		very high
GOLDEN VALLEY	5	884		moderate
BEAVERHEAD	6	9,246		very high
DEER LODGE	7	9,298		very high
GRANITE	8	3,079		lowest
SHERIDAN	9	3,384	Ft. Peck	very high
MISSOULA	10	109,299	Flathead	very high
CHOUTEAU	11	5,813	Rocky Boy's	moderate
ROOSEVELT	12	10,425	Ft. Peck	very high
FERGUS	13	11,586		moderate
PARK	14	15,636		high
RAVALLI	15	40,212		high
SILVER BOW	16	34,200		high
HILL	17	16,096	Rocky Boy's	very high
WIBAUX	18	1,017		low
MEAGHER	19	1,891		lowest
CARBON	20	10,078		moderate
SANDERS	21	11,413	Flathead	very high
JEFFERSON	22	11,406		lowest
BIG HORN	23	12,865	N. Cheyenne & Crow	very high
LINCOLN	24	19,687		very high
CASCADE	25	81,327		high
RICHLAND	26	9,746		low
GLACIER	27	13,399	Blackfeet	high
LAKE	28	28,746	Flathead	high
WHEATLAND	29	2,168		moderate
DAWSON	30	8,966		high

Another county measure used to indicate the severity of prescription drug misuse/abuse was: *drug arrests per 1,000 residents averaged 2005-2011*. This measure includes any drug-related arrests made during the time frame, including prescription drugs. While it's possible to drill down to identify the number of prescription-related drug arrests, at this time the data are not being reported in a consistent fashion and the small numbers per county makes comparing the data across counties less useful. Consequently, using data on all drug arrests is considered a better indicator of drug use in general, which includes prescription drugs.

The following table shows the results for the top 30 counties and the reservations. It also indicates the ranking for prescription drug deaths, the overall county risk ranking (relative to all the counties in the state across all health problems), and the reservations that traverse these counties. A complete listing of counties is provided in Appendix D.

According to these data:

- ❖ 3 of the top 12 counties (25%) ranked as having the highest drug arrests also had high rates of prescription drug deaths.
- ❖ 3 of the 7 reservations are included in the top 12 counties.
- ❖ 75% of the top 12 counties were ranked as very high or high risk across all the measures.
- ❖ Interestingly, the top county for drug arrests, Toole County, had an overall risk ranking of low.

The value of these county measures, from a public health approach, is that the data suggest that the top ranked counties also tend to be at-risk for the other targeted mental and behavioral health problems. There are however, some exceptions such as Toole County. From a planning perspective, this assessment is the first step in trying to get a better understanding of this emerging public health issue.

Severity of prescription drug misuse/abuse: Drug arrests per 1,000 residents (2005-2011)

Key: The lower the number the higher the risk				
County	Drug arrest per 1,000 residents averaged 2005-2011	Prescription drug death per 1,000 averaged 2008-2010	County risk ranking across all health problems	Reservations
TOOLE	1	40	low	
HILL	2	17	very high	Rocky Boy's
BROADWATER	3	4	very high	
LINCOLN	4	24	very high	
PETROLEUM	5	2	high	
DAWSON	6	30	high	
GALLATIN	7	39	moderate	
FLATHEAD	8	43	high	Flathead
MISSOULA	9	10	very high	Flathead
SILVER BOW	10	16	high	
VALLEY	11	49	moderate	Ft. Peck
LAKE	12	28	high	Flathead
SWEET GRASS	13	42	very high	
BEAVERHEAD	14	6	very high	
YELLOWSTONE	15	31	low	
CASCADE	16	25	high	
PARK	17	14	high	
SANDERS	18	21	very high	Flathead
SHERIDAN	19	9	very high	Ft. Peck
GLACIER	20	27	high	Blackfeet
LEWIS & CLARK	21	36	moderate	
WHEATLAND	22	29	moderate	
RAVALLI	23	15	high	
CHOUTEAU	24	11	moderate	Rocky Boy's
CARBON	25	20	moderate	
DEER LODGE	26	7	very high	
GOLDEN VALLEY	27	5	moderate	
BIG HORN	28	23	very high	N. Cheyenne & Crow
ROSEBUD	29	32	high	N. Cheyenne
MADISON	30	33	high	

Assessment of current prevention efforts of state agencies

The online survey results indicate what state agencies are involved in reducing prescription drug misuse and abuse and an overview of their prevention efforts.

Ten of the thirty-six survey respondents reported their agency/entity had been involved in reducing prescription drug misuse/abuse during the last year (2 respondents were from the same agency). The respondents represented six state agencies, four were community providers and one was a consultant. The non-agency entities were funded by block grant dollars, from the Addictive and Mental Disorders Division, to provide prevention services in communities.

The six state agencies included:

- ❖ Department of Justice, Attorney General’s Office
- ❖ Department of Justice, Montana Board of Crime Control
- ❖ Montana State University
- ❖ Department of Corrections: Youth Community Corrections
- ❖ Montana Army National Guard
- ❖ DPHHS, Chronic Disease Prevention and Health Promotion Bureau

Overview of Prevention Efforts:

The following table summarizes: the respondent’s roles in prevention; the goals and objectives of the prevention efforts; challenges experienced that impacted the ability to carry out prevention efforts; and opportunities that contributed to the success of the prevention work. It’s important to remember that the data and discussion that follows is based on the data reported by these survey respondents. It is not a comprehensive account of prevention services available in the counties and reservations.

Role in prevention	Goals/objectives of programs, practices, activities	Challenges to successful implementation	Opportunities that contributed to success
Infrastructure (45%)	Data collection and reporting; analysis of unintentional poisoning related to prescription drugs; adding questions to the BRFSS* to measure use	Staffing (27%)	Collaboration between state agencies
Delivery System (36%)	Working on legislation to create a Drug Registry: HB 83	Financing (18%)	Cooperation between local agencies
Infrastructure & delivery (45%)	Secured grant funding for program manager to oversee the implementation of Drug Registry	Community behavior (18%)	State and communities proactive approach
<i>Infrastructure:</i> funding prevention initiatives, collecting data and reporting on outcomes, requiring the use of evidence based practices. <i>Delivery:</i> includes delivering prevention training to audiences; delivering prevention programs in schools or a community; using evidenced based programs, etc.	Educating public: proper disposal and storage of prescription drugs	Policy issues (18%)	
	Educating public: danger and prevalence of misuse/abuse	Organizational issues (18%)	
	Grants & support to law enforcement to establish community permanent drop boxes	Individual beliefs and desire to medicate (9%)	
	*BRFSS: Behavioral Risk Factor Surveillance System	Community beliefs (9%)	

Roles: As the data indicate, the roles of respondents fall fairly evenly across the categories of infrastructure and delivery system roles. An example is the Prescription Drug Abuse Awareness Program that funds prevention initiatives and delivers preventing training.

Goals: In general, the efforts divided into two categories: 1) *raising public awareness about the risk of misuse and abuse* and 2) *reducing easy access to prescription drugs*. For example, the data generated from the BRFFS could help to address the gaps in knowledge about the severity of the misuse and abuse and could be used to educate the public and target prevention efforts.

Challenges and Opportunities: In general, the challenges to successfully reducing misuse and abuse relate to *system issues* including policies and organization, insufficient staffing and financing; and relate to *community beliefs and behaviors*. However, respondents also noted that efforts were enhanced by the level of cooperation across agencies at the state and local level.

Information about the geographic distribution of prevention efforts, the workforce involved, and the use of evidenced based and non-evidenced based practices/programs/activities was also collected from respondents. The following tables and graphs depict these data.

Counties where prevention efforts occur: As the table below indicates, some level of prevention efforts occurred in all 56 counties during the last twelve months. It’s important to note that *prevention efforts are occurring in some of the locations that have the highest rates of prescription drug deaths*. For example, five of the counties, highlighted in the table, are in the top 25 counties with the highest average rate of prescription drug deaths (2008-2010). For example, Broadwater is ranked number 4 and Beaverhead is ranked number 6.

Counties	% respondents
ALL 56 COUNTIES	54.5%
Beaverhead County	9.1%
Broadwater County	9.1%
Cascade County	9.1%
Gallatin County	9.1%
Madison County	9.1%
Meagher County	9.1%
Park County	9.1%
Phillips County	9.1%
Silver Bow County	9.1%

Note: ¹ The individual counties listed also reflect the geographic location of the prevention specialists who completed a survey.

² These survey data do not specifically reflect what’s happening on the seven reservations in Montana, however, the interviews conducted with Tribal stakeholders revealed that prescription drug abuse and misuse is an emerging issue of concern.

Workforce delivering prevention efforts: The following table shows a *wide range of occupations are involved in reducing prescription drug misuse and abuse*. Some occupations are clearly linked to efforts that reduce access including Pharmacists and law enforcement. Others are likely to be involved in raising public awareness such as the Prevention Specialists.

Employees/volunteers delivering programs, practices, activities	% respondents
Prevention Specialists	45.5%
Pharmacists	36.4%
Police and Sheriff's Patrol Officers	36.4%
Substance Abuse Counselors	27.3%
Mental Health Counselors	18.2%
Family and General Practitioners	18.2%
Volunteers	18.2%
Child, Family, and School Social Workers	9.1%
Mental Health and Substance Abuse Social Workers	9.1%
Elementary, Middle, High School Teachers	9.1%
Health Educators	9.1%
Probation Officers and Correctional Treatment Specialists	9.1%
Social and Human Service Assistants	9.1%
Pediatricians	9.1%
Psychiatrists	9.1%
Registered Nurses	9.1%
Emergency Medical Technicians and Paramedics	9.1%
Licensed Practical and Licensed Vocational Nurses	9.1%
Educational, Guidance, School, and Vocational Counselors	9.1%
Coaches and Scouts	9.1%

Use of Evidenced-Based (EBPs) and Non-Evidenced-Based (Non-EBPs) prevention efforts

In-keeping with the largely universal prevention approach, *most efforts have targeted families, schools and communities rather than individuals*. Some examples include a media safety campaign that targeted families; prescription drug drop boxes placed in communities; presentations to students in health classes; and the Prescription Drug Registry that reduces an individual's ability to "doctor shop" for prescriptions. Also more non-EBPs have been utilized than EBP at this stage.

Programs/Practices/Activities	% using EBPs	% using Non-EBPs
Target individuals	27.3%	36.4%
Target families	18.2%	18.2%
Target schools	18.2%	27.3%
Target communities	18.2%	36.4%
NOT USE	72.7%	54.5%

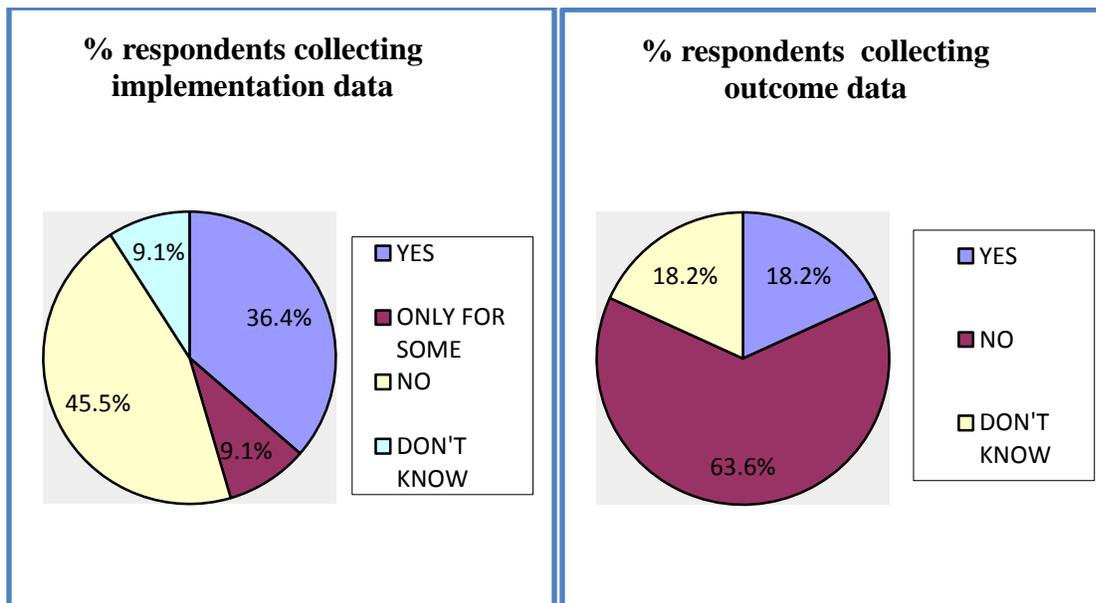
Evidenced-Based: are practices, programs, activities listed on the Federal registry of evidence based interventions, with documented effectiveness for a target audience and documented effectiveness with a targeted outcome. *Non-Evidenced-Based*: practices, programs, activities that are effective and create change but are not listed on the Federal registry.

Data collection and sharing data: The final results from the online survey indicate what percentage of respondents collected implementation and outcome data and shared those data. These results are depicted in the following three graphs.

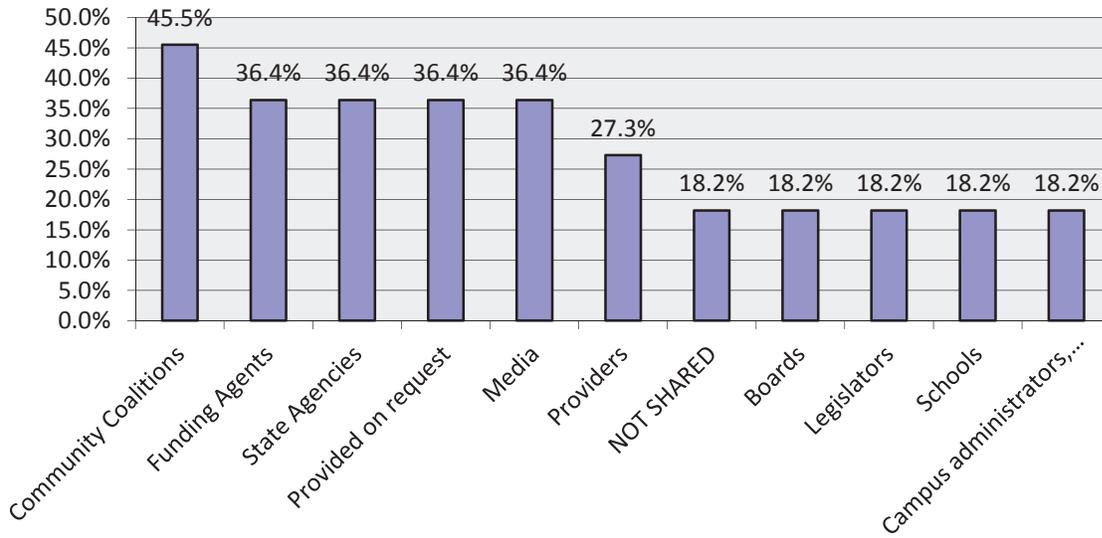
Implementation data: Just over a third of respondents (36%) indicated that implementation data on the EBPs and Non-EBPs were collected in the last 12 months. For example, the number of drug take-back events held, number of pounds of drugs collected, and number of participants attending. The reasons why so few collected implementation are unknown at this time.

Outcome data: The percentage of those who collected outcome data such as changes in knowledge, behaviors or policies was 18%. Some examples included changes in disposal practices and the decrease in crime-related drug theft. Again, the vast majority of respondents are not documenting the impact of the prevention efforts at this time.

Sharing data: Only 18% (n=2 respondents) reported they did not share implementation or outcome data with others. Common recipients included: funding agents, state agencies, the media, and those who requested the data (~ 36% each). The five community providers, who completed the survey, also shared their data with their community coalitions. The remaining recipients included: Boards, Legislators, Schools and campus administrators and program directors (~ 18% each).



In the last year, with whom have you shared implementation or impact information? Please select all that apply.



In summary, these online survey data provide a snapshot of the prevention efforts currently undertaken by some of the agencies involved in this planning process. Not all SPE members completed a survey therefore it's not possible to provide a complete picture of all the efforts being undertaken.

To a large degree, the state-level efforts to prevent prescription drug misuse/abuse have been primarily spearheaded by the Montana Department of Justice, under the leadership of the Attorney General who identified this health risk as a priority for his administration.¹⁴ The following is a detailed look at those efforts.

Within six months of taking office, the Attorney General, Steve Bullock convened the first meeting of the Prescription Drug Abuse Advisory Council (June 2009). This Council was mandated to “develop a comprehensive, Montana-made plan to combat prescription drug abuse”.¹⁵ The strategies employed are in keeping with the prevention recommendations in the national Prescription Drug Abuse Prevention Plan, *Epidemic: Responding to America’s Prescription Drug Abuse Crisis*. These efforts include: 1) educating the public, 2) prescription drug monitoring, 3) safe drug disposal, and 4) effective enforcement. These responses are aimed at comprehensively addressing all areas of drug control and supply.

A Closer Look at the Problem

According to the AG’s office, prescription drug misuse/abuse has been on the rise. Initially overshadowed by the Meth epidemic that dominated the 1990s, prescription drug abuse started to fill some of the void left by Meth. In the early to mid-2000’s law enforcement officers started to seize more and more prescription drugs.

What happened in Montana could reflect what’s happened across the country. According to the Director of the Office of National Drug Control Policy, “the vast majority of abused pharmaceutical drugs originally enter into circulation through a prescription. And we know that most prescription painkillers are prescribed by primary care physicians, internists, dentists, and orthopedic surgeons, not pain management specialists ... once they are prescribed and dispensed, these drugs are frequently diverted and misused. [Based on a national survey], over 70 percent of people abusing or misusing prescription pain relievers obtained them from friends or family, 17 percent obtained them from one doctor, while just over 4 percent got them from a drug dealer or other stranger, and 0.4 percent bought them online. [The prevention strategies] seek to strike a balance between preventing diversion and abuse of pharmaceuticals with the need to ensure legitimate access.”¹⁶

Prior to the Initiative:

- ❖ Montana ranked 3rd in the nation for teen abuse of prescription pain relievers with 9.6 percent reporting abuse in the past year (2008)
- ❖ Nationally, over 4 million people used prescription drugs for nonmedical purposes for the first time in 2008.
- ❖ Nearly 60 percent of abusers get prescriptions free from a friend or relative, while over 14 percent buy or steal them from a friend or relative.
- ❖ Only 24 percent of parents have talked with their kids about the dangers of prescription drugs. (DoJ Press Release, 9/22/2009)

¹⁴ Source: Interview with Jennifer McKee, Prescription Drug Abuse Awareness Program Coordinator, Attorney General’s Office; 7/24/2012. Information from Montana Department of Justice website: <https://doj.mt.gov/prescriptiondrugabuse>.

¹⁵ <https://doj.mt.gov/prescriptiondrugabuse/what-were-doing/>

¹⁶ (Statement of Director Kerlikowske before the Senate Caucus on International Narcotics Control: "Responding to the Prescription Drug Abuse Epidemic", July 2012. <http://www.whitehouse.gov/ondcp/news-releases-remarks/senate-intl-narcotics-caucus-statement-rx-drug-abuse>).

The Director also notes, “It is these pain relievers that are behind many of the negative consequences of prescription drug abuse. In fact, data indicate a six-fold increase in addiction treatment admissions for individuals primarily abusing prescription painkillers from 1999 to 2009.^[4] These increases span age groups, gender, race, ethnicity, education, employment level, and region.”

The Response

With the support of state agencies and entities (i.e., law enforcement, legislators, judiciary), the medical community (i.e., pharmacists, physicians, nursing) and local communities, efforts to prevent prescription drug abuse/misuse in Montana have been identified and gradually implemented since 2009. As noted earlier, the initial leadership was provided by the AG’s Office within the Department of Justice.

The mission of the Department of Justice is “to pursue activities and programs that seek to ensure and promote the public interest, safety, and well-being through leadership, advocacy, education, regulation and enforcement¹⁷. Within this mission, Goal 1 is to: *Promote public policy that is in the best interests of the citizens we serve*. The first two Objectives to meet this goal are to:

1. Reduce prescription drug abuse and misuse, thereby reducing the threat to public health and safety.
2. Reduce drunk and drugged driving in Montana, particularly the number of repeat DUI offenders, making our highways safe.

The plan to address Objective 1 was the responsibility of the Prescription Drug Abuse Advisory Council¹⁸. The twenty-member Council included legislators, law enforcement, pharmacy, judicial system, physicians and nursing, student council, and the coordinator of the DPHHS Suicide Prevention program. The role of the Council was to advise the Attorney General on: 1) prevention strategies and policy solutions; 2) serve as a liaison to their communities to spread awareness; 3) identify potential partners to help spread the message; and 4) to examine Montana’s prevention efforts and make recommendations to improve them¹⁹.

The strategies used to operationalize Objective 1 targeted the environmental risks that are known to contribute to prescription drug misuse and abuse including: a) low perception of risk by the public; b) easy access to prescription drugs; c) lack of proper drug disposal process and mechanism; and d) insufficient law enforcement.

¹⁷ <https://doj.mt.gov/about/goals-objectives/>

¹⁸ <https://doj.mt.gov/2009/09/bullock-announces-prescription-drug-abuse-advisory-council/>

¹⁹ <https://doj.mt.gov/prescriptiondrugabuse/what-were-doing/>

Which drugs are abused?

- ❖ The drugs most commonly present in drug-related deaths in Montana are hydrocodone, oxycodone, methadone and Fentanyl, according to the Montana Attorney General’s office.
- ❖ Vicodin and Lortab contain hydrocodone, the most frequently prescribed opiate in the United States.
- ❖ OxyContin (“oxy”), Percodan and Percocet (“percs”) contain oxycodone, which treats pain, but has a long history of abuse. These are most popular among teens.
- ❖ Methadone is generally used to treat addiction to heroin and other opiates, but carries its own potential for abuse.
- ❖ Fentanyl, most often in the form of a patch, is a pain reliever 100 times more potent than morphine.

<https://doj.mt.gov/prescriptiondrugabuse/percs-oxys-sprinkles/>

The four strategies were:

1. *Public Education*
2. *Establish a Prescription Drug Monitoring Program (PDMP)*
3. *Safe disposal of unused and expired medications*
4. *Enhancing Law Enforcement's ability to address diversion as the source of prescription drugs*

1. *Public Education*: In September 2010 a statewide ad campaign and website, **invisibleepidemic.com**, was unveiled. The radio, television and print ads sought to raise awareness particularly among teens and parents, of the problems caused by the misuse, abuse and diversion of prescription drugs; the website provided additional information on how to talk with children and how to properly disposal of unused and outdated medications. It also provided links to treatment providers. Financing for broadcast and placement of the radio, television and print ads came from the generosity of corporations and private foundations, not public funds.²⁰

2. *Establish a Prescription Drug Monitoring Program (PDMP)*.

Legislation that would permit the establishment of a state-wide Drug Registry was successfully passed in 2011; HB83. The *Montana Prescription Drug Registry (MPDR)* monitors the prescribing and dispensing of controlled substances and enables doctors and pharmacists to track prescriptions, identify drug seekers, and provide better care for patients. The 2011 legislature is well remembered as being subject to political deadlocks, yet Montana passed HB 83 with overwhelming support.²¹ In doing so Montana became the 44th state to pass such a law.

The Registry website reports that the MPDR is being implemented in phases. “The MPDR began accepting prescription data from pharmacies on March 12, 2012. The Drug Registry will be sustained by the MT Board of Pharmacy. The program will ultimately be funded by fees collected from Montana practitioners who prescribe or dispense controlled substances. This includes all Physicians, Physician Assistants, Podiatrists, Advanced Practitioner Registered Nurses, Dentists, Optometrists, Pharmacists, and Naturopaths”.²²

According to the Montana Board of Pharmacy, “Providers who use the MPDR can determine whether their patients are receiving controlled substances prescribed or dispensed by other providers, thereby identifying individuals exhibiting drug seeking behavior or who may be diverting their prescription drugs for illegal use. The provider can then offer appropriate counseling and optimize the prescription drug care they

HB83: AN ACT CREATING A PRESCRIPTION DRUG REGISTRY; PROVIDING DEFINITIONS; ESTABLISHING PRESCRIPTION DRUG REPORTING REQUIREMENTS; PROVIDING FOR THE USE OF PRESCRIPTION DRUG REGISTRY INFORMATION; PROVIDING FOR FEES TO FUND THE PROGRAM; ALLOWING SANCTIONS AND PENALTIES; PROVIDING FOR IMMUNITY; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTION 37-7-101, MCA; AND PROVIDING AN EFFECTIVE DATE AND A

²⁰ Bullock Unveils invisibleepidemic.com; Press Release, 9/7/2010.

²¹ <http://data.opi.mt.gov/legbills/2011/Minutes/House/Exhibits/huh20a03.pdf>

²² http://bsd.dli.mt.gov/license/bsd_boards/pha_board/board_page.asp

offer to their patients”. As of June 1, over 650,000 prescriptions had been entered into the database.²³

3. *Safe disposal of unused and expired medications:* The AG’s Office has worked with local law enforcement, public health officials and community groups to establish permanent drop-boxes, state-wide; offered grant funding to assist local law enforcement agencies with establishing the drop boxes; and hosted Prescription Drug Take-Back Days on a regular basis to reduce the amount of unused medications in homes that can be diverted to illicit uses.

Since the summer of 2010, thousands of Montanans have turned in several tons of unwanted or expired prescription drugs through a series of statewide “take-back” days sponsored by the Montana Department of Justice, in coordination with local law enforcement and U.S. Drug Enforcement Agency (DEA). Additionally, the Montana Department of Justice launched a traveling Take-Back Tour in the spring of 2011, collecting hundreds of pounds of unwanted drugs from Browning to Baker — and points in between.

The following table, **Counties participating in Drop Box and Take-Back Initiatives** shows which of the top 30 counties, ranked as at-risk by the number of prescription drug deaths, have established Drop Boxes counties and have participated in the Take-Back Initiatives held in 2012. For example, Mineral County is ranked as having the highest average prescription drug death per 1,000 (2008-2010) and in July 2012, the town of Superior established a Drop Box to serve the county residents. In Beaverhead County, ranked 6th, established a Drop Box location in Dillon and participated in the April 2012, Take-Back Initiative. For a complete listing of counties that have participated in these strategies, please go to Appendix D.

4. *Enhancing Law Enforcement’s ability to address diversion as the source of prescription drugs:* “Preventing prescription drug addiction and keeping these powerful drugs out of the hands of addicts are important steps in cracking down on this epidemic. But prevention alone won’t clean out today’s dealers. For that we need law enforcement. The Justice Department’s Division of Criminal Investigation reports that almost half – 42 percent – of the drug cases agents handled in 2009 deal with prescription drug abuse, up from only seven percent just six years ago.”²⁴ In 2009, a six-person Drug Diversion Unit was funded to fight the rampant abuse of prescription drugs. The \$1,230,902 grant was awarded by the U.S Department of Justice and is funded by the American Recovery and Reinvestment Act.

The statewide team includes three investigators, a public outreach and education coordinator, a prosecutor available to handle cases throughout Montana and an administrative assistant. This unit has been responsible for and involved in public outreach with schools, law enforcement, and prevention coalitions giving presentations about the dangers of prescription drugs and making people around Montana aware of the Prescription Drop Boxes and Take-Back Days. Representatives from the Drug Diversion unit also participated on the Advisory Council to the Board of Pharmacy.

²³ http://bsd.dli.mt.gov/license/bsd_boards/pha_board/board_page.asp

²⁴ <https://doj.mt.gov/prescriptiondrugabuse/what-were-doing/>

Counties participating in Drop Box and Take-Back Initiatives

Key: The lower the number the higher the risk

County	Ranked on risk: Prescription drug death per 1,000 average 2008-2010	Population 2010	Reservations	County risk ranking across all health problems	Drop Box Locations n=15 (as of 7/16)	Take-Back Initiatives April 2012 n=36
MINERAL	1	4,223		moderate	Superior (new)	
PETROLEUM	2	494		high		
MUSSELSHELL	3	4,538		moderate		
BROADWATER	4	5,612		very high	Townsend (new)	
GOLDEN VALLEY	5	884		moderate		
BEAVERHEAD	6	9,246		very high	Dillon (new)	1 site
DEER LODGE	7	9,298		very high		1 site
GRANITE	8	3,079		lowest		
SHERIDAN	9	3,384	Ft. Peck	very high		
MISSOULA	10	109,299	Flathead	very high	Missoula	8 sites
CHOUTEAU	11	5,813	Rocky Boy's	moderate		
ROOSEVELT	12	10,425	Ft. Peck	very high		
FERGUS	13	11,586		moderate		
PARK	14	15,636		high	Livingston	1 site
RAVALLI	15	40,212		high	Hamilton	1 site
SILVER BOW	16	34,200		high	Butte	1 site
HILL	17	16,096	Rocky Boy's	very high	Malta	
WIBAUX	18	1,017		low		
MEAGHER	19	1,891		lowest	White Sulphur Springs	
CARBON	20	10,078		moderate		
SANDERS	21	11,413	Flathead	very high		
JEFFERSON	22	11,406		lowest		
BIG HORN	23	12,865	N. Cheyenne & Crow	very high		
LINCOLN	24	19,687		very high		
CASCADE	25	81,327		high	Great Falls	1 site; 2 sites on air force base
RICHLAND	26	9,746		low		
GLACIER	27	13,399	Blackfeet	high		1 site
LAKE	28	28,746	Flathead	high		1 reservation
WHEATLAND	29	2,168		moderate		1 site
DAWSON	30	8,966		high		

Recommendations for Planning

The following are areas that could be considered for enhancement in the 5-year strategic plan.

Leadership Opportunity: According to the Prescription Drug Abuse Awareness Program Coordinator, the Advisory Council has largely been disbanded as it completed the tasks assigned. At the time of the July interview with the Program Coordinator, there were no plans for future activities. There will be a new Attorney General in 2013 and it's unknown if Prescription Drugs will be a priority for the new AG. This provides an opportunity for new leadership in the prevention of prescription drug misuse and abuse and a new tack that complements the work of the Department of Justice and uses a public health model and strategies.

Expand Prevention Strategies: To date, the state-level prevention strategies have focused on controlling the drug supply; an important component of a comprehensive approach. Another essential step is to **educate prescribers** (including primary care physicians, internists, dentists, and orthopedic surgeons) in pain management, substance abuse and safe prescribing practices.

This strategy is endorsed by the *Prescription Drug Abuse Prevention Plan*. "Surveys of health care professionals and schools reveal significant gaps in education and training on pain management, substance abuse, and safe prescribing practices. For these reasons, the Administration continues to support mandatory prescriber education. [Two major resources needed for this strategy are legislation and curriculum.] Several states, including Iowa, Massachusetts, and Utah, now have mandatory prescriber education legislation. These laws require important education for health care providers and prescribers on the abuse potential of prescription medications and the best ways to deliver quality care while ensuring the safety of the patient and the general public. The HHS Substance Abuse and Mental Health Services Administration (SAMHSA) is providing training on prescription drug abuse for physicians both in person and online. On the Federal level, manufacturers of ER/LA opioids will be expected to provide educational materials and continuing education courses for prescribers. Also provide information that prescribers can use when counseling patients about the risks and benefits of opioid use."²⁵

²⁵ (Statement of Director Kerlikowske before the Senate Caucus on International Narcotics Control: "Responding to the Prescription Drug Abuse Epidemic", July 2012. <http://www.whitehouse.gov/ondcp/news-releases-remarks/senate-intl-narcotics-caucus-statement-rx-drug-abuse>).

Preventing suicide and attempted suicides in the general population, American Indians, Military Families and the LGBTQ populations

Severity of suicide and attempted suicide in Montana: The Problem

The EPI workgroup was charged with collecting data on the severity of suicide and attempted suicide in Montana. The reporting of suicide was part of the data snapshots broken down by age groups and by the high risk groups -- Military families, LGBTQ populations, and American Indians.²⁶ As noted earlier, state-level data were used as they were deemed more reliable, valid and accessible compared to county-level data.

The following discussion focuses primarily on rates of completed suicide. While measures of attempted suicide contributed to the priority rankings, data on and discussion about attempted suicides was minimal.

Accordingly, the EPI workgroup ranked **suicide and attempted suicide as the highest area of concern of all targeted mental and behavioral health areas**

- ❖ Highest risk populations: *high school/teenagers and adults, followed by young adults and university age adults.*
- ❖ *Suicide among Military families, LGBTQ populations and American Indians was not ranked as a priority by the EPI workgroup.*

The SPE members, particularly the Suicide Prevention Coordinator for Montana, the Montana Safe Schools Center representative and the Montana Army National Guard, struggled to understand how no priority was given for suicide and attempted suicide for American Indians and for Military families. These rankings were the subject of much discussion. Based on their perspectives, suicide and attempted suicide is clearly a problem in Montana for American Indians and Military families. Unfortunately there were no members who could speak with authority about the public health concerns of the LGBTQ populations, but members acknowledged there was more to be learned about this particular at-risk population.

The EPI workgroup reported a number of data challenges and some contributed to the rankings:

- ❖ there is “very little data connecting suicide to these groups [LGBTQ, Military families and American Indians]”
- ❖ “only national data are available on LGBTQ populations”
- ❖ “due to confidentiality issues, Public Health and Safety Division guidelines require that no data is publically released if the frequencies of cell sizes is less than five or calculation of rates are based on fewer than 20 events”
- ❖ the lower ranking for young adults and university aged adults “may reflect a lack of [suicide and attempted suicide] indicators specific to these ages”, and
- ❖ it is difficult to talk about the suicide data from a public health perspective as it is rarely cross-tabbed or linked with the other targeted health problems. For example, there are “very few data linkages between underage and adult problem drinking and suicide”.

²⁶ Suicide and Attempted Suicide Report can be found in Appendix E.

The ranking issue aside, the following table highlights some important characteristics and demographics associated with the rates of suicide in Montana that emerged from the EPI workgroup report. For example in the Montana Army National Guard, it appears that more suicides occur among those “who have never been deployed compared to those in theatre or returning veterans”. The table also shows that *for the general population, those aged 26 and older are at highest risk; within the American Indian population, those aged 19-25 year are at the highest risk and for the Military, those aged 26-30 are at highest risk*. Unfortunately nothing can be discussed about the LGBTQ community risk as there are no state-level data available.

All Montanans	American Indians	Military Families	LGBTQ
Where trend data were available for suicide measures, the rates/number have increased.	Average suicide rate for American Indians was 24.11 per 100,000 compared to 19.95 for Non-Indians (2000-2009)	Suicide rate for MT veterans was 46 per 100,000 (2003-2009)	No state-level specific statistics on suicide or attempted suicide among LGBTQ in Montana
Ranking of average suicide rate per 100,000, all races (2006-2010): ❖ 26+ age group: highest ❖ 19-25 year olds ❖ 10+ year olds ❖ 10-18 year olds: lowest	Ranking of average suicide rate per 100,000, by age (2006-2010): ❖ 19-25 year olds: highest ❖ 10-18 year olds ❖ 10+ year olds ❖ 26+age group: lowest	At-risk groups: ❖ 26-30 year olds: highest number of suicides (2011) ❖ 31-35 year olds next highest number (2011) ❖ 18-44 year olds with depression diagnosis (2011) ❖ Those never deployed	

Another important source of information about the severity of suicide and attempted suicide in Montana is from the *Montana Strategic Suicide Prevention Plan, 2013*.²⁷ The following discussion describes what is known about the severity of suicide and attempted suicide for American Indians, Military families, the LGBTQ population and for all age groups in Montana. It also includes the risk factors that can contribute to suicide; “Risk factors are long standing conditions, stressful events, or situations that may increase the likelihood of a suicide attempt or death” (p.20).

American Indians: According to the *Montana Strategic Suicide Prevention Plan, 2013 (p.11)*

The highest rate of suicide in Montana is among American Indians. The rate is 27.2 per 100,000. American Indians are 6% of MT's population. Caucasians have the second highest rate at 22.2 per 100,000. They are 90% of the state population (2009 data)

²⁷ Montana Department of Public Health and Human Services (2013). *Montana Strategic Suicide Prevention Plan*. <http://prevention.mt.gov/suicideprevention/StateSuicidePlan.pdf>

In order to better understand this public health problem, the following table shows the average suicide rates, per 100,000 people, for each of the seven reservations in Montana (2001-2010). These data are derived from the Montana DPHHS, Office of Vital Statistics.²⁸

The table below rank orders the 2001-2010 data by the *crude rate for all ages*, going from highest rate to the lowest rate. The crude rate is the average rate without taking into account age-adjustment.

Primary County	Reservation	All ages	15-24 year olds	25-34 year olds	35-44 year olds	55-64 year olds
Roosevelt	Ft. Peck	37.4 (24)	82.6	56.1	68.2	
Blaine	Ft. Belknap	36.3 (10)	32.5	83.7	53.7	
Rosebud	Northern Cheyenne	31 (10)	63.9	55.9	26.9	
Lake	*CSKT	29.2 (20)	48.5	47.7	49.2	75.8
Glacier	Blackfeet	25.9 (21)	38.5	78.4	37.3	
Hill	Rocky Boy's	24.8 (8)	44.4	44.3	24.3	56.1
Big Horn	Crow	19.1 (13)	40.8	30.1	20.9	
MONTANA	All people	25.2	41	44.8	41.2	

*CSKT: Confederate Salish Kootenai Tribes

As the table indicates, the Ft. Peck Nation had the highest overall crude rate of suicide *for all ages* with 37.4 suicides per 100,000 and the Crow Nation registered the lowest rate, with 19.1 suicides per 100,000. This compares to the MT average of 25.2 suicides for this same 10 year period.

The table also highlights what age groups had the highest rate of suicide for each specific reservation. For example, during this time period an average of 83.7, 25-34 year olds completed suicides on the Fort Belknap reservation.

It's important to note that, "The small population of American Indians residents in Montana results in highly variable rates by year. A small increase in the actual numbers of deaths can have, what appears to be, a catastrophic impact on the rate for that year". [However even taking this into account,] American Indians in Montana have the highest rate of suicide in the state" (State plan; p. 14).

Risk factors associated with suicide: According to the state prevention plan, "Specific risk factors for American Indian communities contribute to the suicide rates for this population. These include high unemployment rates, substance abuse, alienation and varying cultural views on suicide. A major issue among the American Indian communities is the separation taking place between generations. Traditionally, the youth have looked towards the tribal elders for guidance and identity. However, in recent generations, there has been a breakdown in this guidance. Subsequently, American Indian youth appear more hopeless and unsure of their place in their culture. This may contribute to the high number of suicides among American Indian youth" (State Plan, p. 15).

"Risk factors do not cause suicide, but when many factors are present, these may increase an individual's vulnerability".

²⁸ Email from Suicide Prevention Coordinator, 11/24/2012. American Indian, Montana Resident, Suicide Rates, 2001-2010. Montana DPHHS, Office of Vital Statistics, Feb, 2012.

Military Families: The low ranking, by the EPI workgroup, for the Military families may be in part, explained by the paucity of reliable data. As noted earlier, a SPE member explained that the Department of Defense states that 75% of “suicides” are still under investigation and the data cited by the CDC is not current; it’s from 2009.

On the federal level, there is a push to coordinate and track reliable suicide data through the Department of Defense (DoD), Veteran’s Affairs (VA), Military, and the Center for Disease Control (CDC). Each federal agency keeps only a piece of information. Because of status changes throughout a soldier’s career span and the varying government entities involved before, during and after active duty, transferability of information is not cohesive. For example, until recently, the DoD only kept active duty personnel suicide data, and fewer than half of the states recorded military service on their death certificates. This has shifted to a more comprehensive approach to addressing suicide for soldiers. The DoD now publishes monthly military-related suicides and has hired more behavioral health workers to address suicide prevention, and to support members and their families. Montana’s large proportion of military veterans in the state could benefit from these new policies and resources in the coming years.

Until recently, the Montana suicide prevention plan did not include specific rates of suicide among the military veterans. According to the State Coordinator, the reason for this paucity of data is related to the fact that it’s only been “recently [that] they added [suicide] to the official death certificate whether the person was in the military or not”. The most recent plan includes those rates (p. 32).

“Between 2002 and 2011, there were 460 suicides by Montana veterans of all ages, which gives Montana veterans an estimated rate of 53 per 100,000”

The plan also reports that “Montana has more than 100,000 veterans or nearly one person in every 10. Montana had the highest recruitment in the nation per capita into the U.S. Army in 2004 and 2005. Montana has more than 700 Army National Guard Soldiers between the ages of 18 and 24 who have been deployed to date for both CONUS [Continental United States] and OCONUS (Outside the Continental United States) missions in support of OIF [Operation Iraqi Freedom] and OEF [Operation Enduring Freedom]”, p. 32). The implications of this demographic information is that within communities across Montana there are high populations of Veterans who are at an even higher risk of suicide than the general population, which is already at a high risk.

The following table shows the crude rate of suicide, across age groups of Veterans from 2002 to 2011. Based on these available data, the age groups with the highest rates are the youngest and the oldest age groups for Montana Veterans. It’s important to recognize that these data do not capture the 18 to 24 age range.

Suicide among Montana Veterans, 2002-2011

Age Groups	25-34	35-44	45-54	55-64	65-74	75-84	85+
Number of Suicides	34	45	76	109	68	75	41
Population	54,721	88,491	129,579	226,914	179,268	135,921	41,449
Crude Rate (>20 events)	62.1	50.9	58.7	48.0	37.9	55.2	98.9

Crude Rate: the number of deaths divided by the total population.

Risk factors associated with suicide: Based on national research of Veterans, the risk factors associated with increased chances of suicide for Military families include: 1) lack of easy access to health care, 2) depression, and 3) depression and substance abuse problems.

LGBTQ Populations: The EPI workgroup reported there were *no state-level data sources that had specific statistics on suicide or attempted suicide among LGBTQ in Montana.*

Paucity of LGBTQ data could suggest a *cultural competency* problem with current data collection systems.

Consequently, the state suicide prevention plan does not include specific rates of suicide for this population. The plan notes that “there is little research concerning how much [thoughts of suicide and sexual orientation is] a factor in Montana”. Even determining the number of gay and lesbian youth living in Montana is challenging. However, according to a report from the Williams Institute (Gates, 2006), as of 2005, there were 1,600 same-sex couples in Montana, up from 1,200 in 2000. This number is considered to be significantly lower than the actual number, especially since this number does not include youth. This study indicated that there were a similar number of same-sex male couples (806) as there were same-sex female couples (853). The report estimated that 2.6% of Montana’s population was gay, lesbian, or bisexual. Based on the Montana’s 2011 estimated population (US Bureau of the Census, www.census.gov), this equates that the gay, lesbian, or bisexual adult population in Montana is just under 26,000” (p. 44).

Risk factors associated with suicide for the LGBTQ community: Based on national data cited in the state prevention plan, risk factors include:

- ❖ Previous suicide attempt
- ❖ Suicidal behavior among friends
- ❖ Mental illness (depression, anxiety)
- ❖ Substance abuse
- ❖ Family dysfunction (parental alcoholism, domestic violence, divorce)
- ❖ Identity conflict or identity confusion
- ❖ Interrupted social ties or lack personal support networks (including rejection by family)
- ❖ Social inequity (limited social and legal protection, hostile school or work environment, physical and verbal victimization, harassment and persecution)
- ❖ High levels of depression and alcohol abuse

Suicide across all age groups in Montana: According to the state prevention plan, *Montana has the highest rate of suicide, for all age groups, in the United States* (based 2009 data, p. 11).

In Montana, between 1999 and 2009, suicide was the *number two cause of death* for children ages 10-14, adolescents ages 15-24, and adults ages 25-34 (CDC, 2012).

When all ages are combined, suicide is ranked the *9th leading cause of death* for Montanans.

However, when those rankings are examined across age groups, the risk for suicide becomes an obvious public health issue, from adolescence throughout the life span, as illustrated in the following table.

Montana Suicide Rates by Age Group, 2010-2011

Age Groups	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
# Suicides	57	75	62	88	91	36	23	15
Population	270,303	248,150	224,537	294,568	284,722	165,464	92,658	40,955
Crude Rate (>20 events)	21.1	30.2	27.6	29.9	32	21.8	24.8	#
Age Adjusted Rate (> 20 events)	27.3	37.9	35.4	36.8	39.2	30.1	37.2	#

Note: # indicates there were less than 20 incidents and a rate is not reported when the n < 20 cases.

Risk factors associated with suicide for all ages:

According to the National Strategy of Suicide Prevention (2001), the following are the socio-cultural and environmental risk factors that can increase a person’s vulnerability for suicide.

Socio-cultural risk factors

- ❖ Lack of social support and sense of isolation
- ❖ Stigma associated with help-seeking behavior
- ❖ Barriers to accessing health care, especially mental health and substance abuse treatment
- ❖ Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- ❖ Exposure to, including through the media, and influence of others who have died by suicide

Environmental risk factors

- ❖ Job or financial loss
- ❖ Relational or social loss
- ❖ Easy access to lethal means
- ❖ Local clusters of suicide that have a contagious influence

Risk factors have also been identified for specific age groups including the young and the elderly (for a complete list, please refer to the state plan).

The following are *risk factors for the young*²⁹

Family risk factors	Environmental risk factors	Behavioral risk factors
<ul style="list-style-type: none"> ❖ Family history of suicide (especially a parent) ❖ Changes in family structure through death, divorce, re-marriage, etc. ❖ Family involvement in alcoholism ❖ Lack of strong bonding/attachment within the family, withdrawal of support ❖ Unrealistic parental expectations ❖ Violent, destructive parent-child interactions ❖ Inconsistent, unpredictable parental behavior ❖ Depressed, suicidal parents ❖ Physical, emotional, or sexual abuse 	<ul style="list-style-type: none"> ❖ Access to lethal means ❖ Frequent mobility ❖ Religious conflicts ❖ Social isolation/alienation or turmoil ❖ Exposure to a suicide of a peer ❖ Anniversary of someone else's suicide ❖ Incarceration/loss of freedom ❖ High levels of stress; pressure to succeed ❖ Over-exposure to violence in mass media 	<ul style="list-style-type: none"> ❖ One or more prior suicide attempt(s) ❖ Alcohol/drug abuse ❖ Aggression/rage/defiance ❖ Running away ❖ School failure, truancy ❖ Fascination with death, violence, Satanism

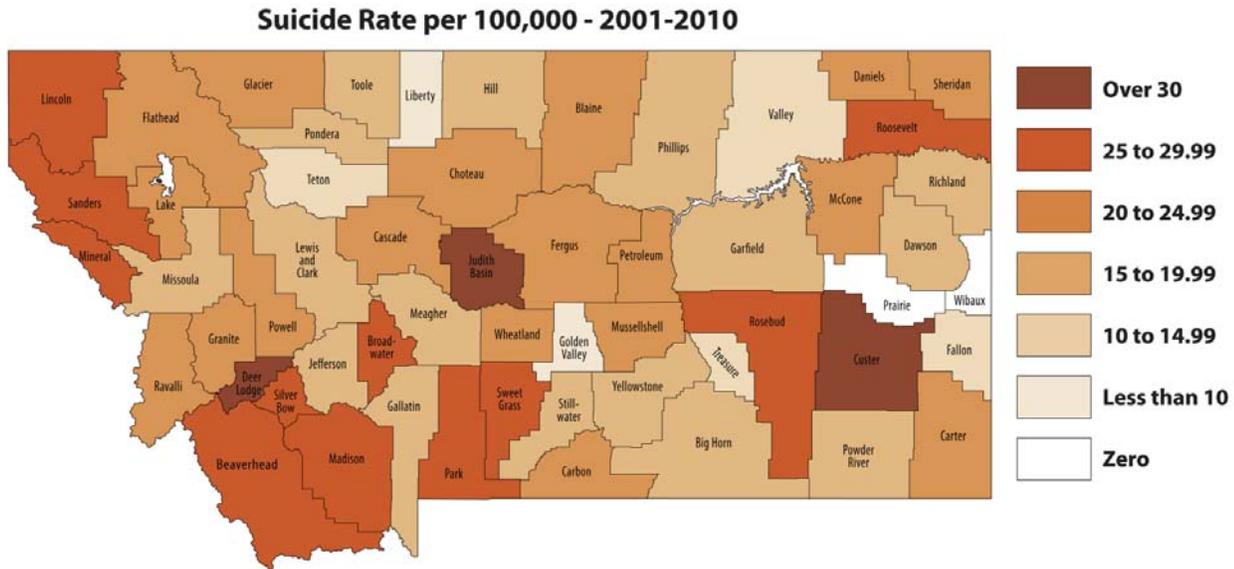
Personal risk factors
<ul style="list-style-type: none"> ❖ Mental illness/psychiatric conditions such as Depression, Bipolar, Conduct and Anxiety disorders ❖ Poor impulse control ❖ Confusion/conflict about sexual identity ❖ Loss of significant relationships ❖ Compulsive, extreme perfectionism ❖ Lack of skills to manage decision-making, conflict, anger, problem solving, distress, etc. ❖ Loss (or perceived loss) of identity, status ❖ Feeling powerless, hopeless, helpless ❖ Victim of sexual abuse ❖ Pregnancy or fear of pregnancy ❖ Fear of humiliation

Understanding the risk factors involved helps target prevent planning efforts. “Risk factors can be divided into those that can be changed and those that cannot be changed to reduce a person’s risk of suicide. *Some changeable risk factors include; substance abuse, exposure to bullying and violence, and development of resiliency and problem-solving skills.* Factors that cannot be

²⁹ Maine Youth Suicide Prevention Program, 2006, created through the Maine Department of Health and Human Services and by the Montana Strategic Suicide Prevention Plan Work Group, 2008

changed include age, gender, and genetics. *While it's not possible to change any of these factors, it's important to be aware of the increased risk for suicide that these factors present.*

The county level measure of the “consequences” of this behavior was: suicide rate per 100,000 averaged 2001-2009.



This figure shows the suicide rate for all 56 counties in Montana. As indicated, the northwestern portion of the state trends toward a higher rate of suicide. A closer examination of the counties also reveals that most of the counties with the highest rates of suicide are fairly small and relatively isolated, with higher than average unemployment and negative population growth.

As reported earlier, counties were ranked from 1 to 56 depending how high they rated on this measure. A rating of 1 meant that particular county had the highest death rate per 1,000 across the 56 counties. The following table shows the top 30 counties as well as the population size of the county, the reservations that traversed these counties and the overall risk ranking (relative to all the counties in the state across all health problems). A complete listing of the counties is provided in Appendix D.

Using the table on the following page, it's interesting to consider what is known about these communities that can contribute to these rates. One of the most well documented predictors related to high rates of suicide is isolation and a lack of connection to the local community. Isolation is compounded by easy access to lethal means (firearms), limited mental health services, socioeconomic factors, and a strong stigma concerning mental illness that exists throughout Montana. Judith Basin and Custer County rank second and third in suicide rates and are very isolated and sparsely populated counties. For example, Custer County covers 3,783 square miles, has a population of 11, 752 people, which equates to 3.1 people per square mile. Deer Lodge County, which has the highest suicide rate in the State, has a dwindling population, minimal economic growth, high unemployment, is isolated off the main highway, and access to lethal means are readily available.

Common means of suicide in MT

- ❖ 64% firearms
- ❖ 17% suffocation
- ❖ 15% poisoning
- ❖ 4%: Carbon monoxide poisoning; overdose; motor vehicle accidents; jumping from heights.

(State prevention plan, p. 16)

Severity of suicide in 56 counties and 7 reservations

Key: The lower the number the higher the risk				
County	Ranked on risk: suicide rate per 100,00 averaged 2001-2009	Population 2010	Reservations	County risk ranking across all health problems
DEER LODGE	1	9,298		very high
CUSTER	2	11,699		Moderate
JUDITH BASIN	3	2,072		Low
PARK	4	15,636		High
ROOSEVELT	5	10,425	Ft. Peck	very high
SANDERS	6	11,413	Salish/Kootenai	very high
SWEET GRASS	7	3,651		very high
BEAVERHEAD	8	9,246		very high
SILVER BOW	9	34,200		High
MADISON	10	7,691		High
LINCOLN	11	19,687		very high
ROSEBUD	12	9,233	N. Cheyenne	high
BROADWATER	13	5,612		very high
MINERAL	14	4,223		Moderate
FERGUS	15	11,586		moderate
WHEATLAND	16	2,168		moderate
CARTER	17	1,160		very low
MCCONE	18	1,734		low
SHERIDAN	19	3,384	Ft. Peck	very high
RAVALLI	20	40,212		high
MUSSELSHELL	21	4,538		Moderate
DANIELS	22	1,751	Ft. Peck	very low
GLACIER	23	13,399		high
LAKE	24	28,746	Salish/Kootenai	high
FLATHEAD	25	90,928	Salish/Kootenai	high
PETROLEUM	26	494		High
BLAINE	27	6,491	Ft. Belknap	low
CASCADE	28	81,327		high
GRANITE	29	3,079		very low
CHOUTEAU	30	5,813		moderate

Montana has many of the common environmental and social risk factors that increase vulnerability to suicide including geographic and social isolation, easy access to lethal means, limited access to health care, stigma associated with help seeking behavior, economic difficulties and unemployment, and high rates of other public health problems such as underage and adult problem drinking.

For example, Montana is the 4th largest state in the U.S., encompassing 147,042 square miles with the 3rd lowest population density and with many isolated communities. Another risk factor associated with this geographic and social isolation is the lack of easy and adequate access to mental and behavioral health care professionals. There are only three counties in the state that are not designated as federally recognized behavioral health care shortage areas, meaning 53 counties have a lower than average ratio of health care professionals per population. Compounding this challenge is: 1) the potent social stigma associated with seeking mental health services and concerns about maintaining confidentiality in small communities and 2) roughly 17% of the population has no health insurance.³⁰

Yet another important risk factor in Montana is the availability of lethal means, particularly firearms which account for 64% of the suicides in the state (compared to 50% nationally). In 2010, Montana was ranked as having the third highest number of guns per capita in the nation³¹. Access to means -- such as guns – plays a critical role in completed suicides. Understanding what counties have the most guns per capita maybe useful for planning purposes.

Assessment of current prevention efforts of state agencies

The online survey results indicate what state agencies are involved in preventing suicide and attempted suicide for youth, adults, American Indians, Military families and the LGBTQ population, and an overview of their prevention efforts.

Youth Suicide American Indian & Non-Indian	Adult Suicide American Indian & Non-Indian	Military Families	LGBTQ
5 state agencies	5 state agencies	2 state agencies	0 state agencies
4 community providers	4 community providers	1 community provider	1 community provider

As the table indicates, 9 of the 36 survey respondents work to prevent Youth suicide and 9 to prevent Adult suicide; 3 target Military families and 1 community provider reported serving the LGBTQ population “on a very limited basis but [we] recognize the increased risk”. Three of the non-agency entities were funded by block grant dollars, from the Addictive and Mental Disorders Division of DPHHS, to provide prevention services in communities and one was a partner with Youth Community Corrections.

Gender differences:
 Montana males were three times more likely than females to complete suicide (2010-2011).
 ❖ Males: 350 completed suicides
 ❖ Males: chose irreversible means such as firearms
 ❖ Females: 102 completed suicides
 ❖ Females: chose *reversible means* such as poison

³⁰ <http://prevention.mt.gov/suicideprevention/StateSuicidePlan.pdf>; p. 8.

³¹ <http://www.thedailybeast.com/articles/2010/06/28/states-with-the-most-guns.html> .

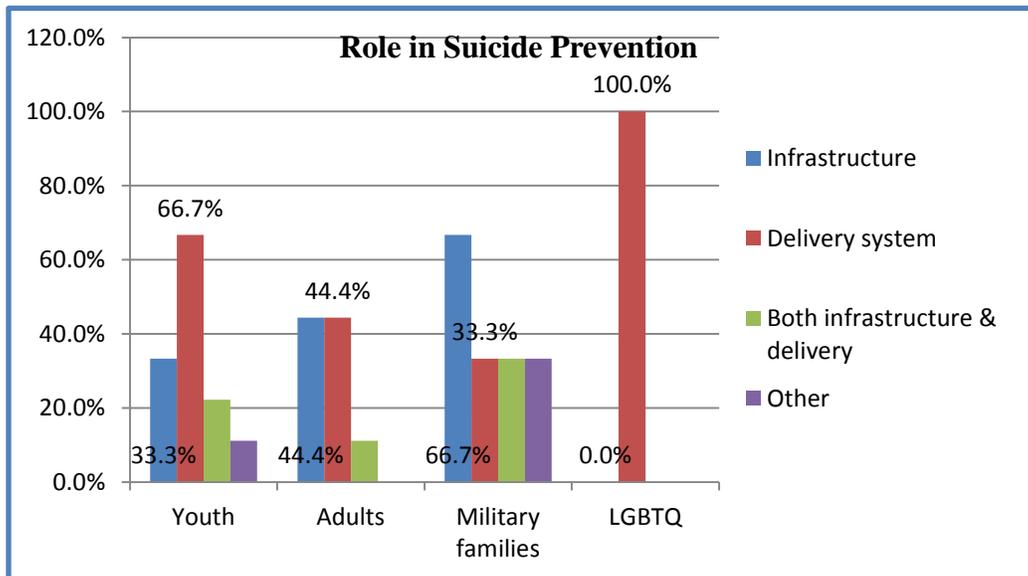
The state agencies included:

- ❖ DPHHS: Suicide Prevention Program
- ❖ Department of Corrections: Youth Community Corrections
- ❖ Montana Safe Schools Center, The University of Montana
- ❖ Montana Army National Guard
- ❖ DPHHS: the Addictive and Mental Disorders Division

Overview of Prevention Efforts:

The following summarizes: their roles in prevention for all groups; the goals and objectives of the prevention efforts; challenges experienced that impacted the ability to carry out prevention efforts; opportunities that contributed to the success of the prevention work; data collection activities and sharing of data. When reported, information related specifically to Military families, American Indians and LGBTQ is highlighted. It's important to remember that the data and discussion that follows is based on the data reported by these survey respondents. It is not a comprehensive account of prevention services available in the counties and reservations.

Roles: As the following graph indicates *the roles of respondents varied by the target population*. For example, activities such as delivering prevention programs to youth was reported by almost 67% of the respondents with only a third involved in infrastructure roles such as funding initiatives. This compares to serving Military families where the three respondents mainly worked on infrastructure, particularly requiring the use of evidenced based practices. For the one community provider that reported working with the LGBTQ population, the role related to delivering a gender based violence prevention program.



Note: Youth and Adults includes American Indians and non-Indians.

Infrastructure: funding prevention initiatives, collecting data and reporting on outcomes, requiring the use of evidence based practices.

Delivery: includes delivering prevention training to audiences; delivering prevention programs in schools or a community; using evidenced based programs, etc.

Goals: In general, the efforts divided into two categories: 1) *raising public awareness* about the risk and signs of suicide; and 2) *training professionals* to recognize the signs, to respond appropriately and to use evidenced based practices. For example, the goal of prevention efforts by the Montana Safe Schools Center was to provide “ASIST training to [reservation communities] ... and CBITS training to the school counselors on the reservation and funded them to conduct CBITS groups”.³²

Challenges and opportunities: In general, the challenges in successfully carrying out the prevention efforts related to *system issues* including insufficient staffing and financing, and *community beliefs and behaviors*. However, respondents also noted that efforts were enhanced by: 1) the level of *cooperation across agencies* at the state and local level; 2) additional *training* by other sources and with other funding; 3) access to valuable *resources* such as those offered through the Montana Suicide Prevention Network, the State Suicide Prevention Coordinator and the National Coalition Building Institute; and 4) changes in *policies and organizational structure* to facilitate prevention efforts for Military families.

Information about the geographic distribution of prevention efforts, the workforce involved, and the use of evidenced based and non-evidenced-based practices/programs/activities was also collected from respondents. The following tables depict these data.

Counties where prevention efforts occur: As the following table indicates, some level of prevention efforts occurred in all 56 counties during the last twelve months. Counties where efforts targeted a specific population are color-coded. For example, the green shading shows Missoula County as the sole site serving the LGBTQ population.

It’s important to note that prevention efforts are occurring in some of the locations that have the highest average rates of suicide. For example, nine of the counties, highlighted in the table, are in the top 25 counties with the highest average suicide rate (2001-2009). For example, Park County is ranked number 4 and Roosevelt County is ranked number 5. It’s also important to note that four of the reservations - Crow, Ft. Peck, Rocky Boy’s and Blackfeet - traverse counties where efforts are occurring. Two respondents clearly indicated working with the Rocky Boy’s, Ft. Peck and Blackfeet nations.

³² *Applied Suicide Intervention Skills (ASIST) Training* is for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide (<http://www.livingworks.net/page/Applied%20Suicide%20Intervention%20Skills%20Training%20>). *Cognitive Behavioral Intervention for Trauma in Schools (CBITS)* provides mental health screening and therapy sessions in schools to reduce a child's symptoms related to existing traumatic experiences and to enhance skills to handle future stresses (<http://www.rand.org/health/projects/cbits.html>).

Counties	% respondents	County Risk Ranking on Suicide	Color Key:
ALL 56 COUNTIES	44.4%	n/a	Youth
ALL 56 COUNTIES	44.4%	n/a	Adults
ALL 56 COUNTIES	66.7%	n/a	Military
Park County	11.1%	4	LGBTQ
Roosevelt County	11.1%	5	
Roosevelt County	11.1%		
Beaverhead County	11.1%	8	
Silver Bow County	11.1%	9	
Madison County	11.1%	10	
Broadwater County	11.1%	13	
Ravalli County	11.1%	20	
Ravalli County	11.1%		
Ravalli County	33.3%		
Glacier County	11.1%	23	
Glacier County	11.1%		
Flathead County	11.1%	25	
Flathead County	11.1%		
Missoula County	11.1%	33	
Missoula County	22.2%		
Missoula County	33.3%		
Missoula County	100.0%		
Hill County	11.1%	34	
Hill County	11.1%		
Meagher County	11.1%	47	
Big Horn County	11.1%	48	

Note: Youth and Adults includes American Indians and non-Indians.

The next table shows a *wide range of occupations* involved in preventing suicide and attempted suicide.

Workforce delivering prevention efforts

Employees/volunteers delivering programs, practices, activities	% respondents	Color Key:
Child, Family, and School Social Workers	100.0%	Youth
Child, Family, and School Social Workers	66.7%	Adults
Child, Family, and School Social Workers	22.2%	Military
Child, Family, and School Social Workers	22.2%	LGBTQ
Clergy associated workers	33.3%	
Clergy associated workers	11.1%	
Clergy associated workers	11.1%	
Coaches and Scouts	11.1%	
Educational, Guidance, School, and Vocational Counselors	22.2%	
Elementary, Middle, High School Teachers	33.3%	
Elementary, Middle, High School Teachers	11.1%	
Emergency Medical Technicians and Paramedics	11.1%	
Emergency Medical Technicians and Paramedics	11.1%	
Health Educators	33.3%	
Health Educators	33.3%	
Health Educators	22.2%	
Mental Health and Substance Abuse Social Workers	44.4%	
Mental Health and Substance Abuse Social Workers	33.3%	
Mental Health and Substance Abuse Social Workers	33.3%	
Mental Health Counselors	66.7%	
Mental Health Counselors	55.6%	
Mental Health Counselors	33.3%	
Other	22.2%	
Police and Sheriff's Patrol Officers	11.1%	
Police and Sheriff's Patrol Officers	11.1%	
Prevention Specialists	44.4%	
Prevention Specialists	44.4%	
Prevention Specialists	33.3%	
Probation Officers and Correctional Treatment Specialists	22.2%	
Probation Officers and Correctional Treatment Specialists	11.1%	
Registered Nurses	11.1%	
Social and Human Service Assistants	11.1%	
Substance Abuse Counselors	44.4%	
Substance Abuse Counselors	44.4%	
Substance Abuse Counselors	33.3%	
Volunteers	11.1%	
Volunteers	11.1%	

Note: **Youth and Adults** includes American Indians and non-Indians. **Other** – Youth/Adults: social work; sociology; psychology; educational faculty. Youth: service members; state staff; certified QPR trainers.

Employee/volunteer categories are linked to specific populations by color-coding. For example, it's clear that Child, family and school Social Workers are involved in delivering prevention programs, practices and activities across all the population groups. Clergy-associated workers are also involved with most of the groups. What these data suggest is *there is a broad range of people involved in efforts for most of the targeted groups but with little support for the LGBTQ population.*

Use of Evidenced-Based (EBPs) and Non-Evidenced-Based (Non-EBPs) prevention efforts

This next table shows the percentage of respondents who used EBPs and non-EBPs with the targeted population groups. For example, 78% of those focusing on preventing youth suicide use Evidence-Based programs, practices or activities targeted at the individual and 56% used Non-EBPs targeted at the individual. *Across all groups most efforts, both EBPs and Non-EBPs, have targeted individuals.* Some examples include Battle Buddies and ASIST with the military, and Reconnecting Youth and CAST³³ with youth.

Programs/Practices/Activities	% using EBPs	% using Non-EBPs	Color Key:
Target the individual	77.8%	55.6%	Youth
Target the school	33.3%	11.1%	Adults
Target the family	11.1%	11.1%	Military
Target the community	11.1%	22.2%	LGBTQ
NOT USE	11.1%	44.4%	
Target the individual	66.7%	77.8%	
NOT USE	33.3%	22.2%	
Target the school	22.2%	22.2%	
Target the family	11.1%	33.3%	
Target the community	11.1%	33.3%	
Target the individual	66.7%	100.0%	
NOT USE	33.3%	0.0%	
Target the individual	100.0%	100.0%	

Evidenced-Based: are practices, programs, activities listed on the Federal registry of evidence based interventions, with documented effectiveness for a target audience and documented effectiveness with a targeted outcome. *Non-Evidenced-Based:* practices, programs, activities that are effective and create change but are not listed on the Federal registry.

Data collection and sharing data: The final results from the online survey indicate what percentage of respondents collected implementation and outcome data, and shared those data. These results are depicted in the following three tables.

Implementation data: For all groups except the LGBTQ population, the vast majority of respondents reported collecting implementation data. For example, 67% of those involved in efforts targeting youth and adults reported collecting these types of data. The table also

³³ Coping and Support Training (CAST) is a school-based small group counseling program for at-risk youth that has demonstrated decreased suicide risk factors among other positive outcomes in adolescents.

shows that 56% of those who served Military families reported collected implementation data, but no data were collected by the one provider serving the LGBTQ population. Examples of the types of data collected included: numbers trained and number of Crisis Response Teams.

Percentage of respondents collecting implementation data

Answer Options	% respondents	Color Key:
YES	66.7%	Youth
YES	66.7%	Adults
YES	55.6%	Military
NO	33.3%	LGBTQ
NO	22.2%	
NO	22.2%	
NO	100.0%	
ONLY FOR SOME PROGRAMS/PRACTICES/ACTIVITIES	11.1%	
DON'T KNOW	11.1%	
DON'T KNOW	11.1%	

Percentage of respondents collecting outcome data

Answer Options	% respondents	Color Key:
YES	33.3%	Youth
YES	22.2%	Adults
YES	22.2%	Military
ONLY FOR SOME PROGRAMS/PRACTICES/ACTIVITIES	22.2%	LGBTQ
ONLY FOR SOME PROGRAMS/PRACTICES/ACTIVITIES	11.1%	
DON'T KNOW	11.1%	
DON'T KNOW	11.1%	
NO	100.0%	
NO	66.7%	
NO	55.6%	
NO	44.4%	

Note: Outcome data defined as progress in changing knowledge, attitudes, behavior & policies.

Outcome data: Only a small percentage collected outcome data; 33% of those who targeted the military and 22% of those who targeted youth and adults. Some examples included Law Enforcement surveys and post-testing after training.

Sharing data: As the next table shows, respondents shared data about their prevention efforts with a wide variety of recipients. The recipients varied by the population served. For example, those who served Military families shared information with community coalitions, the Department of Defense, legislators, the media, state agencies, and data was provided on

request. As can be expected, no data were shared by those who served the LGBTQ population because no implementation or outcome data were collected.

Percentage of respondents sharing information

Recipients	% respondents	Color Key:
Boards	44.4%	Youth
Boards	22.2%	Adults
Community Coalitions	66.7%	Military
Community Coalitions	44.4%	LGBTQ
Community Coalitions	33.3%	
Dept of Defense	33.3%	
Funding Agents	55.6%	
Funding Agents	44.4%	
Legislators	33.3%	
Legislators	33.3%	
Legislators	22.2%	
Media	55.6%	
Media	33.3%	
Media	33.3%	
Provided on request	55.6%	
Provided on request	44.4%	
Provided on request	33.3%	
Providers	44.4%	
Providers	44.4%	
Schools	44.4%	
Schools	33.3%	
Schools	33.3%	
State Agencies	66.7%	
State Agencies	44.4%	
State Agencies	33.3%	
NOT SHARED	100.0%	
NOT SHARED	33.3%	
NOT SHARED	22.2%	
NOT SHARED	22.2%	
OTHER	22.2%	
OTHER	22.2%	

In summary, these online survey data provide a snapshot of the prevention efforts currently undertaken by some of the agencies involved in the planning process. Not all SPE members completed a survey therefore it's not possible to provide a complete picture of all the efforts undertaken.

The Response

Up until 2000, Montana did not have a strategic suicide prevention plan that addressed suicide as a major statewide public health priority. In 2000, the Montana DPHHS helped create the Montana Suicide Prevention Steering Committee which led to Montana's initial statewide strategic plan that was published in 2001 and subsequently revised in 2005.³⁴

In the following years, a broad array of prevention strategies were undertaken to prevent and reduce the incidence of suicide and attempted suicide in Montana. Some examples are listed below. Please refer to previous plans and the 2013 plan for a complete listing.

Policy Response: In 2007, the Montana Legislature supported major legislation passing Senate Bill 478 creating a suicide prevention program through the Department of Public Health and Human Services with an annual budget of \$400,000 to go toward suicide prevention programs in the state. The bill also required additional support for a state suicide prevention hotline, a biennial suicide reduction plan, and the creation and revision of the state suicide prevention plan. Furthermore, money has since been allocated to increasing public awareness and creating a partnership with tribes and providing grants for new and existing prevention efforts. The fifth addition of the statewide plan is currently going through a public comment period and is available at: <http://prevention.mt.gov/suicideprevention/StateSuicidePlan.pdf>.

Training and Technical Assistance: To increase public awareness and concern around the issue of suicide

- ❖ The Suicide Prevention Coordinator has delivered innumerable trainings in the past two years to a variety of audiences, such as Detention Officers in county jails and Senior Care Givers.
- ❖ Over 12,000 people trained in QPR (Question, Persuade, Refer), and over 600 trained in ASIST around the state and on tribal lands.
- ❖ State-wide media campaigns have been launched on Bresnan Communication, the Montana Broadcaster's Association, Facebook and Cha Cha.
- ❖ Suicide prevention webinars were provided to physicians and emergency room staff in 27 Montana hospitals.
- ❖ Trained 200 *Comprehensive School and Community Treatment* (CSCT) school staff across the state.
- ❖ Coordinated with the Department of Revenue, Liquor Control, to provide training to bartenders and liquor distributors on recognizing the signs of suicide and who to call in the event one should suspect a possible suicide attempt.
- ❖ Crisis Intervention Training for over 600 law enforcement officers and first responders.
- ❖ A basic mental health course has been added to the core curriculum at the Montana Law Enforcement Academy.
- ❖ Suicide assessment software was sent to all licensed psychiatrists in the state.
- ❖ Core competency training for 105 therapists working with suicidal clients.
- ❖ Suicide Prevention Toolkit for Rural Primary Care Providers in 120 medical clinics and available, at no cost, at www.prc.mt.gov/suicideprevention.

³⁴ http://www.archive.org/stream/8831502C-87B2-4B21-9BBC-A30F70D811C3/8831502C-87B2-4B21-9BBC-A30F70D811C3_djvu.txt

Activities targeting American Indian, Military Families and LGBTQ populations

The plan also highlights some specific prevention activities that address suicide in two of the targeted populations.

American Indian

- ❖ Over 1,500 people in communities and reservations trained in ASIST (Applied Suicide Intervention Skills Training).
- ❖ By 2013, provide gatekeeper (QPR, ASIST) curriculum to 50% of Montana's American Indian population on reservations as measured by Planting Seeds of Hope.

Military Families

- ❖ Disseminate suicide awareness postcards to Veterans (over 102,000) in the state.
- ❖ Provide statewide webinars to all VAs on the treatment of suicidal and PTSD veterans.

LGBTQ Populations

The Plan does not identify any activities targeted to the LGBTQ populations, however it does raise awareness about the severity of the problem.

While the number of specific activities are few, it may be assumed that many of the universal prevention strategies may also apply to these specific populations. It's also probable, that the plan reflects the state of the research at this time. That is, the best that can be done is to describe what is known about the risk to these populations; the culturally appropriate strategies to prevent suicide and attempted suicide are probably still under development.

Culturally competent activities: A special example of a culturally appropriate activity, being used in Montana, addresses the risk of easy access to firearms. As noted earlier, 64% of suicides in Montana involve the use of a firearm. Firearms are particularly dangerous because of their relationship with impulsive behavior and therefore carry the highest rate of suicide completion of all attempted methods. In Montana, the prevention plan takes the approach of promoting gun safety; emphasizing the safe storage of weapons that also reduces easy access to weapons. Research at the Harvard School of Public Health has shown that gun locks and gun safes can be the difference between life and death.³⁵

The Montana Suicide Prevention Program is promoting a firearm safety program aimed at protecting and promoting the safe use of firearms. Nearly 5,000 of the high quality combination locks have been distributed to a number of county health departments and Planting Seeds of Hope. The locks have been handed out at various community settings including community music events, hunter safety courses, home health care visits, tribal events, and child care organizations. The target populations are families with children who have unprotected firearms in the home. The program, in its second year, has been nationally recognized by the Suicide Prevention Resource Center.

³⁵ <http://www.hsph.harvard.edu/means-matter/means-matter/>

Preventing/reducing the consequences of underage drinking and adult problem drinking

Severity of the consequences of underage drinking and adult problem drinking: The Problem

The EPI workgroup was charged with collecting data on the severity of underage drinking and adult problem drinking and the consequences. The data snapshots were broken down by age groups; high school/teenagers, young adults/university students and adults.³⁶ As noted earlier, state-level data were used as they were deemed more reliable, valid and accessible compared to county-level data.

To fully understand this public health concern a comprehensive list of data points were examined and from this list, the following indicators were identified as areas of concern for the respective age groups:

- ❖ **Rates of drinking** by high school/teenagers; young adults/university age; adults (30 day & binge drinking)
- ❖ **Approval of underage drinking**; high school/teenagers
- ❖ **Drinking and driving**: high school/teenagers; young adults/university age; adults
- ❖ **Minor in Possession case files**: young adults/university age
- ❖ **Liquor law violations**: young adults/university age
- ❖ **Alcohol-related crashes and fatalities**: adults
- ❖ **DUI offenses and convictions**: adults
- ❖ **Needing but not receiving treatment** for alcohol use: adults
- ❖ **Adult alcohol dependence or abuse**, past year
- ❖ **Adults treated for alcohol abuse only**

According to the EPI workgroup, the priority ranking for consequences of drinking is:

- ❖ Highest risk population: **young adults and university age adults**
- ❖ Second highest risk population: **high school/teenagers**, then
- ❖ **Adults**

These priority rankings raise awareness about the severity of underage and adult problem drinking by university-aged students (including those aged under 25 years, but not necessarily at university). The EPI data and recommendations will be used in developing the strategic plan.

The county level measures of the “consequences: underage and adult problem drinking included:

- ❖ DUIs per 1,000 residents averaged; 2005-2011
- ❖ Liquor law violations per 1,000 averaged; 2005-2011
- ❖ % of car crashes involving alcohol averaged; 2005 – 2009

The following tables show the results of the top 30 counties and the reservations.³⁷

³⁶Snapshots for all age groups can be found in Appendix E.

³⁷ A complete listing of counties is provided in Appendix D.

Consequence of underage and adult problem drinking: DUIs across 56 counties and 7 reservations

Key: The lower the number the higher the risk				
County	DUIs per 1,000 residents average 2005-2011	County risk ranking across all health problems	Population 2010	Reservations
SWEET GRASS	1	very high	3,651	
HILL	2	very high	16,096	Rocky Boy's
BIG HORN	3	very high	12,865	N. Cheyenne & Crow
CASCADE	4	high	81,327	
MISSOULA	5	very high	109,299	Flathead
DAWSON	6	high	8,966	
LINCOLN	7	very high	19,687	
FLATHEAD	8	high	90,928	Flathead
BEAVERHEAD	9	very high	9,246	
GALLATIN	10	moderate	89,513	
SILVER BOW	11	high	34,200	
ROSEBUD	12	high	9,233	N. Cheyenne
VALLEY	13	moderate	7,369	Ft. Peck
LEWIS & CLARK	14	moderate	63,395	
SHERIDAN	15	very high	3,384	Ft. Peck
CUSTER	16	moderate	11,699	
CARBON	17	moderate	10,078	
ROOSEVELT	18	very high	10,425	Ft. Peck
BROADWATER	19	very high	5,612	
PRAIRIE	20	lowest	1,179	
RICHLAND-	21	low	9,746	
SANDERS	22	very high	11,413	Flathead
MINERAL	23	moderate	4,223	
RAVALLI	24	high	40,212	
STILLWATER	25	low	9,117	
FALLON	26	lowest	2,890	
LAKE	27	high	28,746	Flathead
PONDERA	28	low	6,153	
MADISON	29	moderate	7,691	
PARK	30	moderate	15,636	

**Consequence of underage drinking: Liquor Law Violations across 56 counties and 7 reservations
(the vast majority are MIP [Minor in Possession] violations)**

Key: The lower the number the higher the risk				
County	Liquor law violations per 1,000 average 2005-2011	County risk ranking across all health problems	Population 2010	Reservations
BEAVERHEAD	1	very high	9,246	
MISSOULA	2	very high	109,299	Flathead
HILL	3	very high	16,096	Rocky Boy's
DAWSON	4	high	8,966	
VALLEY	5	moderate	7,369	Ft. Peck
ROOSEVELT	6	very high	10,425	Ft. Peck
CASCADE	7	high	81,327	
LEWIS & CLARK	8	moderate	63,395	
BIG HORN	9	very high	12,865	N. Cheyenne & Crow
CUSTER	10	moderate	11,699	
FALLON	11	lowest	2,890	
GARFIELD	12	low	1,206	
WIBAUX	13	low	1,017	
FLATHEAD	14	high	90,928	Flathead
SWEET GRASS	15	very high	3,651	
PHILLIPS	16	low	4,253	Ft. Belknap
ROSEBUD	17	high	9,233	N. Cheyenne
LINCOLN	18	very high	19,687	
RICHLAND-	19	low	9,746	
RAVALLI	20	high	40,212	
GALLATIN	21	moderate	89,513	
STILLWATER	22	low	9,117	
CHOUTEAU	23	moderate	5,813	Rocky Boy's
SILVER BOW	24	high	34,200	
PRAIRIE	25	lowest	1,179	
DANIELS	26	lowest	1,751	Ft. Peck
YELLOWSTONE	27	low	147,972	
MCCONE	28	low	1,734	
SHERIDAN	29	very high	3,384	Ft. Peck
GLACIER	30	high	13,399	Blackfeet

Consequence of underage and adult problem drinking: % car crashes involving alcohol across 56 counties and 7 reservations

Key: The lower the number the higher the risk

County	% of car crashes involving alcohol average 2005 - 2009	County risk ranking across all health problems	Population 2010	Reservations
ROOSEVELT	1	very high	10,425	Ft. Peck
GARFIELD	2	low	1,206	
GLACIER	3	high	13,399	Blackfeet
GOLDEN VALLEY	4	moderate	884	
BIG HORN	5	very high	12,865	N. Cheyenne & Crow
BLAINE	6	low	6,491	Ft. Belknap
LAKE	7	high	28,746	Flathead
SANDERS	8	very high	11,413	Flathead
CARBON	9	moderate	10,078	
PETROLEUM	10	high	494	
DEER LODGE	11	very high	9,298	
MUSSELSHELL	12	moderate	4,538	
MADISON	13	moderate	7,691	
WHEATLAND	14	moderate	2,168	
MCCONE	15	low	1,734	
BEAVERHEAD	16	very high	9,246	
LINCOLN	17	very high	19,687	
SHERIDAN	18	very high	3,384	Ft. Peck
TOOLE	19	low	5,324	
HILL	20	very high	16,096	Rocky Boy's
PHILLIPS	21	low	4,253	Ft. Belknap
PONDERA	22	low	6,153	
VALLEY	23	moderate	7,369	Ft. Peck
FLATHEAD	24	high	90,928	Flathead
MEAGHER	25	lowest	1,891	
LIBERTY	26	lowest	2,339	
SWEET GRASS	27	very high	3,651	
WIBAUX	28	low	1,017	
YELLOWSTONE	29	low	147,972	
RICHLAND	30	low	9,746	

A review of the data from these three tables indicate some interesting facts to consider from a public health perspective For example,

- ❖ Big Horn County is listed in the top 12 counties at highest risk for all three measures: DUIs, Liquor Law violations and percentage of car crashes.
- ❖ Beaverhead, Cascade, Dawson, Hill and Missoula counties are listed in the top 12 counties for DUIs and Liquor Law violations.
- ❖ Garfield and Roosevelt counties are listed in the top 12 counties for Liquor Law violations and percentage of car crashes involving alcohol.
- ❖ 92% of the top 12 counties for DUIs were also ranked as very high risk or high risk for all the targeted mental and behavioral health problems.
- ❖ 58% of the top 12 counties for Liquor Law violations were also ranked as very high risk or high risk for all the targeted mental and behavioral health problems.
- ❖ 58% of the top 12 counties for percentage of car crashes involving alcohol were also ranked as very high risk or high risk for all the targeted mental and behavioral health problems.

Alcohol use is a primary risk factor for the three leading causes of death among youth: 1) unintentional injuries (including motor vehicle crashes and drowning), 2) suicides, and 3) homicides. In Montana in 2008, nearly **one in five injuries** occurring in a motor vehicle accident was **alcohol-related**. (Turner & Associates, 2011)

In Montana, the consequences of underage drinking and adult problem drinking are addressed by multiple state agencies, using a variety of prevention and intervention strategies. This is a well recognized public health concern. At this stage there is no unified approach to preventing or reducing the consequences, however, there is evidence of agencies coming together to discuss the issues, identify common goals and coordinate prevention activities; particularly addressing underage drinking. For example, in October 2010, the Montana Office of Public Instruction (OPI) partnered with the Montana Department of Public Health and Human Services to launch the Montana Substance Abuse and Violence Prevention Workforce. “The Task Force includes 30 members representing a broad cross-section of state public and nonprofit agencies whose work promotes the health and safety of Montana students”.³⁸ One of the goals of the Task Force is to “maintain a state prevention infrastructure”. The ICC workgroup has also targeted the younger age groups and their work is highlighted in this document.³⁹

At this stage, not enough is known about the coordinated prevention efforts that target the consequences of drinking by university-aged students and adults. Certain information is revealed in the online survey completed by some of the SPE members, however more information needs to be gathered from the relevant agencies during Phase II.

³⁸ Turner and Associates (2011). Montana Youth Substance Abuse and Violence Assessment Report. http://opi.mt.gov/Programs/TitlePrgms/SafeSchools/#gpm1_1.

³⁹ The list of member agencies is provided in Appendix B.

Assessment of current prevention efforts of state agencies

The online survey results indicate what state agencies are involved in preventing/reducing the consequences of underage and adult problem drinking.

Thirty-five survey respondents reported their agency/entity had been involved in prevention/reduction activities in the last year. The respondents represented six agencies and thirteen community providers. Twelve of the non-agency entities were funded by block grant dollars, from the Addictive and Mental Disorders Division, to provide prevention services in communities.

The state agencies included:

- ❖ DPHHS: Chronic Disease Prevention and Health Promotion Bureau
- ❖ DPHHS: The Prevention Resource Center
- ❖ DPHHS: Addictive and Mental Disorders Division
- ❖ Department of Corrections: Youth Community Corrections
- ❖ Department of Justice, Montana Board of Crime Control
- ❖ Montana Safe Schools Center, The University of Montana
- ❖ Montana State University
- ❖ Montana Army National Guard

Overview of Prevention Efforts:

The following summarizes: their roles in prevention for both underage and adult groups; the goals and objectives of the prevention efforts; challenges experienced that impacted the ability to carry out prevention efforts; opportunities that contributed to the success of the prevention work; data collection activities and sharing of data. It's important to remember that the data and discussion that follows is based on the data reported by these survey respondents. It is not a comprehensive account of prevention services available in the counties and reservations.

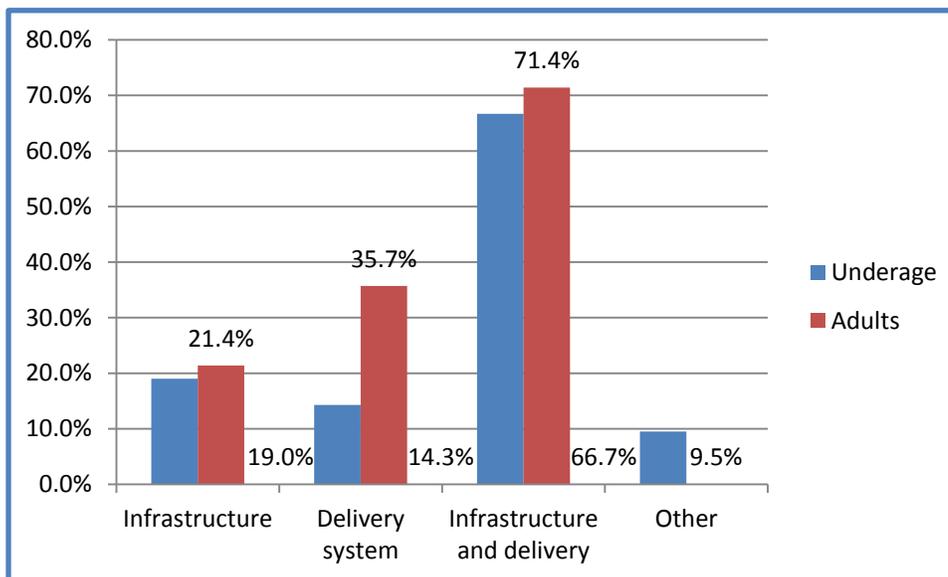
Roles: As the following graph shows, the majority of respondents indicated they were involved in *both infrastructure activities* such as funding prevention initiatives, and *the delivery system* such as delivering training. This held true for both underage and adult problem drinking; 67% targeting underage and 71% targeting the consequences of adult problem drinking.

Goals: In general, the efforts divide into four categories: 1) *raising public awareness* about the consequences of underage and adult problem drinking; 2) *policy work* to promote healthy behaviors; 3) *reducing access* to alcohol; and 4) *encouraging enforcement of laws*.

Examples of raising public awareness include: educating the public about the laws; holding Town Hall meetings about the severity and consequences of underage drinking; sharing Youth Risk Behavior (YRBS) survey and Montana Prevention Needs Assessment (MPNA) data with state agencies; educating health care providers in the use of the SBIRT toolkits to be used with adolescent patients; running positive media campaigns to address the high DUI and suicide rates and social norming media campaigns.

Examples of Policy work are: Social Host Ordinance development in local communities; working with prevention coalitions to promote responsible use by adults; and working with the tribal courts on strengthening and/or developing MIP policies.

Role in preventing/reducing the consequences of underage/adult problem drinking



Infrastructure: funding prevention initiatives, collecting data and reporting on outcomes, requiring the use of evidence based practices.

Delivery: includes delivering prevention training to audiences; delivering prevention programs in schools or a community; using evidenced based programs, etc.

Examples of reducing access to alcohol include: providing Responsible Alcohol Sales and Service (RASS) training to reduce alcohol sales to youth and to reduce over-serving to adults, and supporting the use of compliance checks, shoulder taps, and cops-in-shops.

Examples of encouraging enforcement of laws are: increasing the effectiveness of law enforcement to enforce underage drinking laws; participating in and increasing the number of underage drinking party/kegger patrols and issuance of MIP citations to youth in possession of alcohol; and providing enforcement activities at youth activities where underage drinking is known to occur, i.e., at football games, skate park, and the raceway park.

Challenges and opportunities: Respondents listed a wide variety of *system issues* that challenged the success of carrying out the prevention/reduction activities. These issues included: policy issues, financing, staffing, organizational issues, and poor quality programming. By far the *top challenge* to successful implementation was *community beliefs*. This was reported by 71% of respondents involved in preventing the consequences of underage drinking and 71% targeting adult problem drinking. Another 52% of youth-serving respondents also reported *community behavior* as a challenge.

There were a number of opportunities that arose over the last year that contributed to the success of the prevention work. These included: *opportunities for collaboration* related to the RASS training; *community readiness for change* including retailers requesting RASS training, communities ready to work on social norming, and an increase in community volunteers who were passionate about and ready to promote community change.

Information about the geographic distribution of prevention efforts, the workforce involved, and the use of evidenced-based and non-evidenced-based practices/programs/activities was also collected from respondents. The following tables depict these data.

Counties where prevention efforts occur: Due to the large number of counties listed by respondents, it's not practical to show the entire table in this document.

A summary of the results indicate:

- ❖ 29% of respondents targeting adult problem drinking and 24% working on underage drinking reported working in all 56 counties.
- ❖ 37 counties received prevention activities targeting both underage and adult problem drinking.
- ❖ In 3 counties -- Jefferson, Lewis and Clark and Yellowstone counties -- efforts are primarily targeted at preventing/reducing the consequences of underage drinking.
- ❖ Of the top 12 counties ranked as very high risk for DUIs (page 58), all but two counties -- Rosebud and Sweet Grass -- were not served by the respondents.
- ❖ Of the top 12 counties ranked as very high risk for Liquor Law violations (page 59), all but two counties -- Custer and Fallon -- were not served by the respondents.
- ❖ Of the top 12 counties ranked as very high risk for percentage of car crashes (page 60), all but 6 counties -- Golden Valley, Lake, Sanders, Carbon, Petroleum and Musselshell -- were not served by the respondents.

Workforce delivering prevention efforts: A wide range of occupations were reported to be involved in delivering the prevention efforts. Over 25 occupation categories were identified ranging from pharmacists, pediatricians, and paramedics to coaches and scouts and school teachers, to police and probation officers.

The following table lists those occupations reported by 20% or more of the respondents.

Employees/volunteers delivering prevention efforts	% respondents	Color Key:
Prevention Specialists	78.6%	Youth
Prevention Specialists	71.4%	Adults
Police and Sheriff's Patrol Officers	42.9%	
Substance Abuse Counselors	35.7%	
Police and Sheriff's Patrol Officers	33.3%	
Health Educators	28.6%	
Substance Abuse Counselors	28.6%	
Volunteers	28.6%	
Child, Family, and School Social Workers	23.8%	
Elementary, Middle and High School Teachers	23.8%	
Child, Family, and School Social Workers	21.4%	
Other	21.4%	
Social and Human Service Assistants	21.4%	
Volunteers	21.4%	

Use of Evidenced-Based (EBPs) and Non-Evidenced-Based (Non-EBPs) prevention efforts

The next table shows the percentage of respondents who used EBPs and non-EBPs with youth and adults.

Programs/Practices/Activities	% Using EBPs	% using Non-EBPs	Color Key:
Target the individual	47.6%	47.6%	Youth
Target the family	23.8%	42.9%	Adults
Target the school	23.8%	42.9%	
Target the community	38.1%	47.6%	
NOT USE EBPs	38.1%	33.3%	
Target the individual	64.3%	35.7%	
Target the family	21.4%	14.3%	
Target the school	14.3%	21.4%	
Target the community	35.7%	42.9%	
NOT USE EBPs	21.4%	35.7%	

Note: *Evidenced-Based:* are practices, programs, activities listed on the Federal registry of evidence based interventions, with documented effectiveness for a target audience and documented effectiveness with a targeted outcome. *Non-Evidenced-Based:* practices, programs, activities that are effective and create change but are not listed on the Federal registry.

Some highlights from the table are:

- ❖ Of those using EBPs with youth, the majority used programs, activities, practices that targeted the individual, followed by those that targeted the community, then family and school.
- ❖ Over a third of those working with youth reported not using EBPs or Non-EBPs.
- ❖ For adults, 64% of respondents used EBPs that targeted the individual and 36% used EBPs that targeted the community. Twenty-one percent did not use EBPs and 36% did not use Non-EBPs.

Examples of EBPs used with adults include: the 24/7 program, RASS training and *Screening, Behavior, Interventions, Referral to Treatment (SBIRT)*. Examples of EBPs targeting youth include: Brief Alcohol Screenings and Intervention for College Students and Prime for Life.

Data collection and sharing data: The final results from the online survey indicate what percentage of respondents collected implementation and outcome data, and shared those data. These results are depicted in the following three tables.

Percentage of respondents collecting implementation data

Answer Options	% respondents	Color Key:
YES	66.7%	Youth
ONLY FOR SOME PROGRAMS	19.0%	Adults
NO	9.5%	
DON'T KNOW	4.8%	
YES	85.7%	
ONLY FOR SOME PROGRAMS	7.1%	
NO	7.1%	

Implementation data: The vast majority of respondents reported collecting implementation data; 67% of respondents targeting underage drinking and 86% targeting adult problem drinking. Some examples of the types of data collected include: Numbers attending; type of activities; numbers attaining pass/fail rate; knowledge attained.

Percentage of respondents collecting outcome data

Answer Options	% respondents	Color Key:
YES	38.1%	Youth
ONLY FOR SOME PROGRAMS	28.6%	Adults
NO	19.0%	
DON'T KNOW	14.3%	
YES	35.7%	
ONLY FOR SOME PROGRAMS	28.6%	
NO	28.6%	
DON'T KNOW	7.1%	

Note: Outcome data defined as progress in changing knowledge, attitudes, behavior & policies.

Outcome data: Just over a third of respondents collected data about the impact of the program/practice/activity; 38% by those targeting youth and 36% targeting adults. Some examples were: pre and post testing; Montana Prevention Needs Assessment survey data; Youth Risk Behavior survey data; and results from Compliance Checks.

Sharing data: As the table below shows, the vast majority of respondents shared data about their prevention efforts; less than 10% did not share implementation or outcome data. The recipients of the data varied by population served. For example, 52% reported sharing youth-related data with the media compared to 36% of respondents addressing the consequences of adult problem drinking. The Military; faculty, campus administration; and civic groups and Festival Safety Committees were “other” groups that also received data.

Percentage of respondents sharing data

Recipients	% targeting youth	% targeting adults	Color Key:
Funding Agents	57.1%	64.3%	Youth
State Agencies	52.4%	64.3%	Adults
Providers	23.8%	42.9%	
Community Coalitions	57.1%	64.3%	
Boards	38.1%	42.9%	
Legislators	19.0%	21.4%	
Provided on request	38.1%	42.9%	
Media	52.4%	35.7%	
Schools	47.6%	7.1%	
OTHER	19.0%	14.3%	
NOT SHARED	9.5%	7.1%	

In summary, these online survey data provide a snapshot of the prevention efforts currently undertaken by some of the agencies involved in this planning process. Not all SPE members completed a survey therefore it's not possible to provide a complete picture of all the efforts being undertaken.

The Response

A closer look at prevention efforts targeting the consequences of underage drinking: The ICC Workgroup

In 2010, the Montana Interagency Coordinating Council (ICC) for State Prevention Programs and supporting workgroup, developed a work plan for 2011-2013 that focuses on: 1) challenging the pro-underage-drinking social norms; 2) examining policies, laws and enforcement to limit access and availability of alcohol by youth; 3) raising awareness about the consequences of binge and underage drinking; and 3) promoting responsibility around drinking and driving by teens and young adults. The work plan includes three goals targeting underage drinking.

Goal 1: The ICC Work Group will develop and implement education and media strategies that cultivate changes in social norms in the state regarding the use of alcohol by youth and drinking and driving.

The Problem: Student survey data from the Montana Prevention Needs Assessment (2012) shows that 1 in 3 parents are NOT talking to their children about the risks and dangers of substance use; at the same time, students report that parents are the NUMBER ONE influence in a their decision to drink alcohol.⁴⁰

The Response: The ICC workgroup developed a media campaign, targeting parents with a message that emphasized their importance in their child's decision as to whether they drink in their youth or not.

⁴⁰ Montana Prevention Needs Assessment (MPNA, 2012); page xxii.

<http://prevention.mt.gov/pna/2012/01.%20State%20Data/Montana%202012%20State%20Report.pdf>

The campaign included: 1) two 30 second public service announcements for both radio and television; 2) a new parent focused website: www.parentpower.mt.gov; and 3) a hard copy journal: *The Prevention Connection: Toolbox to Prevention Underage Drinking*.⁴¹ Member agencies contributed funding and human resources to the development of the campaign including: the Montana Board of Crime Control, Montana Department of Public Health and Human Services, Montana Office of Public Instruction, Montana Department of Revenue, and the Montana Department of Transportation. During this same timeframe, Montana created its State video under the STOP Act which bolstered these efforts. The message of the video also targeted parents asking them to adopt three action steps: 1) set clear rules about no underage drinking, 2) know your children's friends, where they are and who they are with, and 3) get involved in local efforts to curb underage drinking. The media campaign ran on three different occasions, targeting the prom to graduation period and Thanksgiving to New Year's holiday season.

The ICC workgroup plans to continue running the media messages, however because of the current tight fiscal times, it's necessary to explore ways to develop earned media and leverage opportunities such as hooking onto other media campaigns being run by agencies.

Goal 2: The ICC Work Group will work with their Agencies, Departments, and community representatives to examine laws, policies, and enforcement protocols that contribute to limiting youth accessibility and availability to alcohol and drinking and driving; and create awareness through information dissemination and education.

The Response: To meet this goal, the ICC workgroup identified key policy areas and initiatives that needed strengthening to address underage drinking, specifically: 1) Montana's Minor in Possession Laws; 2) Social Host Ordinances at the county level; and 3) mandatory Responsible Alcohol Sales and Service (RASS) Training.

1. Minor in Possession Laws:

The Problem: To date the legal system has not addressed MIPs in a systematic manner and MIPs have not been an effective deterrent to counter the pro-social drinking norm. This is a challenge in many states across the nation.

The Response: A sub-group of the ICC workgroup has been working on addressing this challenge. In-keeping with the public health model of looking at the interconnections between risk factors that contribute to underage drinking, the sub-group examined Montana's current Minor in Possession (MIPs) laws in terms of data collection, gaps, inconsistencies and opportunities to improve data collection, as well as the opportunity to intervene with those youth that are on the path to addiction.

Based on a survey of nationwide efforts, Montana is one of very few states targeting the MIP laws as a strategy to reduce the consequences of underage drinking. The MIP law is complex and rendering a reasonable fix is going to take: 1) further buy in, particularly with the courts and more specifically with youth court, and with law enforcement, 2) a universal approach to prevention, and 3) specific recommendations for statute changes. The consequences of this work could be very influential in planning for prevention over the next few years.

⁴¹ The toolbox can be found at: <http://prevention.mt.gov/resource/prevconn/files/2010/spring2010.pdf>.

2. **Social Host Liability Ordinances:**

The Problem: MPNA surveys by 8th, 10th, 12th graders indicate that access to alcohol is often provided by someone they know, usually 21 years of age or older, and is obtained without parent permission and at times with parent permission.

The Response: Over the last four years, about a dozen Montana communities have adopted some form of a local Social Host Ordinance. These ordinances challenge the pro-drinking social norm and establishes clear consequences for adults who provide alcohol to minors. A next desirable step is for the state to pass legislation authorizing county-wide ordinances, supporting a statewide message that social hosting is an unacceptable social behavior. Member agencies of the ICC workgroup worked with others in the 2009 and 2011 legislative sessions to pass a bill; but were unsuccessful. At this time, it is unknown if the members will work on a bill for the 2013 legislature.

3. **Responsible Alcohol Sales and Service Act:**

The Problem: Limiting access to alcohol by youth from retail sales.

The Response: During the 2011 Legislative session, the Responsible Alcohol Sales and Service Act was passed; this makes alcohol server training mandatory for retailers in Montana. The four goals of the training are to: 1) eliminate selling to underage persons, 2) eliminate secondary selling, 3) eliminate selling to intoxicated customers, and 4) training sellers and servers to identify and refuse altered or false identification. These principles support businesses to operate within the constraints of the law and to reduce their liability.

The ICC workgroup members provided information to constituents and policymakers which aided in passing this legislation. Following the passage of the bill, the Montana Department of Revenue partnered with substance abuse prevention grantees of the Addictive and Mental Disorders Division, Montana Department of Public Health and Human Services, to train over 33,000 sales and service staff in 1.5 years.

Goal 3: The ICC Work Group will develop and implement strategies that raise the level of awareness and promote a sense of community responsibility and accountability concerning the use of alcohol by youth and drinking and driving.

The Problem: Addressing pro-drinking norms and community behaviors.

The ICC workgroup have adopted a number of strategies. These included:

1. Strengthening youth driver's education curriculum.
2. Developing and disseminating the OPI, MT Substance Abuse and Violence Prevention Task Force, Key Findings Report, to school administrators, personnel and policy-makers across the state.
3. Engaging youth in designing and implementing prevention efforts.
4. Participating in the development, implementation and monitoring of the Montana Comprehensive Highway Traffic Safety Plan.

**Drivers under 21:
alcohol-related
crashes**
❖ 312 crashes
❖ 7 fatalities
❖ 158 injuries
(2011 data)

1. Strengthening youth driver's education curriculum to reduce Drinking and Driving

The Montana Office of Public Instruction revamped the traffic education curriculum and now requires the teaching of modules on brain development and impaired and distracted driving. Beginning spring 2012, these updates were rolled out to traffic educators across the state and implementation began.

2. Developing and disseminating the Key Findings Report

The Task Force was formed to develop an effective network to:

- ❖ identify, understand, and assess the State's existing youth prevention infrastructure
- ❖ detect gaps and weaknesses
- ❖ eliminate areas of duplication
- ❖ chronicle best practices and model interventions, and
- ❖ prepare to build and maintain the State's support of schools in their work to create safe and healthy learning environments

Two specific products were developed from this partnership including: The Key Findings Report (October 2011) and a dynamic website for educators.⁴²

Some selected findings include:

- An increasing percentage of Montana youth are making good decisions about alcohol use.
- High-school students who attend alternative schools report higher percentages of use of illegal substances and greater rates of participation in problem use and violence than do other students.
- Montana schools provide strong protective factors for students.

3. Engaging youth in designing and implementing prevention efforts

In 2013, the ICC workgroup member agencies will coordinate with community level youth groups to implement the *Above the Influence Media Campaign*. This campaign engages youth in partnership with their community, and informs and inspires teens to reject substance use. This positive message campaign is about being an individual, not a follower; standing up to negative influences, knowing the facts about drugs and alcohol, and making smart decision about drugs and alcohol.

4. Montana Comprehensive Highway Traffic Safety Plan

Several ICC workgroup members participated in the annual update of the Plan.⁴³ Emphasis areas included reducing the number and severity of the traffic crashes, injuries and fatalities on Montana highways; underage impaired driving is addressed in the plan.

A closer look at prevention efforts targeting the consequences of adult problem drinking

As noted earlier, at this stage not enough is known about the coordinated prevention efforts that target the consequences of drinking by university-aged students and adults. The following are examples of prevention efforts that are known to have occurred.

⁴² http://opi.mt.gov/Programs/TitlePrgms/SafeSchools/#gpm1_1

⁴³ http://www.mdt.mt.gov/publications/docs/brochures/safety/safety_plan.pdf; pages 17.

Prevention and reduction efforts targeting college students/young adults

The Problem: According to the Montana State University Campus Alcohol and Drug Policy (2012),⁴⁴ there are a numerous mental and behavioral consequences associated with binge drinking or heavy episodic drinking.

- ❖ **Social problems** such as driving under the influence, fighting, unwanted sexual contact, vandalism, trouble with authorities, unsafe sexual behavior.
- ❖ **Academic problems** including poor grades, missed classes, memory loss, falling behind in class work or projects.
- ❖ **Personal problems** such as depression, illness and injury, experiences unwanted attempted or completed sexual intercourse, suicide, being the victim of violence or racial harassment, being unable to control drinking or drug use, and/or alcohol poisoning.
- ❖ **“Second hand” effects** resulting from other people’s drinking or drug use, often experienced by those who choose not to use drugs or alcohol in a high-risk manner. Effects include: disruptions of sleep, having one’s property damaged, feeling unsafe, intoxicated driving, vandalism, violence and sexual assault.
- ❖ **Longer-term consequences** are experienced by both young adult and adult populations including “second hand” effects and risks associated with dependency (also known as addiction). For some, substance use escalates to dependency. Adverse effects of dependency can include illnesses such as liver disease, peripheral neuropathy, and cerebella degeneration. Additional health risks can include blackouts, alcoholic hallucinations, and delirium tremens.

The Response: Montana institutions of higher education are addressing alcohol and drug use through policies, procedures, and environmental prevention efforts. For example, at the University of Montana, the drug and alcohol prevention program is based in part on environmental management strategies devised by the US Department of Education’s Higher Education Center for Alcohol and Other Drug Prevention.⁴⁵ Prevention efforts being used on campus include: Montana State University requires all incoming students under the age of 21 to take the AlcoholEdu online course (<http://www.montana.edu/health/healthpromo/alcoholedu.php/>); and The University of Montana uses the PROs program (Peers Reaching Out), targeting students in the dormitories (<http://life.umt.edu/curry/Departments/HEALTH/Peers%20Reaching%20Out.php>).

Policies governing access to alcohol on university campus are required by The Montana Board of Regents of Higher Education.

Policy 503.1: Alcoholic Beverages: Each Montana campus shall adopt policies governing the possession, consumption, sale and service of alcohol on property belonging to the university system that are consistent with legal age restrictions, legal consumption by persons of legal age within approved areas on campus, sales and server education/training including age verification through photo identification checks, and tailgate rules (<http://mus.edu/borpol/bor500/503-1.pdf>).

⁴⁴ http://www2.montana.edu/policy/security_report/alcohol_drug_policies.html.

⁴⁵ The University of Montana Drug and Alcohol Biennial Review 2008-2010, January 6, 2012.

Both the University of Montana and Montana State University have in-place campus alcohol and drug policies, sanctions in place for violations, access to campus and community resources and treatment services, and they conduct student risk assessments.

Prevention and reduction efforts targeting drinking and driving for all ages

The Problem: Alcohol-related car-crashes are a major problem in Montana.

As the following table shows, young adults aged 21-24 have the highest number of alcohol-related crashes followed by the 35-44 age group, 25-29 group, the 45-54 year olds, the 30-34 age group, the 55-64 year olds, and the oldest drivers have the fewest alcohol-related crashes.⁴⁶

Consequences	21-24 age group	25-29 age group	30-34 age group	35-44 age group	45-54 age group	55-64 age group	65+
Crashes	413	362	296	389	341	215	85
Fatalities	10	15	14	27	11	13	10
Injuries	187	176	133	199	147	108	48

The Response: Multiple state agencies are involved in efforts to address this public health problem for example, the Department of Justice, Department of Revenue, DPHHS, and the State Highway Traffic Safety Office in the Montana Department of Transportation.

According to a planner from the Statewide and Urban Planning, Rail, Transit and Planning Division, “there are strategies and activities – current and new – within the Comprehensive Highway Safety Plan (CHSP) that are being done within a couple of the emphasis areas that [address the underage/adult problem drinking and prescription drug misuse/abuse] when an impaired driver is involved in a severe crash. These activities, among others are efforts to address the CHSP Goal: *to reduce fatalities and incapacitating injuries ... by half in two decades from 1,704 in 2007 to 852 by 2030.*

Alcohol-and Drug-Impaired Driving Crashes

Prevention and Reduction Activities

Within Emphasis Area 2, there are 53 current documented program activities in place⁴⁷. Some of the new strategies being pursued include:

- ❖ Enhanced Traffic Safety Resources Prosecutor (TSRP) training for public and law enforcement on stronger penalties for BAC test refusal; MCA 61-8-402.
- ❖ Provide training on new search warrant for BAC law and promote consistency between jurisdictions and within the criminal justice system.
- ❖ Promote responsible drinking.

⁴⁶ . 2011 data. Montana Comprehensive Highway Traffic Safety Plan, ps. 17-19.

http://www.mdt.mt.gov/publications/docs/brochures/safety/safety_plan.pdf

⁴⁷ List of activities found at:

http://www.mdt.mt.gov/publications/docs/brochures/safety/chsp_annual_element.pdf

- ❖ Increase public education regarding impairment from marijuana, prescription drug and especially alcohol.
- ❖ Promote discontinuation of Happy Hour and 2-for-1 drink specials that encourage over consumption.
- ❖ Enhanced alcohol screening, brief intervention and referral to treatment.”⁴⁸

Policies addressing drinking and driving

Key legislation was passed in 2011 that attaches consequences to driving under the influence of alcohol or drugs. These new DUI laws, to reduce the incidence of adult problem drinking through meaningful consequences, are some of the most comprehensive in Montana.

- ❖ HB 106 – created a *24/7 Sobriety Project* for an offender convicted of a second or subsequent offense.
- ❖ HB 12 – *DUI penalties*: increased jail time for first time offense from 10 days to 6 months; second offense from 30 days to one year; third offense jail time increased from 6 months to one year.
- ❖ HB 69 – *DUI Court participation*: revised jail penalties and mandatory minimums. Changes included: encouraging DUI Court participation by allowing for the suspension of all jail time except for the mandatory minimum, and increasing potential jail time to one year for second offenses.
- ❖ HB 102 – *Driver’s license and DUIs*: 1) revised probationary driver’s license for DUI Court participations with key provisions around second and third convictions; 2) longer licensure suspensions; and 3) completion of chemical dependency programs before a license is reinstated.
- ❖ SB 15 – *created Misdemeanor Crime for Aggravated DUI*. This applies if one of the following is true: 1) the driver has a BAC of .16 or more; 2) the license is suspended or revoked for prior DUI/BAC; 3) the driver is required to have an ignition devise; 4) the driver refuses testing and had previously refused testing in the past; or 5) the driver has a previous DUI-related conviction in the previous 3 years or 2 DUI-related convictions in the previous 7 years. The penalty includes a maximum jail sentence of one year and a maximum fine of \$1000.
- ❖ SB 42 – *Blood or breathalyzer testing*. Authorizes warrants to obtain blood/breath DUI cases if the suspect refuses to provide breath, blood or urine sample. An officer may apply for a search warrant to be issued that allows for the collection of a person’s blood for testing. Also, proof of refusal is still admissible in court even if a sample is obtained.

A closer look at the 24/7 Program in reducing the consequences of drinking and driving

The Problem: “Drinking and driving has been a chronic – and deadly – problem on Montana’s roadways for decades. In 2008, Montana was ranked as the deadliest state in the nation when it came to per capita DUI-related traffic fatalities. Law and policy makers responded with a list of changes to the Montana legal code, all aimed at ending Montana’s “culture of drinking and driving.” Some changes were monumental: Like banning for the first time open containers of

⁴⁸ Email from a planner of the Montana Department of Transportation; 11/1/2012.

alcohol in moving vehicles. But Montanan's continued to read news stories and watch television reports about Montanans getting their fourth, fifth, sixth DUIs – or more.

The Response: Against this backdrop, Attorney General Steve Bullock proposed the Montana 24/7 Sobriety Program in March, 2010. The program was initially run as a pilot in Lewis and Clark County. Under the program, people accused of their second or subsequent drunken driving offense can be ordered by a judge to take twice-daily alcohol breath tests as a condition of their release from jail, pending trial. Or they may be ordered to wear an alcohol-monitoring bracelet. Some offenders can be sentenced to the program if they plead or are found guilty of a DUI.

The 24/7 program is structured to have the offender pay the cost of the monitoring so the program is essentially free to counties and taxpayers.

The results of the Lewis and Clark County were astounding: Out of thousands of tests administered, more than 99 percent came back clean. Offenders were staying clean. Buoyed by the success of the pilot program a bill was presented to the legislature in 2011 and with broad, bi-partisan support, House Bill 106 was passed.

The program went statewide in October, 2011. As of October 2012, 22 sheriffs' offices were participating in the program:

- | | |
|------------------------|---------------------|
| 1. Anaconda-Deer Lodge | 12. Granite |
| 2. Beaverhead County | 13. Jefferson |
| 3. Big Horn | 14. Lincoln |
| 4. Blaine | 15. Lewis and Clark |
| 5. Broadwater | 16. Musselshell |
| 6. Butte-Silver Bow | 17. Powell |
| 7. Cascade | 18. Sanders |
| 8. Custer | 19. Sheridan |
| 9. Dawson | 20. Sweet Grass |
| 10. Flathead | 21. Teton |
| 11. Gallatin | 22. Yellowstone |

An additional 16 counties have taken the 24/7 Sobriety Program training in preparation to start the program:

- | | |
|------------------|---------------|
| 1. Daniels | 9. McCone |
| 2. Fergus | 10. Meagher |
| 3. Garfield | 11. Mineral |
| 4. Golden Valley | 12. Ravalli |
| 5. Hill | 13. Richland |
| 6. Judith Basin | 14. Roosevelt |
| 7. Lake | 15. Rosebud |
| 8. Madison | 16. Wheatland |

It's interesting to note, that eleven of the twelve counties that were ranked as highest risk for DUIs on page 58 are participating or ready to participate in the 24/7 Program. Only Missoula County is not participating.

The program verifies what Montana judges have consistently required of DUI defendants – that they stay out of bars and places where alcohol is served and that they abstain from drinking. The 24/7 Program verifies that offenders are complying with judges orders. Based on the feedback

from the participants, the 24/7 program is working. Stories from offenders in the program report that the 24/7 has helped them be accountable and more effective as parents and citizens.”⁴⁹

At this stage, the 24/7 program is not being implemented on any reservations. There are several counties that overlap with reservations that are running a program (for example, Yellowstone, Big Horn, Sanders, Flathead, Roosevelt counties), but at this point, the tribes are not doing testing. There are a couple of ways that they could. One way would be for the tribe to act as a designated agency for the county – this would likely involve an MOU or contract. Another option would be for the reservation to implement its own 24/7 program using its tribal courts, tribal police, etc. There may be some nuances to Indian law and state law that would need to be worked through, but if a tribe was interested in doing the program, it could definitely be accomplished (Source: Conversation with AG’s Office; November 2012).

Recommendations for planning to prevent/reduce the consequences of underage and adult problem drinking

- ❖ Identify funding for continuing compliance checks by law enforcement to support retailers to be responsible servers and sellers of alcohol.
- ❖ In terms of addressing primary prevention and consequences of adult problem drinking, the state of Montana, has not in recent years, examined the current status of the incidence and occurrence of Fetal Alcohol Spectrum Disorders, Fetal Alcohol Effect and Alcohol-exposed Pregnancies. Although this topic was not raised as a major concern during the SPE discussions, as the state progress in its planning, this is an area recommended for future discussion and exploration of impact.
- ❖ More information about coordinated prevention efforts that target the consequences of drinking by university-aged students and adults needs to be gathered from the relevant agencies during Phase II.

⁴⁹ Source of information for 24/7 collected from: <https://doj.mt.gov/247-sobriety-program/>

Assessment of current prevention efforts on the seven reservations: The Highlights

Montana is home to seven Indian Reservations, with the majority of the 53,000 American Indian populations living on these reservations. The seven reservations are: the Blackfeet, Crow, Flathead, Fort Belknap, Fort Peck, Northern Cheyenne and Rocky Boy's. These tribal nations are diverse; each has unique cultures, languages, traditions, histories and geographic conditions.

This discussion highlights: 1) which targeted mental and behavioral health problems are of most concern, 2) what common themes emerged during the interviews, 3) what protective factors are important in preventing and reducing these public health problems, and 4) what type of relationship is wanted between the reservations, federal and state agencies.⁵⁰

We acknowledge this is not an exhaustive compilation of what is happening in Indian Country. However, it is a summary of what is happening on each of the reservations using the words of the interviewees.

Mental and behavioral health problems of concern

According to the interviewees, alcohol and drug abuse in families and communities is a public health crisis on Montana reservations. They perceive that American Indian's use and abuse *alcohol and other drugs at younger ages and at higher rates than other ethnic groups*. Underage drinking and binge drinking are common to all seven reservations. Many interviewees linked substance use and misuse, both alcohol and prescription drugs, to dealing with issues of oppression, historical trauma and identity loss. Chief Earl Old Person noted, "choices concerning alcohol and substance abuse are tied in some way to self-esteem and at the root of this is the breakdown of the family unit. Many youth today are living and coping with someone else's trauma in the home."

Prescription drug misuse and abuse was of great concern as was *attempted and completed suicides*. One message that resonated throughout the interviews was prescription drug and alcohol abuse are the number one problems. "They seem to go hand in hand (alcohol and prescription drugs). Addicts/dealers are waiting outside of hospital emergency rooms and paying patients top dollar for prescription narcotics." And, according to the professionals interviewed, the consequences are multi-generational and co-occur with other mental and behavioral health issues (i.e., depression, self-hate, cultural shame, stress-related acting out, and attempted and completed suicides).

Common themes that emerged from the interviews

- ❖ *Culture* plays a significant role in preventing public health problems; it is essential to see the connections between community, culture, and prevention.
- ❖ Exposure to *historical trauma* is a risk factor associated with public health problems.⁵¹

⁵⁰ The Interview Report is found in Appendix F.

⁵¹ "Historical trauma (HT) is defined as cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma. To our knowledge, the concept of historical trauma among American Indians first appeared in the clinical literature in 1995." Brave Heart, Yellow Horse, M., Chase, J., Elkins, J. & Altschul, D. (2011). Historical Trauma among

- ❖ Promoting a community's sense of having some *control over its daily life* can be empowering and contribute to the sense of general well-being.
- ❖ *Cultural identity* is an important protective factor.
- ❖ *Youth involvement* can shape community norms and be used as a protective factor.

Protective factors important in preventing and reducing the public health problems

These included, but were not limited to:

- ❖ embracing traditional cultural practices, beliefs, norms and values, languages, rituals
- ❖ peer/community support for avoiding substance abuse
- ❖ commitment by the communities to keep the culture, traditions and languages alive
- ❖ close family/home ties
- ❖ respectful communication between youth and parents.

Interviewees talked of the significance of returning to and, in some cases, reintroducing *culture to all generations* and how *valuing language and culture leads to better coping skills* and *building a strong identity is key* to preventing suicide and addictions.

The importance of *sharing personal interaction with one another* was another common theme. One interviewee described it as, "A person has to be in a state of wellness in order to be able to relate to himself and his people" to maintain harmony. In contrast, the concept of "un-wellness" was defined as disharmony in body, mind and spirit. Geographic isolation and social availability of alcohol and prescription drugs were considered the most common barriers to "wellness".

Interviewees also noted the connection between *economic well-being and family well-being*. They explained that, "a working parent who feels they are a contributing member of society dramatically affects the youth and other family around them to do the same." Family, in its most inclusive sense, is often where strength and resiliency is found. Elders and mentors are essential members of families. *Lack of family is a source of stress*.

Many interviewed agreed that youth are protected when there's family supervision, discipline and clear and positive standards of behavior; when family and peer norms discourage alcohol and drug use; when there's support for academic achievement; when there are meaningful opportunities to feel a part of the community; and most importantly when there are strong relationships within the family and between parents/caregivers.

Tribal/State/Federal Relationship

- ❖ Those interviewed wanted more information and resources from state and federal programs and wanted these governments to better understand tribal sovereignty and to respect and increase their cultural awareness about each tribe.
- ❖ Better communication between prevention programs, better coordination of activities and to build relationships.

- ❖ Culturally responsive prevention to be recognized as valuable prevention tools. For many tribes, the reality of what works in Indian Country is rooted in practice-based evidence as opposed to evidence-based practice.
- ❖ Recognizing that “one size fits all” approach does not work for all communities, especially since each community has their own capacity challenges. For example, prevention programs often experience staff turnover which in turn can create chaos. Also a greater understanding that each reservation has its own systems, coordinated efforts, and own challenges.
- ❖ The interviewees wanted training in data collection, evaluation, and skill building. For example, they wanted information about current substance use and abuse trends and training in information-gathering. More community trainings in *Question, Persuade and Refer* (QPR) and *Signs of Suicide* (SOS) to enhance suicide prevention skills.
- ❖ Ways of sharing and exchanging information among those interviewed and between state and federal programs/agencies. One specific example was the importance of collaboration between state and tribal Law Enforcement agencies.
- ❖ Workforce development is an issue. Committed individuals are working to improve the lives of families, but they have educational training and technical assistance needs.
- ❖ The Affordable Care Act implementation will certainly have potential effects on both services and reimbursement issues related to substance abuse prevention and treatment, and behavioral health services. The manner in which SAMHSA distributes block grants has the potential to and will likely change.

Looking Forward: Culture is Prevention

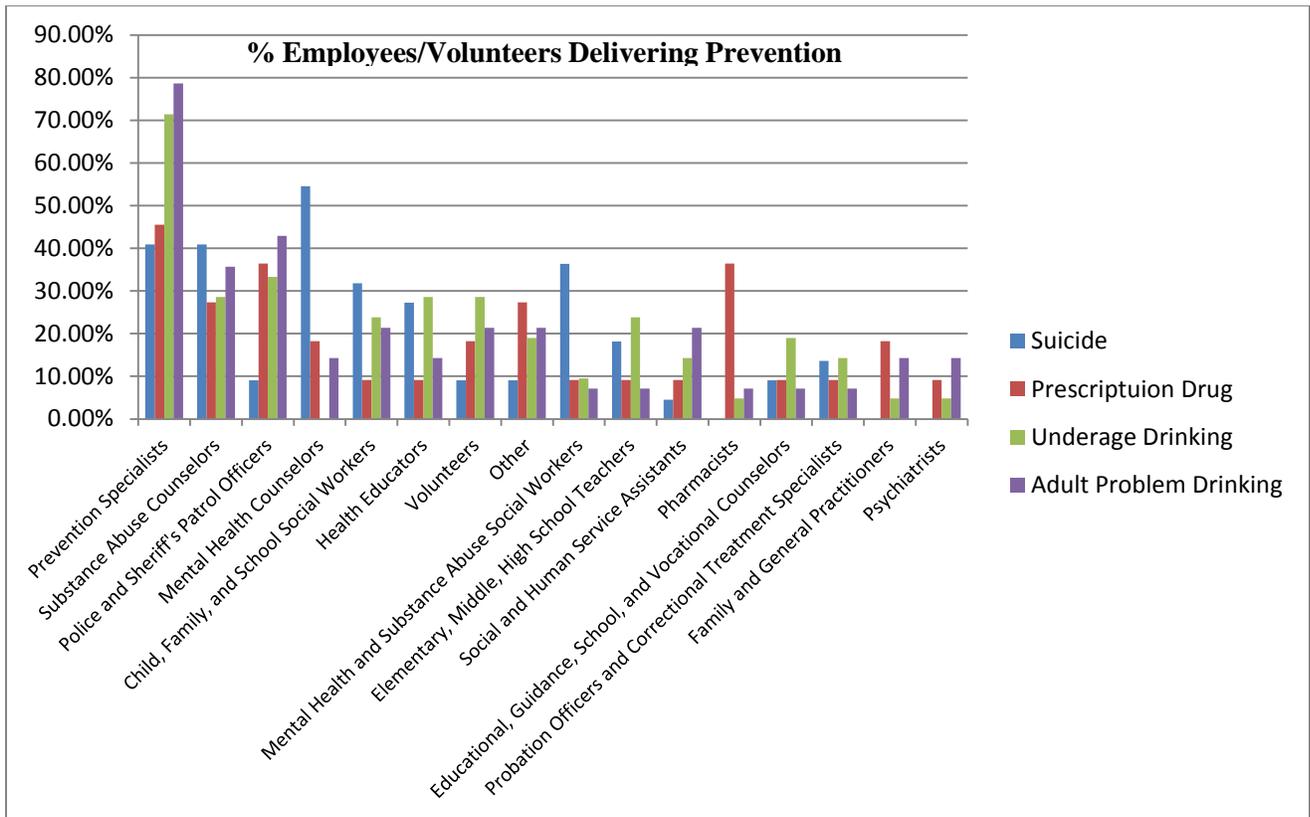
Interviewees shared a hope for the future. They want to be proactive about shaping the future of their communities and generations to come. Next steps will be to bring together the best of culturally based approaches into the western evidence based prevention methods to create a structure and system for addressing the public health problems.

Workforce Needs Assessment

The data used in this assessment include workforce information from the online survey administered to the SPE Consortium and county-level measures, including: 1) Quarterly Census on Employment and Wages; 2) Occupational Employment Statistics; 3) Licensure data; and 4) data from the Montana Medical Association Physician Directory.

Online survey data - Workforce Assessment

A total of 36 respondents completed the online survey. The majority were involved in more than one health promotion area, and used a wide variety of employees and volunteers to deliver the prevention practices, programs, or activities. The following graph depicts the *extensive workforce involved in each of the targeted mental and behavioral health areas.*



Note: This may not be a complete representation of the workforce utilized. For example, the MT Suicide Prevention Program Plan indicates that primary care providers are important partners in the prevention effort, however this workforce category was not selected by the relevant survey respondent.

A detailed discussion of the workforce associated with the respective mental and behavioral health areas can be found in the earlier discussions of the targeted areas. Some highlights of these aggregated data that relate to the following discussion are: 1) Prevention Specialists, while not a formally licensed or certified employment category, deliver prevention in all of the targeted health areas; 2) professionals in the mental health and primary care categories are already involved in varying degrees in all of the targeted public health areas.

County-level assessment of workforce needs - The Challenge

Collecting and analyzing workforce data about prevention and behavioral health specialists is extremely challenging in Montana. Aside from issues related to multiple data sources and the problems associated with them, there is also a structural challenge to the analysis.

When we first sat down with experts in these fields and looked at job types that might be considered the workforce of prevention, over 30 job titles were considered from the Occupational Employment Statistics (OES) and the Quarterly Census of Employment and Wages (QCEW) data. None of these job categories were specific to prevention. These were jobs types in fields broadly related to education, health and human services. Determining the quantity of these jobs at the county level was impossible because of the inability to disclose employment data on such a micro level using OES and QCEW data.⁵²

Furthermore, while it might be inviting to intuitively pick particular jobs that one may associate with prevention, these workers may not have the skills of a prevention specialist. It is possible to train many workers to recognize signs that someone might need assistance or might be experiencing crisis. For example, many occupations such as teachers, coaches, even bartenders, can be trained in understanding the signs of suicide or alcohol abuse. However, these are not the skills that would be required of a "prevention specialist".

This challenge should not be surprising. Currently prevention is not provided by licensed or certified professionals. Prevention services and activities are provided by individuals working within a variety of settings with a broad range of missions. Additionally, sometimes services and activities are provided by volunteers. This "workforce" is not included in the economic standard list of job categories and is a hidden source of support in communities and a challenging group to track.

Another approach taken to better understand the "prevention" workforce was to link two data sets: the job categories identified in the online survey and the number of licenses issued at the county level for the same job categories. In this case, licensure data is the best data source because of the ability to disclose all of the information at the county level. One of the draw backs however, is that licenses are tracked back to where a person lives and not necessarily where they work. Behavioral health workers tend to travel a great deal in order to service this vast frontier state. For example, a school psychologist may reside in Billings and provide services in schools in Carbon, Treasure, and Rosebud counties but the licensure data only lists this psychologist as working in Yellowstone County.

While not a perfect measure, it illustrates an important feature of working in a frontier state, that is, the workforce is not evenly distributed across the state and can be concentrated in a small number of counties. The following table shows the number of healthcare workers, per county, in six prevention-related professions: Clinical Social Workers; Clinical Professional Counselors; Addiction Counselors; Psychologists; Pharmacists and Medical Doctors.

⁵² A more thorough description of these data sets is presented earlier in the document.

Number of Behavioral Healthcare Licenses by County (2012)

County	Clinical Social Worker	Clinical Professional Counselors	Addiction Counselors	Psychologist	Pharmacist	Medical Doctor	Population estimate 2012
Beaverhead	7	6	1	1	11	16	9,255
Big Horn	2	2	1	0	5	16	12,904
Blaine	3	4	0	0	7	3	6,395
Broadwater	3	5	0	0	3	4	5,926
Carbon	4	7	1	1	8	14	10,189
Carter	0	0	0	0	0	0	1,126
Cascade	45	84	47	12	94	210	81,523
Chouteau	0	3	2	0	7	0	5,782
Custer	6	7	8	2	17	27	11,700
Daniels	0	1	1	0	2	0	1,705
Dawson	3	9	7	0	9	12	8,948
Deer Lodge	5	12	13	5	10	15	9,275
Fallon	0	0	0	0	3	1	2,901
Fergus	1	14	6	1	14	19	11,526
Flathead	50	91	51	17	106	289	94,947
Gallatin	39	136	23	28	79	256	95,236
Garfield	0	0	0	0	0	0	1,192
Glacier	3	4	11	1	7	12	13,430
Golden Valley	1	0	0	0	0	0	857
Granite	3	1	3	0	0	2	3,133
Hill	5	19	14	5	23	24	15,985
Jefferson	8	13	4	0	19	28	11,714
Judith Basin	0	0	2	0	2	0	2,026
Lake	13	13	12	4	30	38	29,232
Lewis & Clark	87	76	51	17	83	183	65,142
Liberty	0	0	0	0	3	2	2,378
Lincoln	8	16	7	1	19	24	19,865
Madison	0	1	0	0	4	10	7,880
McCone	0	0	0	0	0	0	1,691
Meagher	0	0	0	0	1	0	1,883
Mineral	4	1	2	0	4	3	4,297
Missoula	134	126	62	65	187	403	112,379
Musselshell	0	1	0	0	2	1	4,546
Park	9	12	10	4	13	29	15,624

Number of Behavioral Healthcare Licenses by County -- Continued

County	Clinical Social Worker	Clinical Professional Counselors	Addiction Counselors	Psychologist	Pharmacist	Medical Doctor	Population estimate 2012
Petroleum	0	0	0	0	0	0	494
Phillips	0	1	0	0	4	1	4,189
Pondera	0	8	1	0	4	3	6,101
Powder River	0	0	0	0	2	0	1,721
Powell	1	9	7	2	6	7	6,997
Prairie	0	1	0	0	0	1	1,175
Ravalli	25	24	15	6	34	64	41,136
Richland	2	5	3	0	11	14	9,762
Roosevelt	6	6	10	1	6	3	10,387
Rosebud	4	5	4	3	4	5	9,203
Sanders	8	9	5	0	5	9	11,678
Sheridan	2	1	1	0	5	2	3,265
Silver Bow	29	34	60	3	50	78	34,120
Stillwater	4	4	3	0	5	3	9,322
Sweet Grass	1	1	0	1	2	4	3,659
Teton	2	3	2	0	5	3	6,003
Toole	3	1	2	0	7	4	5,336
Treasure	0	0	0	0	0	1	694
Valley	1	3	2	1	8	8	7,310
Wheatland	0	1	0	0	0	0	2,151
Wibaux	0	0	0	0	1	0	1,007
Yellowstone	82	192	119	22	196	561	152,232
TOTALS	613	972	573	203	1127	2412	1,010,533

Some highlights of the data include:

- ❖ 19 counties (34%) of counties have three or fewer of the licensed professional categories (*highlighted in the table*); 37% of these counties are ranked as moderate or high risk for the targeted mental and behavioral health problems.
- ❖ 32 counties (57%) have no licensed Psychologists.
- ❖ 80% of licensed Psychologists are located in only 6 counties which constitutes 60% of the state population.
- ❖ 78 % of Social Workers, Clinical Professional Counselors and Addictions Counselors are located in just 8 counties. These counties constitute 65 % of the state population.

What these data suggest is a shortage of trained professionals working in frontier communities across Montana. This shortage is well documented in state and federal reports.⁵³ There are

⁵³ http://healthinfo.montana.edu/MTHWAC/FINAL_FINAL.pdf

numerous reasons to be concerned about a shortage of healthcare professionals. The most obvious is what it means for access to healthcare. Less obvious is what it means about the relative *health* of the communities experiencing the shortage. Communities experiencing a shortage of healthcare workers are typically low-income, have a high level of geographic isolation and can be marked by wide disparities in income. These could be considered risk factors that contribute to a diminished healthy community.

As a result of these initial analyses, it became obvious that there was no easy way to determine the numbers of trained professionals delivering prevention activities, programs, and practices in order to assess "prevention" workforce shortage areas. Given these parameters, the Consortium agreed to look at the broader category of Health Providers as a workforce involved in delivering prevention services; those data are more accessible.

Health Provider Shortage Areas - Criteria and implications for planning

One measure of this shortage is the number of Health Professional Shortage Areas (HPSAs). In cooperation with the federal government, the Montana Primary Care Office designates counties and regions within the state as being HPSAs. The Health Resources and Services Administration (HRSA) uses a number of criteria to designate these areas based on a geographic area, population group, or a particular facility.⁵⁴

Designation Criteria:

1. A *geographic HPSA* can be designated based on the provider to population ratio of a given area. This designation is commonly used in frontier areas where people must travel extensive distances (over 40 minutes) to receive health services. Geographic designations are the broadest and simplest designation to achieve.
2. Another type is a *population group* designation; this indicates that a subpopulation of individuals living in an area has insufficient access to health services. Populations that can be designated include low-income, Medicaid eligible, homeless, migrant farm worker and American Indian. For example, low-income and Medicaid eligible designations can only be made if 30% of the population of the service area is 200% below the Federal Poverty Level. American Indian populations automatically meet criteria for the population HPSA criteria.
3. The last major way a HPSA can be designated is through a *facility designation*. The types of facilities eligible for these designations would include correctional facilities, public and nonprofit healthcare facilities, and state and county mental hospitals.

Within each of these three basic designations there may be a further designation based on the type of healthcare being provided Mental Health, Primary Care, or Dental services.

4. Yet another branch of designations is known as *Medically Underserved Populations* (MUP) and *Medically Underserved Areas* (MUA). Both of these designation types use an Index of Medical Underservice (IMU). The IMU involves four variables - ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population 65 years of age or over.

⁵⁴ For more information please visit:

<http://bhpr.hrsa.gov/shortage/hpsas/designation/criteria/mentalhealthhpsaoverview.html>

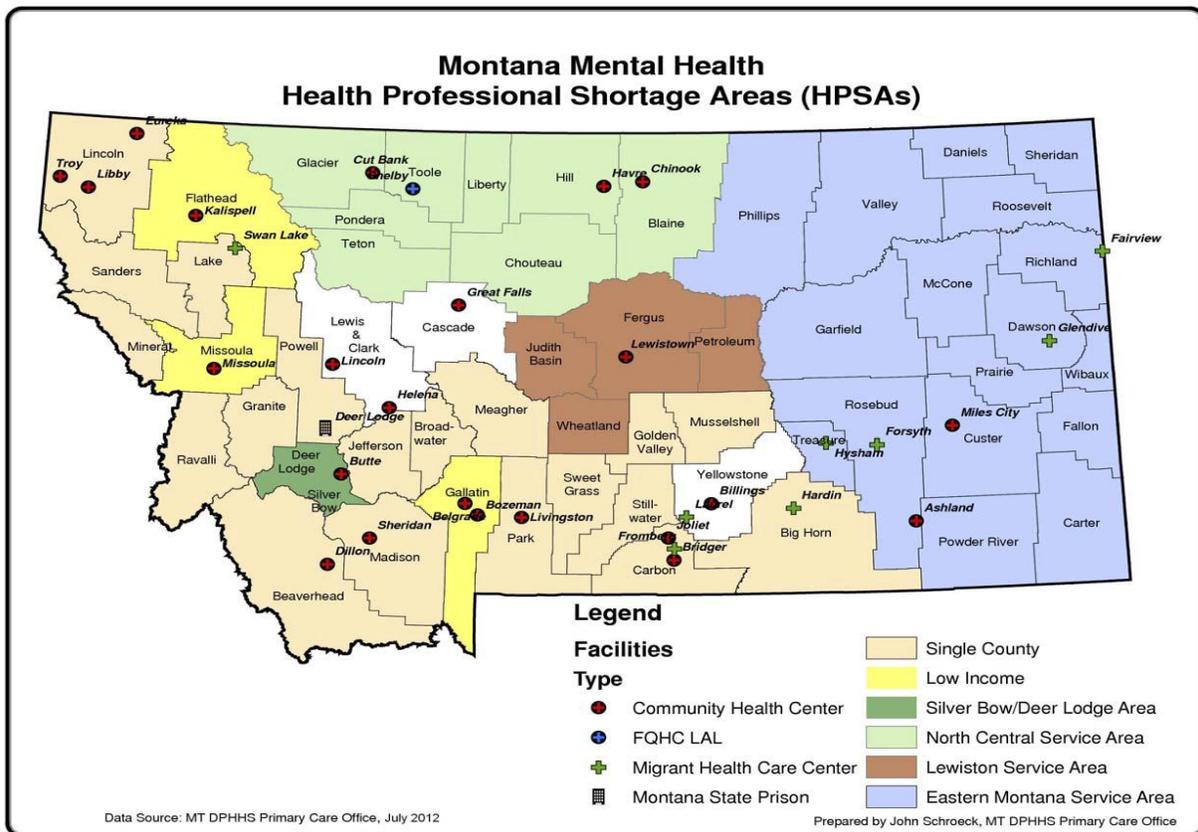
The main difference between MUAs and MUPs is that the entire population in an area is considered for a MUA and specific subpopulations are considered for MUPs. Population groups eligible for MUP designation include those with economic barriers (low-income or Medicaid-eligible populations) or cultural and/or linguistic "access" barriers to primary medical care services.

The Montana Office of Primary Care produces maps of Health Professional Shortage Areas (HPSA) by county for the entire state. The three most cited HPSAs are: 1) Mental Health, 2) Primary Care and 3) the Medically Underserved Population (MUP) at the county level.

Implications for planning:

The following maps, are based on all these extensive criteria, and indicate the counties designated as having a shortage of mental health professionals and a shortage of primary care health professionals. These professionals are often the first line of defense in screening for the targeted mental and behavioral health problems. For example, they are an integral partner in the Montana Suicide Prevention program.

Assessing mental health shortages: In Montana, 53 counties fit some level of criteria for Mental Health HPSA designation.⁵⁵

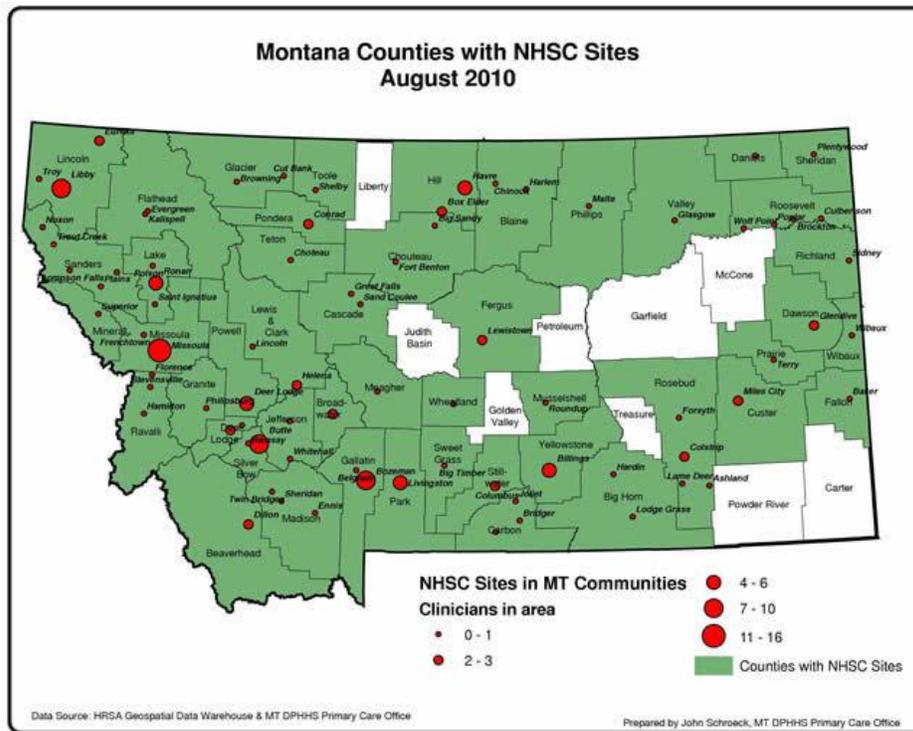


⁵⁵ The criteria revolve around a population-to-core-mental-health professional ratio greater than or equal to 6,000:1 and a population-to-psychiatrist ratio greater than or equal to 20,000:1.

For example, some of these counties are designated based on low-income and some on population demographics. At first glance it may be a surprise that Missoula, Flathead, and Gallatin County are Low-Income Mental Health HPSAs considering the facilities and resources in Missoula and Bozeman. However, these three counties meet the low-income criteria because 20 percent of the population is below the poverty level, showing the income disparity in these otherwise relatively well-off counties.

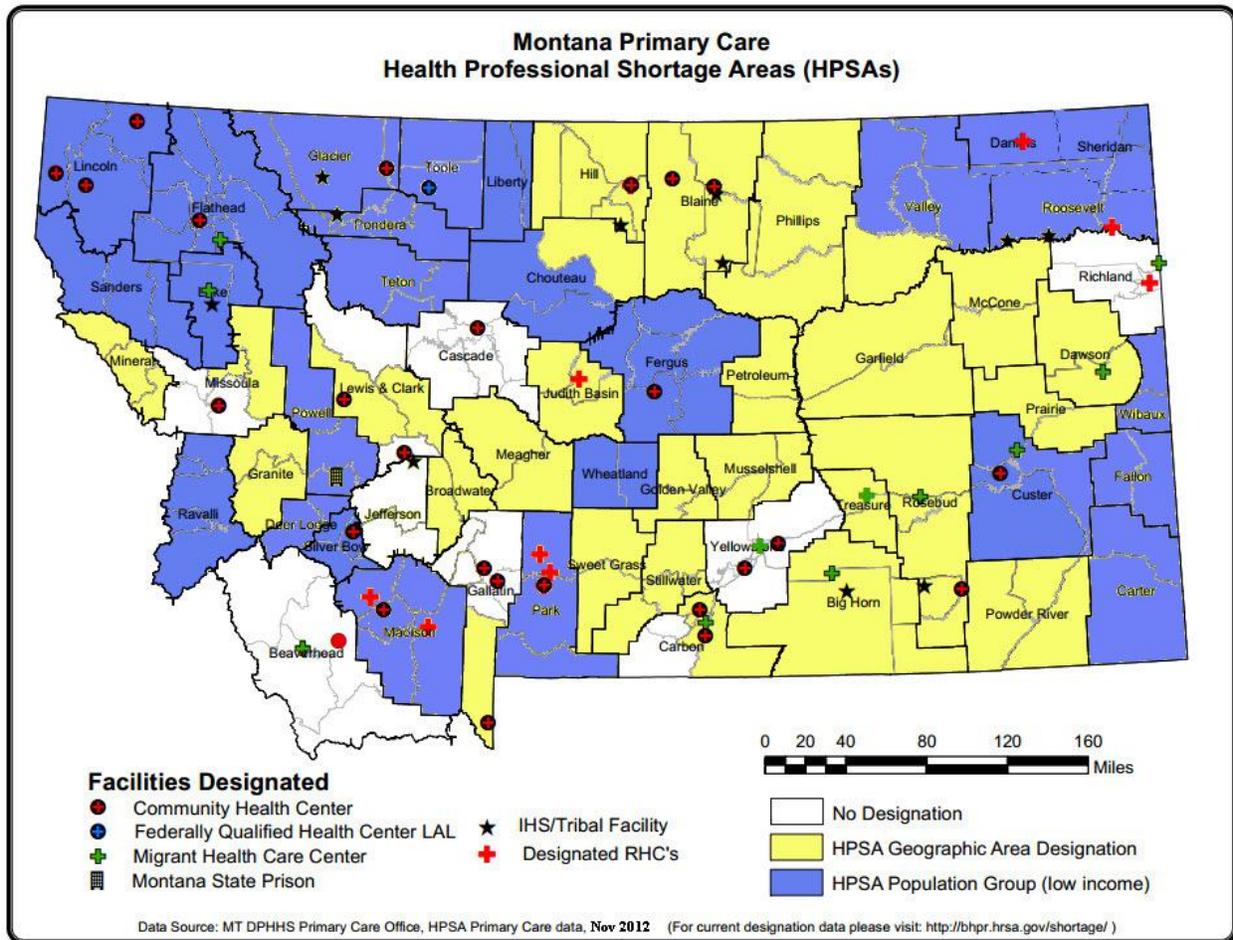
In Montana, there are seven Indian Reservations within and crossing county lines, each with their own health services with numerous hospitals. All seven reservations are designated HPSAs as a result of the population designation criteria. While we know that these are all shortage areas, it is less clear exactly how many people work in "prevention" because the data from Indian Health Services is incomplete and not easily available. In addition to the assumed shortages, the reservations experience other challenges including geographic isolation and high unemployment.

It should also be noted, however, that with these designations can come benefits such as loan payment for recent graduates in mental health fields such as Masters of Social Work. This is intended to attract healthcare workers to counties with a shortage of professionals. The map below documents the 240 National Health Service Corps (NHSC) approved sites in Montana, as of August 2010. The NHSC provides clinicians with financial support in the form of loan repayment and scholarships.



The last map documents those counties identified with a shortage of primary care physicians. In 2011, 48 counties were considered Primary Care HPSAs. Only eight counties were not classified as HPSAs and are shaded in white on the map. Additionally in twelve of the counties, not a single Primary Care Physician was available. Those counties include: 1) Carter, 2) Garfield, 3) Golden Valley, 4) Judith Basin, 5) McCone, 6) Meagher, 7) Musselshell, 8) Petroleum, 9) Powder River, 10) Treasure, 11) Wheatland, and 12) Wibaux. Four of these counties are also

ranked as high and moderate risk counties on the targeted mental and behavioral health problems.



Overall, the state has been dealing with mental health and primary healthcare shortages for at least the last 10 years, with the majority of counties designated as having inadequate numbers of providers. For example, 41% of Montanans live in a county where the ratio of patients to physicians is much higher than the national average of 1:1105 patients to primary care physicians⁵⁶.

Moving away from the complexities of these designations, an understanding of what they really tend to indicate and what is important from a prevention perspective is necessary. Each of these designations has broader implications. For example, if a region, county, or sub population is part of a designation we can conclude there are a number of barriers to accessing mental and behavioral healthcare services. Additionally, it's harder for prevention programs, such as the Montana Suicide Prevention Program, to easily identify partners to train in the evidence based practices and use the prevention resources.

⁵⁶ State Physician Workforce Data Book (2011).
<https://www.aamc.org/download/263512/data/statedata2011.pdf>

Similarly, geographic designations could indicate higher levels of isolation which means there are fewer of the sorts of activities and opportunities that lead to a highly integrated and productive community. Isolated communities are common in a frontier state like Montana. One of the most well documented predictors related to high rates of suicide is isolation and a lack of connection to the local community.⁵⁷ This isolation could be also an indicator of a lack of resources and services that support positive youth development.

Recommendations for Planning:

The online survey data clearly show there is a broad range of state and community employees and volunteers working to prevent or reduce the targeted mental and behavioral health concerns. At this stage, it may be less important to know their exact numbers and more important to build connections with those professionals who serve in the very high risk and high risk counties.

In-keeping with the advice for planners to focus on what is feasible, a priority and likely to be implemented, **the recommendation for workforce enhancement relates to professional development rather than increasing numbers in the workforce.**

Phase II (2013) of the plan includes conducting a needs assessment of training and workforce development needs. This will be spearheaded by the EPI workgroup.

⁵⁷ Montana Department of Public Health and Human Services (2013). Montana Strategic Suicide Prevention Plan. <http://prevention.mt.gov/suicidepreventioniStateSuicidePlan.pdf>

Assessment of SPE Consortium's Planning Capacity

Context: Starting in December, 2012 the SPE Consortium met regularly to work through the planning process, but planning and collaborating together, on this comprehensive and ambitious scale, was new and daunting to all involved. The members were struggling and the process was becoming very frustrating. Karen Ray and Associates' were hired to enhance the capacity of the members to undertake the planning process.

After the first session in June, Karen observed that "At the moment people are struggling with the planning process because we're asking them to do work they are not yet ready to do. We're asking them to have the ability to look internally within their own agency and externally across agencies and plan. They each need to have their "internal ducks in a row" before they can plan across agencies" (email, 7/25/2012).

Assessment Outcomes: Over a three month period (June 2012 to August 2012), Karen assessed the readiness and capacity of the SPE Consortium to effectively collaborate together to plan for prevention. The following excerpts from her report documents her assessment and recommendations to build capacity.

Readiness to collaborate:

As Consortium members worked through this planning process, the cooperation and coordination that was occurring, and was *not* occurring, became obvious. While there was an underlying value system for sharing information and doing tasks together among organizations and professionals, the environment that promotes partnership often did not exist.

Tribal participation in the Consortium fell to four members representing two of the reservations (The Confederated Salish and Kootenai Tribes of the Flathead Reservation and the Rocky Boy's Indian Reservation) and the Montana/Wyoming Tribal Leaders Council. There are current formal relationships between these two reservations. The Tribal Leaders Council represents all of the tribes and provides a means of communication with tribal leadership. An active voice from all seven reservations was not feasible for both logistical reasons (sheer geographical distances to attend meetings) as well as relational reasons; that is, lacking relationships with tribal members in the prevention field⁵⁸. For those who did attend, the value set for working together was evident in these individual Consortium members, but close coordination with the Indian communities is more challenging.

Collaborative planning is more likely to occur with those communities where there is already a positive relationship between Indian and non-Indian communities. For example, linking with the prevention specialists on the Flathead Reservation maybe possible through the relationship with one of the SPE members who is also an ICC member. This member is an enrolled member of the Confederated Salish and Kootenai Tribes of Montana and is closely connected to members working in prevention on the Flathead Reservation. It's also important to recognize that local

⁵⁸ As noted earlier, 76 interviews were conducted with a broad array of professionals from schools, hospitals, treatment facilities, housing authorities, prevention programs and grants, social services, as well as Elders and leaders in the communities to better understand what's happening in Indian Country to inform the planning efforts. Additionally, this provided an opportunity to make connections and build relationships.

tribal priorities for prevention vary from tribe to tribe. Consequently any planning must respect and respond to the divergent priorities.

Readiness to plan:

There were also moments of personal “ahas”; we were deep into the planning process before a member from a particular agency revealed that their strategic prevention plan was being updated. It seems to go against the culture of human service/health/community organizations in Montana to share concrete information about their internal agency processes. This must be addressed in any prevention plan.

Knowing what prevention activities are occurring across state agencies and within departments is one of the roles of *The Prevention Resource Center*, within the Department of Public Health. This is no easy task as the “silo” culture is still evident among and within state agencies. Individual bureaus are naturally focused on planning to meet their own priorities with little resources to expand beyond their purview. At times working through this planning process, engaging members and achieving results was very challenging. Each professional in each unit is working at capacity; creating urgency for collaborative prevention planning will have to come from the Director, each Bureau Chief and every supervisor.

Some of the liveliest discussions centered on data practices. Coalition members alternately described Montana state and tribal agencies as having “a wealth of data” and “data paucity”. Every agency represented has a stated objective of making decisions based on data; this urgency has driven each agency and the units within the state agencies to develop and use separate data banks. Currently efforts to locate data, link data, share data, and use the data to inform the planning process are challenging. An assessment of the current data collection systems including the data sets related to the four targeted health areas and process and outcomes measures will be carried out in 2013 during Phase II of the plan.

Recommendations to enhance Capacity Building:

Leadership Development: During the planning process individual members of the Consortium became more knowledgeable, and more excited, about the potential results of deeply collaborative prevention planning and programming.

The members recognized that to successfully collaborate, implement and sustain multi-agency strategic planning, political and fiscal leverage was essential. The Interagency Coordinating Council for State Prevention Programs (ICC) was identified as possessing these attributes and in September, by way of the ICC workgroup, the ICC agreed to the Consortium’s request to expand their role and lead the effort to create a collaborative environment for prevention.

The ICC has the authority to engage the leaders, of all the partner agencies, to endorse and encourage integrated planning activities. This includes making it a priority, for the specific staff engaged in prevention planning, to build it into their work plans. It also means providing the time and the structures necessary for specific staff to work together, and rewarding collaborative planning and programming.

Support Basic Cooperation: The Department of Public Health could improve collaborative prevention planning by upgrading the centralized resource directory of who does what prevention planning and when and sustain it. If everyone knew who was responsible for creating and updating prevention planning activities, then it would be easier for any given professional to

suggest co-planning activities. If the Department had this directory, it would be easier to work with groups outside the Department.

Promote Values and Vocabulary of Partnerships: Coalition members found value in being able to talk apples-to-apples and oranges-to-oranges. The ICC workgroup could sponsor training activities for planners that encourage the use of the definitions of Collaboration, Coordination and Cooperation and their elements, and promote the value of planning in partnership.

Pilot an Effort in one Prevention Area: The complexities of collaborating for prevention planning have been detailed. If leadership could agree to specifically target an area of prevention such as prescription drug misuse/abuse, then an experiment in true collaborative planning could be constructed and its results measured.

Strengths and Capacity to Build a *Vision for Montana*

At the close of Phase I, there are a number of indications that Montana is now in a better position to build and implement a 5-year strategic prevention plan.

Firstly, the capacity for *sound policy development* now rests with the ICC workgroup. This Policy Consortium has a clear commitment to prevention planning and the leadership capacity to catalyze state agencies to develop and implement the plan.

Secondly, the capacity of the ICC workgroup and SPE Consortium members to *effectively plan and collaborate together* was enhanced by the training and technical assistance provided during this Phase.

1. Empowered Policy Consortium

During the planning process the SPE Consortium agreed that the best policy consortium to build the vision was *The Montana Interagency Coordinating Council for State Prevention Programs* (ICC). The ICC can provide the critical leadership to advocate for the focus on prevention, catalyze actions across agencies, spearhead the development of the plan, and support the implementation of the plan elements. Eleven of the ICC workgroup members are also SPE Consortium members who developed the planning document and understand the Vision for Montana. Those agencies, not currently part of ICC workgroup are willing to join; including adult Mental Health, Montana Army National Guard and the state Suicide Prevention Program.

Leadership Capacity

The Montana Interagency Coordinating Council for State Prevention Programs was created in 1993 by the Montana Legislature (Statute 2-15-225) during a special legislative session. This council was created in response to the need to unify and integrate all state level prevention efforts, to build partnerships and to more effectively fund prevention.

In 1996, *The Prevention Resource Center* was established within the Montana Department of Public Health and Human Services to staff the Interagency Coordinating Council as well as operate a large scale AmeriCorps*VISTA (Volunteer in Service to America) grant. The ICC is a part of the organizational structure of the state government, illustrating its institutionalized position and relationship to state agencies.

The Council includes members from twelve state agencies, and two people, appointed by the governor, with prevention program/services experience in the private/non-profit sectors. The working arm of the council is the ICC workgroup. This group has 15 members drawn from the respective state agencies and non-government organizations. The time and resources allocated for the operation of the Council and working group are in-kind contributions by each of the state agencies.

ICC Members

1. Attorney General
2. Director of the Department of Public Health and Human Services
3. Superintendent of Public Instruction
4. Presiding officer of the Montana Children's Trust Fund board
5. Administrator of the Board of Crime Control
6. Commissioner of Labor and Industry
7. Director of the Department of Corrections
8. State Coordinator of Indian Affairs
9. Director of the Department of Transportation
10. Director of the Department of Revenue
11. Commissioner of Higher Education
12. Designated representative of a state agency who wants to participate and is acceptable to a majority of the other members
13. Two governor appointees.

Committed Focus on Prevention

The ICC and the workgroup have four mandates that clearly illustrate a commitment to planning prevention activities, using a public health model of prevention, and a commitment to cross-agency cooperation and coordination of prevention services.

Prevention Mandates

1. Develop, through interagency planning and cooperation, comprehensive and coordinated prevention programs that will strengthen the healthy development, well-being, and safety of children, families, individuals, and communities;
2. Develop appropriate interagency prevention programs and services that address the problems of at-risk children and families and that can be provided in a flexible manner to meet the needs of those children and families;
3. Ensure that a balanced and comprehensive range of prevention services is available to children and families with specific or multiagency needs; and
4. Assist in the development of cooperative partnerships among state agencies and community-based public and private providers of prevention programs.

Since 1993, the ICC has demonstrated its capacity to successfully adapt to changing political, fiscal and prevention priority landscapes. The Council started with 23 broad based prevention goals and refined those to the following five goals that promote emotional health of youth.

Current ICC Goals

1. Reducing child abuse and neglect by promoting child safety and healthy family functioning;
2. Reducing use by youth of tobacco, alcohol, and other drugs by promoting alternative activities and healthy lifestyles;
3. Reducing youth violence and crime by promoting the safety of all citizens;
4. Reducing the school dropout rate by increasing the percentage of high school students who successfully transition from school to work, post-secondary education, training, and/or the military; and
5. Reducing teen pregnancy and sexually transmitted diseases by promoting the concept that sexual activity, pregnancy, and child rearing are serious responsibilities.

These five goals and their benchmarks directly align with the Department of Public Health and Human Services, Prevention Resource Center's Mission Statement: *create and sustain a coordinated, comprehensive system of prevention services in the State of Montana.*⁵⁹

The ICC operates under four assumptions about prevention; these assumptions directly influence how prevention efforts are planned and implemented. These assumptions are in-keeping with those advocated for the five-year strategic plan.

⁵⁹ ICC goals and benchmarks: <http://prevention.mt.gov/icc/goals/index.php>

The five-year plan adds one more assumption -- *effective prevention takes time and is a developmental process with each step building on the other.*

Assumptions about Prevention

1. Effective prevention incorporates strategies that are evidence-based, grounded in current theory and data, and developmentally appropriate for the population served.
2. Effective prevention takes into account the complex environment within which youth live, work and play (family, peer, institutional, community and cultural influences on behavior)
3. Effective prevention must be collaborative, involving all members of the community (family, schools, campuses, law enforcement, hospitality industry, etc.)
4. Effective prevention must be comprehensive: no one strategy alone will make a substantive impact. Strategies should target two levels of influence:
 - Individual (education, early intervention, treatment)
 - Environmental (restricting access, limiting marketing, creating and enforcing community & state laws and policies.

Capacity to catalyze actions across state agencies

For the past twelve years, the ICC and its workgroup has demonstrated the capacity to garner and sustain cross-agency commitment to prevention. This is the capacity, of those with decision-making authority within each state agency, to recognize the value of coordinated prevention efforts and to allocate resources and support their staffs to participate in planning and implementing prevention activities.

Prevention is everyone's business. We can do better together.

The infrastructure of the ICC provides state agencies with the statutory authority and a mechanism to share and coordinate resources for prevention activities. For example, during Spring 2012, five state agencies funded 30 second television and radio PSAs that were heard state-wide. The message reminded parents to talk with their children about underage drinking. The PSAs aired during prom and through graduation time. This was the second year that the PSAs were funded. Interestingly, it was the media that approached the ICC workgroup to run the PSAs again as the messages were deemed powerful and important public health messages.

Not all prevention activities require the coordination of fiscal resources but instead rely on the coordination of human capital, across multiple state agencies and communities. In September 2012, the ICC workgroup agreed to adopt the *Above the Influence* (ATI) National Media Campaign and tool kit as part of their underage drinking prevention messaging and to gradually implement the campaign through their extensive networks and community partners.

The capacity of the ICC infrastructure has also been recognized on a national level as it was an essential component needed to secure a State Incentive Grant, a Strategic Prevention Framework State Incentive Grant (SPF SIG – Cohort 2), and the Strategic Prevention Enhancement Grant.

At the August meeting of the ICC workgroup, the Director of *The Prevention Resource Center* shared the SPE Consortium's request for the ICC to take on the leadership of developing the

five-year strategic plan. The working group discussed the vision and implications of the expanded role and agreed to the request. The graphic illustrates the vision for the ICC.



Capacity to oversee the development and implementation of a five-year strategic plan

It’s already clear that the ICC and its workgroup can provide the needed leadership, advocacy and action to move this planning process forward. It’s also useful to compare the current capacity of the ICC to the “ideal” prevention infrastructure elements of a policy consortium as noted in the grant RFA (pages 10 & 11). The following table provides the comparison. The first column lists the desirable elements, the second column reports on how the ICC rates on these elements, and the final column lists some of the steps that can move the ICC towards the ideal model.

For example, the table shows that the membership of the ICC covers most of the recommended areas such as substance abuse, education, justice and could be expanded to include mental and behavioral health, primary health care and tribal health care. In many cases, the enhancements have already been under consideration and the timing is right to move to the next level.

Ideal Elements of a Policy Consortium	Current Status of the ICC	Steps to Enhance ICC Capacity
<p>Works across divisions and departments to form a consortium of representatives from State/Tribal agencies/authorities involved in the prevention of substance use and associated problems.</p> <p>At a minimum, the lead agencies or authorities representing substance abuse, education, justice, public health, highway safety, law enforcement, mental/behavioral health programs and primary health care within the State/Tribe should be included in the consortium.</p>	<p>ICC Council includes decision makers from twelve state agencies.</p> <p>Ten of the state agencies represent the recommended areas: substance abuse, education, justice, highway safety, law enforcement, and public health.</p>	<p>Expand membership to include: mental/behavioral health, primary health care and tribal health care. This is already slated for 2013.</p>
<p>It should be comprised of State/Tribal level decision makers who will be responsible for managing the cooperative agreement and ensuring that elements outlined in the Capacity Building Infrastructure Enhancement Plan and the comprehensive, 5-year Strategic Plan are in place and operating.</p>	<p>ICC Council includes decision makers from twelve state agencies with the leadership, resources and leverage needed.</p> <p>The ICC workgroup includes agency staff ready to expand the work scope and develop a comprehensive plan and implement the elements.</p>	<p>ICC leadership commits to <i>true</i> collaboration in order to build and sustain the plan. That is, committing to building a mutually beneficial relationship among agencies, not individuals; committing to mutual outcomes; to developing a shared structure and responsibility; to allocating resources; to changing and improving individual agency policies and procedures.</p>
<p>Collaborations should reduce redundancies and build consistency in State/Tribal programming to facilitate the support of communities in achieving outcomes.</p> <p>Expected to develop memoranda of understanding that specify the roles and expectations of each agency/authority represented in the consortium.</p>	<p>Until now informal agreements have been in place. Montana is moving toward developing memoranda of understanding that specify the roles and expectations of each agency/authority represented on the Council.</p>	<p>MOUs will occur in Phase II (2013). Memoranda of Understanding will formalize the commitment to move toward <i>true</i> collaboration. MOUs will cover such topics as data driven funding allocation methods; training and technical assistance; evidence based workgroups.</p>

A Montana Ideal: Agency staffs have clear directions from leadership that *true* collaborative planning is a priority, not an add-on.

2. Enhanced capacity to effectively plan and collaborate

During Phase I, a number of training and technical assistance sessions were held with the SPE Consortium and ICC workgroup members. For example, the members were trained in: 1) the elements of the Public Health Model, 2) the how-to of *true* collaboration and 3) building an Evidenced Based Workgroup. Technical assistance was also provided to the DPHHS grant staff by the collaboration expert in order to enhance and expedite the planning process.

The most recent version of the SAPST training was offered to the ICC workgroup (16 of whom are also SPE Consortium members). This training was also offered to Prevention Specialists in Chemical Dependency and Mental Health working in Montana communities. This version integrates a public health approach to prevention, it embraces behavioral health, and provides guidance on a more sophisticated level of using data, identifying strategies, implementation, and sustainability and evaluation.

Several members of the SPE Consortium, who are concurrent members of the ICC, engaged in discussions about and training in *Adverse Childhood Experiences* (ACEs). Members represented a variety of agencies engaged in their respective prevention efforts including Juvenile Justice, DPHHS and the Wyoming Tribal Council. Discussion among the members revealed an enthusiasm for raising awareness about this approach within their agencies and across agencies to better understand the risk factors that contribute to poor mental and behavioral health. *This capacity building step will be part of the planning process in Phase II.*

This ACES approach fits nicely with the public health model as it provides an understanding of how a broad range of early childhood trauma stressors impact a lifetime of consequences. It recognizes the developmental trajectory of adverse trauma experiences, starting in childhood and accumulating over a lifespan and adversely impacting mental and behavioral health.⁶⁰ Over time, and often during adolescence, the child adopts coping mechanisms, many of which are harmful such as alcohol and tobacco use. The ACES study demonstrated a strong relationship between ACEs and initiation of drug and alcohol use in childhood and adolescence, and the impact persists into adulthood and continues to predict problem drinking behavior and illicit drug use. According to the study authors, responses to underage drinking will not be effective unless youth are helped to recognize and cope with stressors of abuse, domestic violence and other adverse experiences. Further the study indicates that the greater number of ACEs, the increased vulnerability for the risk of suicide, both in adolescence and adulthood.

A powerful outcome of this approach is when adverse childhood experiences are reduced, the impact predicts a simultaneous **reduction across generations** in alcohol and heavy drinking, cardiovascular disease, cancer, separation/divorce, life dissatisfaction, mental health conditions, hopelessness, mental health treatment, anxiety, and HIV risk.

The bottom line -- In the end, we're asking state agencies to *commit to building a relationship* –to move from cooperation and coordination to a more rigorous level – true collaboration. It is a mutually beneficial relationship (not a well-defined task) among agencies, not individuals; to commit to mutual outcomes; to develop a shared structure and shared responsibility; to allocate resources; to reap the rewards; and to change and improve upon individual agency policies and procedures.

⁶⁰ A full description of ACES is provided in Appendix G.

OUTCOMES OF PHASE I

(Outcomes are linked to the goals of the grant proposal)

- ❖ **Empowered Policy Consortium** -- The Interagency Coordinating Council (ICC) and its workgroup – new vision, expanded role to include the targeted health areas. Leadership and infrastructure for future planning and implementation clearly established (**Goals 3, 4**).
- ❖ **Coordination of Services:** Likelihood of coordination of prevention services/efforts is enhanced by the influence of the ICC and ICC workgroup (**Goals 1, 2, 4, 5**).
- ❖ **Needs Assessment Data:** Targeted mental and behavioral health data are available for use in planning (**Goals 3, 4**).
- ❖ **Workforce recommendations** are available for use in planning (**Goals 2, 4**).
- ❖ **Reservation interview data** are available for use in planning (**Goals 1, 3, 4**).
- ❖ **State level data on current prevention efforts** are available for planning (**Goals 1 to 6**).
- ❖ **Maps of Montana and data tables** that indicate the counties and reservations with the highest rates of the targeted mental and behavioral health problems are available. These will help target planning in the highest and very high risk counties and reservations (**Goal 4**).

Grant Goal 1: Montana will build consensus around a culturally competent program of substance abuse and mental illness prevention by *raising awareness of evidence based practices statewide* among a diverse group of stakeholders including consumers of services, providers, policy makers, prevention stakeholders and community leaders.

Grant Goal 2: Montana will identify *specific behavioral health care workforce needs* to enable a targeted approach to work force development. In partnership with Montana's university system, licensing boards and state department of labor, this SPE project will further enhance workforce development efforts in the state to better achieve prevention goals.

Grant Goal 3: Montana will build capacity for sound *policy development* through the *empowerment* of a SPE Policy Consortium, unified under common goals that reach across diverse industries including health care, transportation, education, suicide prevention, veterans' services and public policy.

Grant Goal 4: Montana will create a unified 5 year strategic plan for prevention that meets identified *needs at the state and local level*, will be achievable and have measureable outcomes, and will address needs within the current economic landscape

Grant Goal 5: Montana will *establish a solid foundation upon which to establish a state specific evidence based workgroup*. This workgroup, once established, will identify evidence based practices for implementation, define process and outcome measures and provide expertise in the development of implementation policies. The TA and Training mini-plan will further identify the action steps for this goal.

Grant Goal 6: Montana will work collaboratively with the state university system to *identify process and outcome measures* that are data driven, attainable within our current infrastructure and measurable with the staffing resources available in state.

Developing Coordinated Prevention: A Vision for Montana

As noted earlier, this is not a traditional strategic plan. The document has a developmental approach and follows the steps of the Strategic Prevention Framework. It starts with assessing needs, then building capacity, planning, implementing and piloting strategies, evaluating the effectiveness and sustaining what is identified as effective. By Year 5 Montana will be in a better place; it will be better informed about the targeted health areas and their impact, and state agencies will have experience with planning for and implementing prevention across agencies.

FRAMEWORK FOR BUILDING THE PLAN

Use a public health model to guide how agencies can work together to develop a useful prevention infrastructure to prevent/reduce suicide and attempted suicide, to prevent and reduce the consequences of underage and adult problem drinking, reduce prescription drug misuse/abuse, and to build emotional health.

Assumption: Building *Emotional Health* is considered the ultimate outcome from successfully preventing and mitigating the consequences of underage and adult problem drinking, suicide and attempted suicide, and prescription drug misuse and abuse. No activities are planned to specifically build Emotional Health. Rather the activities and approaches used to address the targeted health areas will culminate in building Emotional Health. That is, by promoting skills and strategies to cope with stress (Source: SAPST Training, 2012)

In using a public health model, by definition, the plan acknowledges that health problems and their consequences overlap and can interact, and that the factors that contribute to poor emotional health can also overlap. The interrelationships mean that prevention efforts can positively impact more than one health problem or risk factor.

Overall goal of plan: EHANCE Emotional Health using environmental strategies to reduce the risk factors (we can influence) and promote the protective factors (we can influence) that are associated with healthy behavior. Promote the conditions in which the healthy choice is the default choice.

Our responsibility: ENHANCE ...

Prevention/reduction of the *consequences* of underage drinking
Prevention/reduction of the *consequences* of adult problem drinking
Prevention/reduction of suicides and attempted suicides
Reduction of Prescription drug misuse/abuse

Note: SAMHSA requires us to address the consequences of drinking, but as a Consortium we recognize that efforts that focus solely on consequences do not necessarily modify behavior. Rather in the plan we also need to focus on attitudes/beliefs to effect behavioral change.

Mental and behavioral health problems in order of priority based on EPI data:

1. Suicide and attempted suicide American Indians; Adults; High school/teens; Young adults/university age; Military families, LGBTQ
2. Underage drinking Young adults/university students; High school/teens
3. Adult problem drinking Young adults/university students; Adults
4. Prescription drug misuse/abuse Across all ages

Caveat: The priority rankings for suicide and attempted suicide specifically for university student/young adults, Military families and LGBTQ populations and Prescription drug misuse and abuse are controversial due to the paucity of data for these two public health problems. The planners will take this into consideration.

The following table outlines the developmental phases of the planning process, including the theme of each phase and the timeline.

Developmental Phase	Theme	Year
Phase I	Needs Assessment	2012
Phase II	Capacity Building to Plan (Additional Needs Assessments)	2013 (Year 1)
Phase III	Planning	2014 (Year 2)
Phase IV	Implementing and Evaluation	2015 (Year 3)
Phase V	Implementation and Evaluation	2016 (Year 4)
Phase VI	Implementation and Evaluation	2017 (Year 5)

In addition to using the public health philosophy to build the Strategic Plan, the steps of the Strategic Prevention Framework will be followed to support the process.⁶¹

⁶¹ Identifying and selecting evidence-based interventions. Revised guidance document for the Strategic Prevention Framework State Incentive Grant Program (January 2009). U.S. Department of Health and Human Services (page 3).



Step One: Needs Assessment – Helped define the problem (Phase I). Conducted assessments to determine: 1) the nature of the health problems; 2) where the problems occurred, 3) whom it affected, 4) what were the consequences, 4) what is being done to address the targeted health problems and 5) the readiness to act.

Step Two: Capacity Building – Mobilizes human, organizational, and financial resources (Phase II). Continue to build capacity at state, policy consortium, and community levels to address the needs and problems identified in Step One. For example: building and training an Evidenced-Based Workgroup; conducting additional needs assessment to address gaps in knowledge.

Ongoing step

Cultural Competency – Take steps to acquire cultural knowledge and skill development to build a culturally competent program for prevention. For example, the Evidenced-Workgroup consults with members of the LGBTQ community, Military Family members, and American Indian populations.

Ongoing step

Sustainability – If true collaboration occurs, the prevention system becomes the norm and the policies, financing and delivery of coordinated services, data collection, sharing and reporting, and training become integrated into agency operations.

Step Three: Planning - Develop a Strategic Prevention Plan (Phase III). The plan expresses a vision for prevention activities and a roadmap for conducting them. It uses the data from the needs assessments to inform the planning. It describes policies and relationships, incentives for groups to work together, and evidence-based actions to be taken. The plan will identify the milestones and outcomes for gauging effectiveness and performance. Figure 1 depicts the roadmap (page 104).

Step Four: Implementation – Carry out the components of the Plan (Phases III, IV, V & VI). For example, pilot the evidenced-based programs and coordinated services, introduce any new policies and practices, conduct trainings and provide technical assistance.

Step Five: Evaluation – Measure the impact of prevention efforts and modify as necessary (Phases IV, V & VI). As programs, practices and policies are piloted, continue to monitor and evaluate efforts. Sustain what has worked well and should be maintained.

Phase I: Needs Assessment -- Outcomes

- ❖ Assessments of the severity of the targeted mental and behavioral health problems in the counties and on the reservations
- ❖ Assessment of current prevention efforts of state agencies and the tribes
- ❖ Assessment of current prevention and healthcare workforce and recommendations
- ❖ Assessment of the capacity and readiness of the SPE Consortium and ICC to plan for prevention

Phase II: Capacity Building to Plan (2013)

Phase II involves continuing Capacity Building and Needs Assessment activities in order to be in a better position to build a plan in 2014. We recognize this is an ambitious schedule of activities and some activities may be carried over to Phase III. This is a developmental process and as capacity builds, activities will occur in their natural order. There's sufficient time built into the plan to allow for flexibility and to accomplish all the activities by the end of Year 5 (2017).

The ICC and partners will apply to SAMHSA for funding to support the activities for Phases II and III. Additionally, theoretically the ICC has the authority to leverage state resources for planning and prevention.

Capacity Building Activities:

1. **Policy Consortium:** ICC and workgroup expands membership to include experts in all the targeted health areas and identifies mechanisms, such as advisory groups, to connect to other champions of prevention including the business community and non-governmental, and youth development organizations. Memorandum of Understanding (MOUs) are developed with the members.
2. ICC establishes an **Evidenced-Based Workgroup (EBW)**. *Goal:* To support state-wide efforts to promote behavioral and mental health and target the risk factors associated with suicide, underage drinking and adult problem drinking and prescription drug misuse/abuse. Define: membership, scope, activities and training needs.
3. **Cultural Competency:** Members of the LGBTQ, Military families and American Indian populations are invited to consult with the EBW.
4. **Cultural Competency:** Identify ways and means to build on the relationships developed during the interviews with the prevention experts on the seven reservations and to build relationships with the Tribal Governments.
5. **Cultural Competency:** Consult with primary health care professionals on how to integrate a holistic approach to substance abuse and mental health into primary health care settings.
6. **Training/Technical Assistance/Cultural Competency:** Educate planning members and respective agencies in the ACES (Adverse Childhood Experiences) theory and approach to reducing the risk factors involved in mental and behavioral health.
7. **Data Capacity and Sharing:** Consult with EPI Workgroup and Data Economist on what data-related capacity building is desirable and possible, with the goal to move away from data silos to linking and cross-tabbing the health data.
8. **Data Capacity and Reporting:** Consult with EPI Workgroup and Data Economist on how to improve data collection and reporting for LGBTQ, Military families and American Indian populations.
9. **Data Sharing:** ICC workgroup members keep their agencies and constituents informed about the plan to build buy-in and readiness to implement the plan.

Needs Assessments Activities:

1. **Workforce development and training:** Review existing training plans to identify the training needs of behavioral health care workforce and prevention specialists. Assessment includes needs around cultural competency, targeted health behaviors, use of appropriate environmental strategies, readiness to approach substance abuse and mental health promotion as co-occurring and interrelated. EPI Workgroup to spearhead and report on these assessments.
2. **Assessment of the very high risk and high risk communities** to identify the risk factors that influence or contribute to the health problems and can be changed; identify the risk factors that overlap and contribute to more than one health problem; and identify the protective factors. EPI Workgroup to spearhead and report on these assessments.
3. **Assessment of the existing resources and readiness** of these communities to address their health problems. Includes assessment of Evidenced-Based and Practice-Based programs currently in use. EPI Workgroup to spearhead and report on these assessments.
4. **Assessment of the current data collection systems** including the data sets related to the four targeted health areas and process and outcomes measures. EPI Workgroup to spearhead and report on these assessments; consulting with health content experts as to data concerns, missing data and recommendations for enhancement.
5. **Assessment of the financial and other resources, organizational cultures and readiness of the ICC and member agencies** to plan and coordinate prevention efforts. EPI Workgroup to spearhead and report on these assessments.
6. **Identify any newly released data** on the targeted health behaviors. EPI workgroup compiles and shares the data.

OUTCOMES OF PHASE II:

(Outcomes are linked to the goals of the grant proposal)

- ❖ Montana has enhanced capacity for **sound policy development and planning** through the empowerment of the ICC and member agencies **(Goals 3, 4)**.
- ❖ Montana has an **Evidenced-Based Workgroup** to evaluate the training needs of the prevention workforce. It has a workgroup with the capacity to raise awareness about the value of cultural competency for prevention and to recommend interventions **(Goals 1, 2, 5)**.
- ❖ Montana has data on **workforce needs; community risk and protective factors and readiness and resources** to address the targeted health problems; and knowledge about the strengths and weaknesses of the current **data collection systems (Goals 1, 2, 3, 4, 6)**.
- ❖ Montana has data on the **fiscal and organizational parameters and readiness of state-level agencies to plan**, and areas for enhancement **(Goals 2, 3)**.

Phase III: Planning for Coordinated Prevention (2014)

Phase III focuses on developing a unified, comprehensive strategic plan. The plan articulates a vision for organizing specific prevention programs, policies, and practices to address the targeted health areas in specific counties/reservations.

We recognize that this is a developmental process and some Phase II activities may still be on-going and will be completed in 2014. There's sufficient time built into the plan to allow for flexibility and to accomplish all the activities by the end of Year 5 (2017).

Planning Activities

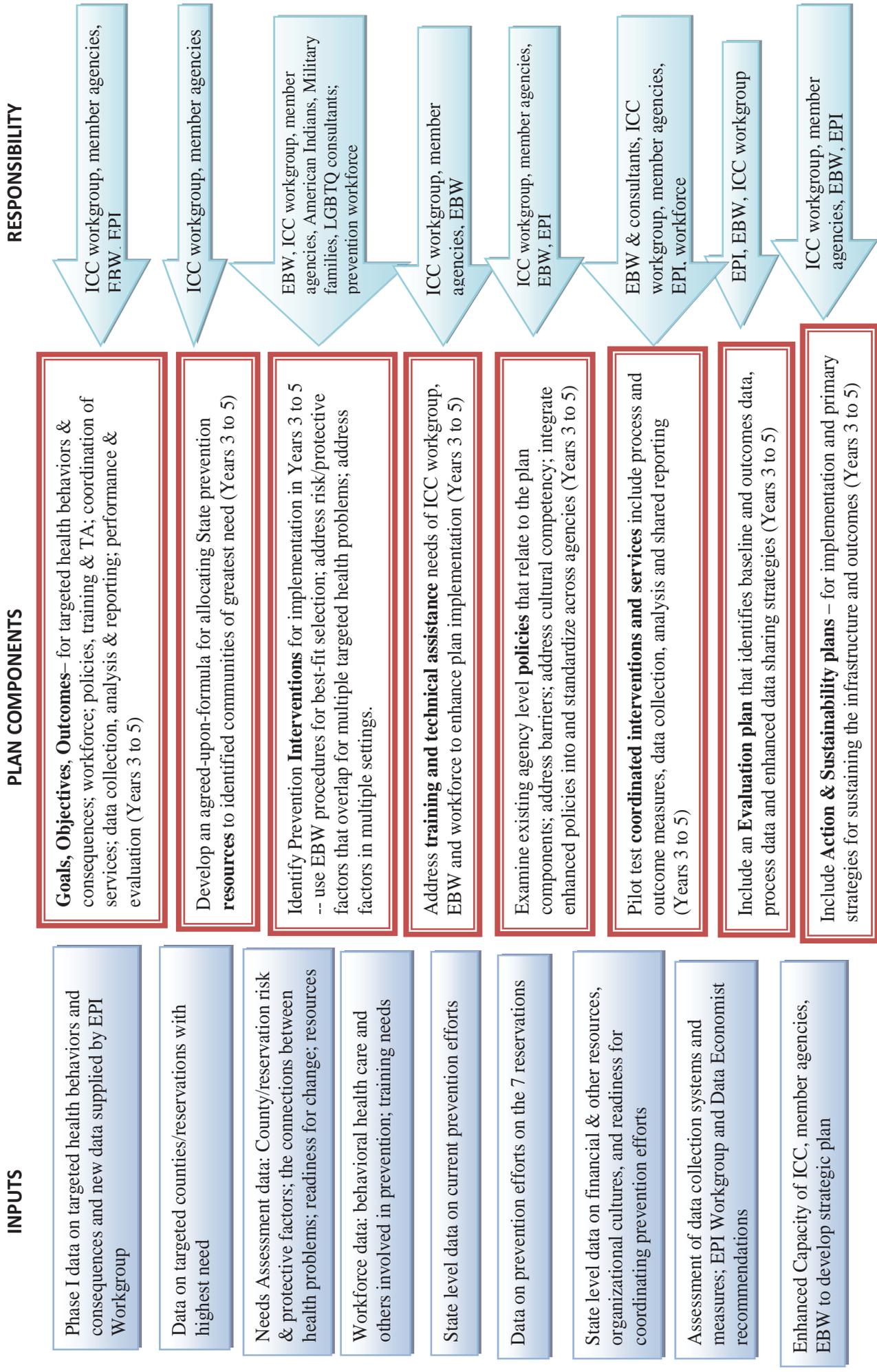
1. The ICC workgroup and member agencies, the EBW and consultants use the public health model to **create a unified strategic prevention** plan that addresses the targeted health areas.
2. Figure 1 outlines the **Logic Model for Planning**. The model includes: 1) the inputs needed in planning such as the needs assessment data and the capacity to plan; 2) the required plan components including goals and objectives, timelines, and 3) indicates those responsible for building and implementing the plan components. *This model includes six of the critical components of a strategic prevention plan required by SAMHSA (RFA No. SP-11-004; pages 13 &14).*
3. The plan will include **a unified, comprehensive approach to prevention**; a combination of Health Promotion (general population), Universal (general population), Selective (targeted to subgroups) and Indicated (targeting particular high-risk individuals) prevention interventions (including programs, practices, strategies).
4. The developers will keep **abreast of strategies and approaches coming out** of SAMHSA for possible inclusion in the plan.
5. **The Plan will be disseminated for review and comments** from agencies and the prevention and health care workforce on reservations and in targeted counties, and members of the targeted risk populations.
6. **Data collection, sharing and reporting activities** will include the new ACES measures that will be collected in 2014 and 2015. This data collection will be funded by one of the ICC partners, The Children's Trust Fund.
7. Once the Plan is finalized the ICC members will **work within their agencies to implement the plan** and with the counties/reservations to cultivate buy-in and foster *true* collaboration.

OUTCOMES OF PHASE III:

(Outcomes are linked to the goals of the grant proposal)

- ❖ Montana has a **five-year Strategic Plan** that was developed with input from state level agencies, the EBW, American Indians, Military families, LGBTQ populations, EPI workgroup, and the workforce responsible for prevention in counties and on reservations (**Goals 1 to 6**).
- ❖ Agencies and counties/reservations are **ready to implement** the plan and recognize the value of prevention for the communities (**Goals 1 to 6**).

Figure 1: LOGIC MODEL FOR PLANNING



Phase IV: Implementing Plan and Evaluation (2015)

Phase IV: Includes both Steps 4 & 5 of the SP Framework.

Step Four: Implementation: Pilot the evidenced-based programs and coordinated services, introduce any new policies and practices, conduct trainings and provide technical assistance. Culturally competent revisions are made without sacrificing core elements of the program.

Step Five: Monitoring and Evaluation: Monitor and evaluate results and the ability to continue. Ongoing monitoring and evaluation is vital for determining whether the desired outcomes are achieved, for assessing the quality of service delivery, and for identifying needed improvements. Sustaining what has worked well should be an ongoing process.

1. ICC and partners implement the Strategic Plan and the Action Plan.
2. Selected interventions are pilot tested in targeted counties/reservations and process and outcome data are collected, analyzed and shared with the partners.
3. ICC and partners monitor and evaluate the successes and follow the Evaluation Plan.
4. ICC and partners use the data to improve on the Action and Evaluation Plans.

Phase V: Implementing Plan and Evaluation (2016)

Phase V: Includes both Steps 4 & 5 of the SP Framework.

Step Four: Implementation: Pilot the prevention activities, programs, practices. Support implementation with training and technical assistance as needed. Culturally competent revisions are made without sacrificing core elements of the program.

Step Five: Monitoring and Evaluation: Monitor pilot testing of interventions; monitor plan implementation; evaluate effectiveness of Phase IV interventions; sustain effective activities; improve or replace those that failed.

1. ICC and partners continue to implement the Strategic Plan and the Action Plan.
2. Selected interventions are continued in targeted counties/reservations; additional interventions are introduced and pilot tested as appropriate.
3. ICC and partners monitor and evaluate the successes and follow the Evaluation Plan.
4. ICC and partners use the data to improve on the Action and Evaluation Plans.

Phase VI: Implementing Plan and Evaluation (2017)

Phase VI: Includes Steps 4 & 5.

1. ICC and partners continue to implement the Strategic Plan and the Action Plan.
2. Selected interventions are continued in targeted counties/reservations; additional interventions are introduced and pilot tested as appropriate.
3. ICC and partners monitor and evaluate the successes and follow the Evaluation Plan.
4. ICC and partners use the data to improve on the Action and Evaluation Plans.

OUTCOMES OF PHASE IV- VI (Outcomes satisfy all 6 goals of the grant proposal)

- ❖ Montana uses a **more culturally competent prevention** program under the **guidance of an EBW**.
- ❖ Montana's health care and prevention **workforce is better prepared**.
- ❖ MT has the capacity for **sound policy** development.
- ❖ Montana uses a **unified prevention plan**.
- ❖ Montana's **data collection and reporting** system is addressing the challenges of the past.

APPENDIX A:
Capacity Building and Infrastructure Mini-Plans
Progress Report

As required, Montana submitted the mini-plans within the first few months of the grant. At that stage there was optimism that, over time, the Consortium members would be able to carry out the plan activities. Indeed four workgroups, comprised of Consortium members, were convened to work on the objectives of the mini-plans. However it became clear that the groups struggled to carry out the objectives, they were frustrated by the experience and it was not a good use of their time. The work ceased on the mini-plan activities.

Instead, the Consortium identified those activities that were doable and the grant manager with the support of the Data Economist, the Epidemiological Workgroup (EPI) and a number of content experts carried out those activities.

The following tables indicate what activities were accomplished in Phase I and what activities will occur in Phases II to VI.

TA and Training Mini-Plan

Goal: The SPE Consortium will assess Montana’s state agencies prevention and health promotion programs training and technical assistance needs and identify areas for enhancement and collaboration. *This was not carried out in Phase I.*

Timelines
Phase I: 2012; Phase II: 2013; Phase III: 2014; Phase IV: 2015; Phase V: 2016; Phase VI: 2017

Objectives	Progress and Timelines
1. Identify ways to restructure current technical assistance and training programs for behavioral health, prevention and primary care professionals.	<ul style="list-style-type: none"> ❖ Phase II: needs assessment conducted; recommendations from EPI workgroup. ❖ Phase III to VI: TA & Training plan developed, implemented and evaluated.
2. Create technical assistance and training systems responsive to the needs of communities and coalitions.	<ul style="list-style-type: none"> ❖ Phase III to VI: TA & Training plan developed, implemented and evaluated.

Coordination of Services Mini-Plan

Goal: The SPE Consortium will assess Montana’s state agencies current coordination of services, policies and system and identify areas for enhancement to include a targeted approach to workforce development.

Timelines

Phase I: 2012; Phase II: 2013; Phase III: 2014; Phase IV: 2015; Phase V: 2016; Phase VI: 2017

Objectives	Progress and Timelines
1. Review agency strategic plans, work plans, goals and objectives and identify prevention goals and objectives.	<ul style="list-style-type: none"> ❖ Phase I: Agency plans were reviewed. Where relevant, goals, objectives and activities were highlighted in the planning document. ❖ Phase II to VI: continue to assess, build plan, implement, and evaluate.
2. Identify program commonalities and aggregate goals and objectives and build consensus around common goals to include in development of a strategic plan.	<ul style="list-style-type: none"> ❖ Phase I: no activities. ❖ Phase III to VI: Coordinated services plan developed, implemented and evaluated.
3. Identify cost savings information from redirecting and braiding support.	<ul style="list-style-type: none"> ❖ Phase I: no activities. ❖ Phase II to VI: assess, plan, implement, and evaluate.
4. Identify ways to enhance provider networks to share information, lessons learned and ways to make changes to benefit the whole system.	<ul style="list-style-type: none"> ❖ Phase I: no activities. ❖ Phase II to VI: assess, plan, implement, and evaluate.
5. Review Evidence-Based presentation.	<ul style="list-style-type: none"> ❖ Phase I: completed.
6. Identify key stakeholders and invite them to participate in evidence based work group.	<ul style="list-style-type: none"> ❖ Phase II: EBW established.
7. Review evidence based projects and programs and note barriers to implementation in Montana.	<ul style="list-style-type: none"> ❖ Phase I: online survey data documents EBPs and non-EBPs used by state agencies. ❖ Phase II to VI: assess county-level use.
8. Create structure for group to be advisory to future program and policy development.	<ul style="list-style-type: none"> ❖ Phase II: EBW scope of work, activities, and training needs identified.
9. Identify opportunities to leverage or share resources to high need communities.	<ul style="list-style-type: none"> ❖ Phase II to VI: assess, plan, implement, and evaluate.
10. Department of Labor reviews Montana’s health care workforce by county level.	<ul style="list-style-type: none"> ❖ Phase I: needs assessment conducted; recommendations provided.
11. Comparison of workforce needs at optimal level to available workforce levels.	<ul style="list-style-type: none"> ❖ Phase II to VI: further needs assessment, planning, implementation and evaluation.

Data Collection, Analysis and Reporting Mini-Plan

Goal: The SPE Consortium will assess Montana’s data collection, analysis and reporting methods relative to the state’s prevention and health promotion efforts.

Timelines
Phase I: 2012; Phase II: 2013; Phase III: 2014; Phase IV: 2015; Phase V: 2016; Phase VI: 2017

Objectives	Progress and Timelines
1. Identify and review the data sets used by state prevention and health promotion programs, services and activities to determine what data are being used and what gaps in data or accessibility to data exist.	❖ Phase I: Data elements, gaps and barriers identified.
2. Review data collection and reporting methods for inclusion in process evaluation.	❖ Phase I: Online survey data documents process and reporting practices.
3. Identify opportunities to leverage or share resources for high need communities.	❖ Phase II to VI: assess, plan, implement, and evaluate.
4. Identify any expansion/enhancement needed for the Epidemiology Workgroup to meet the needs of the SPE project.	❖ Phase I: EPI workgroup completed assessment of severity of targeted mental and behavioral health problems. ❖ Phase II to VI: EPI workgroup continues to assess and support planning, implementation and evaluation.
5. Identify data sets, outcome measures and timeline for implementing a five year strategic plan.	❖ Phases II to VI: assess, plan, implement, and evaluate.

Performance/Evaluation Mini-Plan

Goal: The SPE Consortium will assess Montana’s state agencies prevention and health promotion programs performance and evaluation plan and identify areas for enhancement.

Timelines
Phase I: 2012; Phase II: 2013; Phase III: 2014; Phase IV: 2015; Phase V: 2016; Phase VI: 2017

Objectives	Progress and Timelines
1. Review process and outcome measures.	❖ Phase I: Online survey data documents process and outcome measures used at state-level. ❖ Phase II: EPI workgroup continues assessment.
2. Identify strategies to enhance evaluation systems to collect both process and outcome data using formative and summative methods.	❖ Phase II to VI: EPI workgroup recommends enhancements; supports planning, implementation and evaluation of enhancements.
3. Create a structure whereby process and outcome measures can be integrated into program development.	❖ Phase II to VI: EPI workgroup recommends enhancements; supports planning, implementation and evaluation of enhancements.

APPENDIX B: ICC Workgroup Membership

Member agencies:

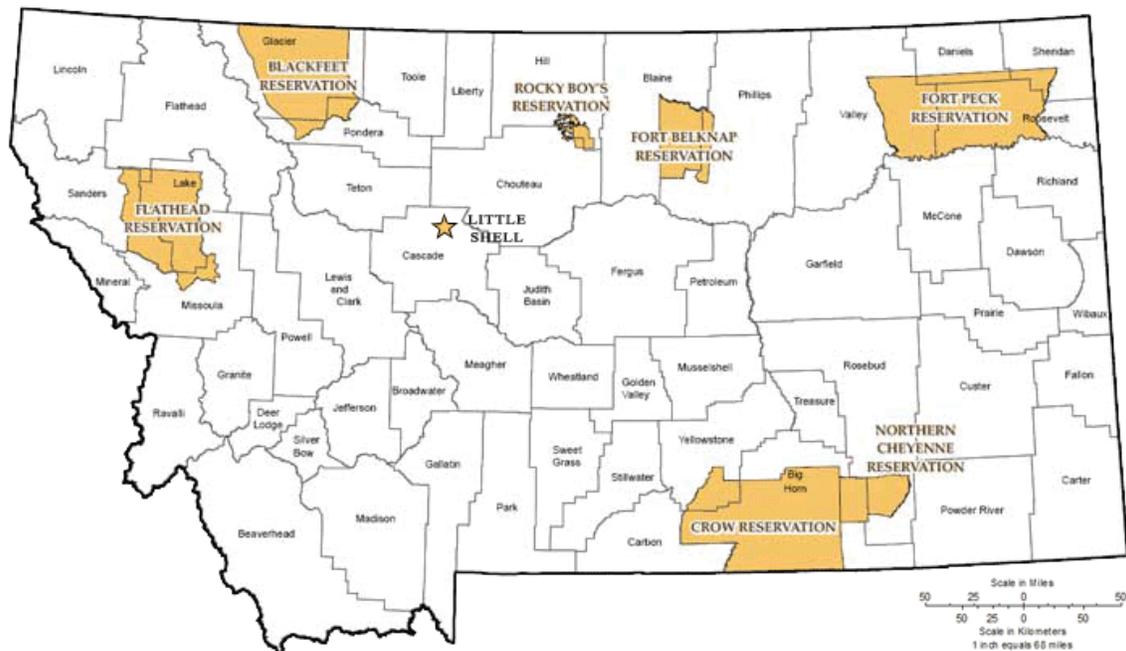
- ❖ Department of Corrections
- ❖ Department of Justice
- ❖ Department of Labor
- ❖ Department of Public Health and Human Services
- ❖ Montana Board of Crime Control
- ❖ Montana Children's Trust Fund
- ❖ Office of Public Instruction
- ❖ Department of Military Affairs
- ❖ Office of the Commissioner of Higher Education
- ❖ Department of Transportation
- ❖ Department of Revenue

APPENDIX C: Montana and the Seven Reservations

Montana is home to seven Indian Reservations, with the majority of the 53,000 American Indian populations living on these reservations. The seven reservations are:

- ❖ The Blackfeet
- ❖ The Crow
- ❖ The Flathead
- ❖ Fort Belknap
- ❖ Fort Peck
- ❖ The Northern Cheyenne
- ❖ Rocky Boy's

The following map depicts the locations of the reservations. One may note that the map recognizes the Little Shell Tribe which is made up of 4,500 members located in Cascade County. The tribe is recognized by the state but not the federal government so they do not receive federal support. The *Little Shell Chippewa Tribe* does not have reserved land and the members of the tribe live throughout the state.



The tribal nations are diverse. Each tribe has unique cultures, languages, traditions, histories and geographic conditions. The largest tribal organizations in Montana include the Blackfeet Nation, the Crow Tribe, and the Fort Peck Tribes with a total lands covering 13,188 square miles (8,440,147 acres).

The reservations are located within fifteen of forty-five counties that are considered Frontier. Frontier counties are defined as having 6 or fewer residents per square mile.

Blackfeet Reservation

The Blackfeet Reservation covers 1.5 million acres (3,000 square miles) and is considered a frontier community. It has a population of about 10,000, including 8,500 enrolled Blackfeet, several hundred Blackfeet descendants' and Indians from other tribes, and a few hundred non-Indians. About half of the members live on the reservation. The Blackfeet Reservation is located in northwestern Montana along the eastern slopes of the Rocky Mountains. It is

bordered on the north by Canada and on the west by Glacier National Park. The Tribal Headquarters and Blackfeet Community College are located in Browning.

Blackfeet Tribal Chief, Earl Old Person, states one of the main issues facing the tribe today is “the high unemployment rate and looking at ways to create permanent employment opportunities rather than relying on government programs for employment.”

Revenue for tribal members is derived from agriculture, livestock production, timber, light industry, tourism, and construction. The leading employers on the reservation are the Indian Health Service, School District No. 9, the Blackfeet Tribe and the Bureau of Indian Affairs. Local craftsmen increase their income by selling crafts to the summer tourists. Much of the labor force depends on firefighting and other seasonal type jobs. According to the Montana Department of Labor and Industry (2012), the average unemployment rate for 2011 was 16.6%.

For more information please refer to: <http://www.blackfeetnation.com/about-the-blackfeet/the-blackfeet-today.html>

Crow Reservation

The Crow Reservation is the largest reservation in Montana, encompassing 2.2 million acres of rolling upland plains, the Wolf, Bighorn and Pryor Mountains, and the bottomlands of the Bighorn River, Little Bighorn River and Pryor Creek. The reservation is home to 8,143 (71.7%) of the 11,357 enrolled Apsáalooke tribal members. About half live on the reservation. The reservation is located in south-central Montana and is considered a frontier community. It is bordered on the south by Wyoming and on the east by the Northern Cheyenne Reservation. The northwestern boundary is about 10 miles from Billings. The Tribal Headquarters and Little Big Horn College are located in Crow Agency.

The economy of the Crow Reservation rests largely upon government services to the residents, and some employment in agriculture, farming and ranching, particularly in spring and summer. According to the Montana Department of Labor and Industry (2012), the average unemployment rate for 2011 was 23.6%.

For more information please refer to <http://www.crowtribe.com/pop.htm>

Flathead Reservation

The Flathead Reservation, home to the Confederated Salish, Kootenai and Pend d’Oreille Tribes, covers 1.39 million acres. Fifty-eight percent is Indian owned, including the first tribally designated and managed wilderness area of 93,000 acres. Much of the tribal land is in various forms of natural management. There are 7,923 enrolled members. About half live on the reservation. The reservation is located in northwestern Montana between Missoula and Flathead Lake. The reservation includes the southern half of Flathead Lake. The Tribal Headquarters and Salish Kootenai College are located in Pablo.

The Tribes have traditionally been the largest employers on the reservation. Other employers include the K-12 school districts and the Salish Kootenai College, which houses the Tribal Business Assistance Center. This office provides workshops related to business management, creating a business infrastructure and entrepreneurship. According to the Montana Department of Labor and Industry (2012), the average unemployment rate for 2011 was 14.0%.

For more information please refer to: <http://www.cskt.org/>

Fort Belknap Reservation

The Fort Belknap Indian Reservation is home to the Gros Ventre and the Assiniboine Tribes and is located forty miles south of the Canadian border and twenty miles north of the Missouri River, which is the route of the Lewis and Clark Expedition. Fort Belknap Indian Reservation is the fourth largest Indian reservation in Montana and is another frontier community. It encompasses an area consisting of 675,147 acres, which extends approximately 28 miles east, and west and 35 miles north and south. Approximately 4,921 members live on or near the reservation. The Tribal Headquarters and Fort Belknap Community College are located in Fort Belknap.

The principal source of employment is agriculturally-related. According to the Montana Department of Labor and Industry (2012), the average unemployment rate for 2011 was 14.9%.

For more information please refer to: http://visitmt.com/places_to_go/indian_nations/nakoda-aaninin-fort-belknap/

Fort Peck Reservation

The Fort Peck Reservation covers 2.1 million acres of which there are an estimated 11,786 enrolled tribal members with about half of the members living on the reservation. Fort Peck is home to two separate Indian nations, the Assiniboine and the Sioux Tribes, each composed of numerous bands. The reservation is in the north eastern corner of Montana, 40 miles west of North Dakota and 50 miles south of Canada. The southern border is the Missouri River. This is considered a frontier community. The Tribal Headquarters and Fort Peck Community College are located in Poplar.

In addition to agriculture, the industrial park in Poplar is one of the largest employers on the reservation and houses an assortment of enterprises such as production sewing and metal fabrication. Other important contributors to the economy include an electronics manufacturer, farming, ranching, and oil extraction. According to the Montana Department of Labor and Industry (2012), the average unemployment rate for 2011 was 11.1%.

For more information please refer to: <http://www.fortpecktribes.org/>

Northern Cheyenne Reservation

The Northern Cheyenne Reservation covers 445,000 acres located in southeastern Montana near Colstrip, Montana. This mineral rich reservation is home to over 9,300 Northern Cheyenne enrolled tribal members with about half living on the reservation. The Northern Cheyenne Reservation is in southeastern Montana. It is bounded on the east by the Tongue River and on the west by the Crow Reservation. This is a frontier community. The Tribal Headquarters and Chief Dull Knife College are located in Lama Deer.

The major employers include the St. Labre Indian School, the federal government, tribal government, power companies and construction companies. The education system, farming, ranching and small businesses contribute to the economy. According to the Montana Department of Labor and Industry (2012), the average unemployment rate for 2011 was 20.5%.

For more information please refer to:

<http://www.bia.gov/WhoWeAre/RegionalOffices/RockyMountain/WeAre/NorthernCheyenne/index.htm>

The Rocky Boy's Reservation

The Rocky Boy's Reservation covers 130,000 acres. There are approximately 5,656 Chippewa Cree enrolled members, with about half living on the reservation. The reservation is located in north central Montana and is bordered on the west by US Highway 87 and on the east by the Bears Paw Mountains. The Rocky Boy's Reservation is the smallest reservation in Montana and the last to be established. The reservation is split by Hill County covering the northeast and Choteau County covering the southwest portion of the tribal lands. There is no town site on the reservation; it is truly frontier in every sense of the word. The community of Rocky Boy's includes the Tribal Headquarters and Stone Child College.

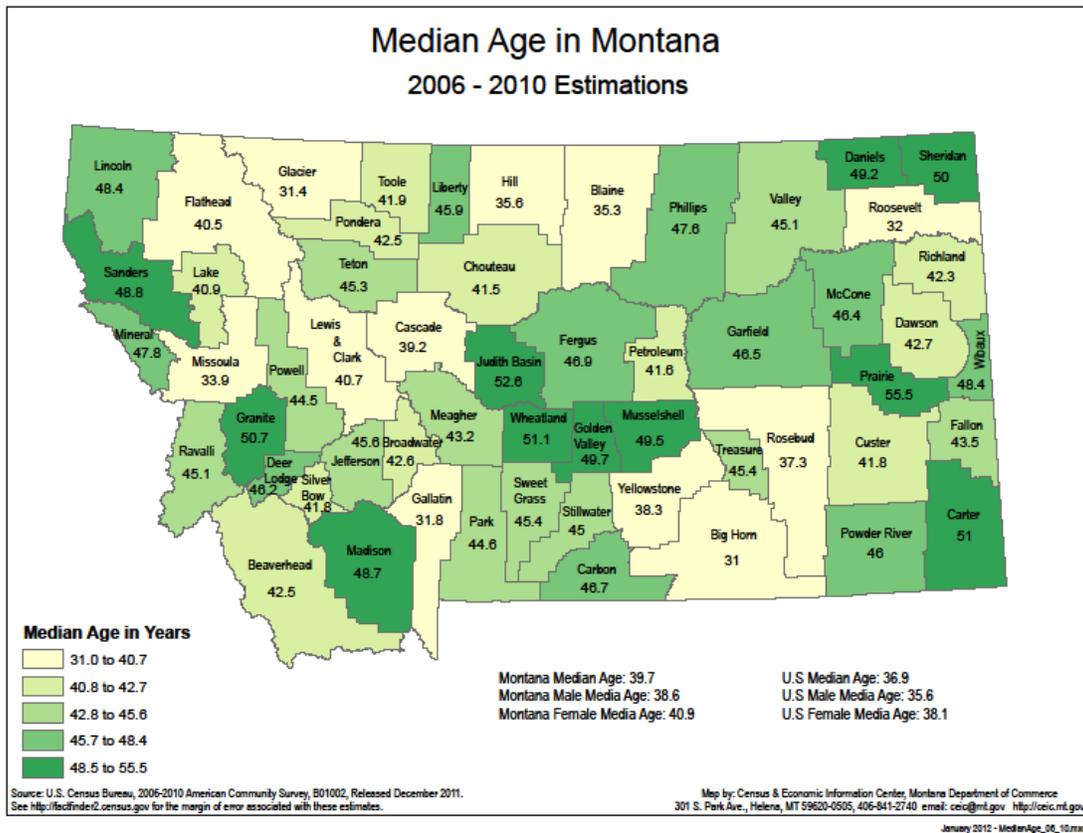
Major employers include the Chippewa-Cree Health Board, the Chippewa-Cree Tribal Office, Rocky Boy Schools, Stone Child College and Box Elder Schools. According to the Montana Department of Labor and Industry (2012), the average unemployment rate for 2011 was 15.6%.

For more information please refer to: <http://www.rockyboy.org/Site%20Map/Info%20Page.htm>

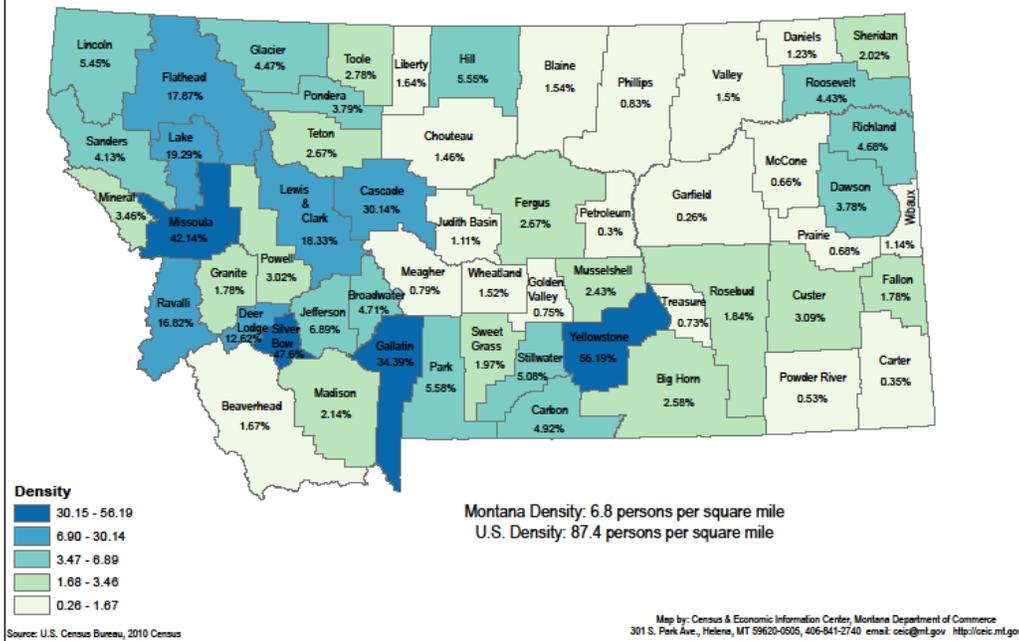
APPENDIX D: Maps and Ranking Tables for 56 Montana Counties

Maps:

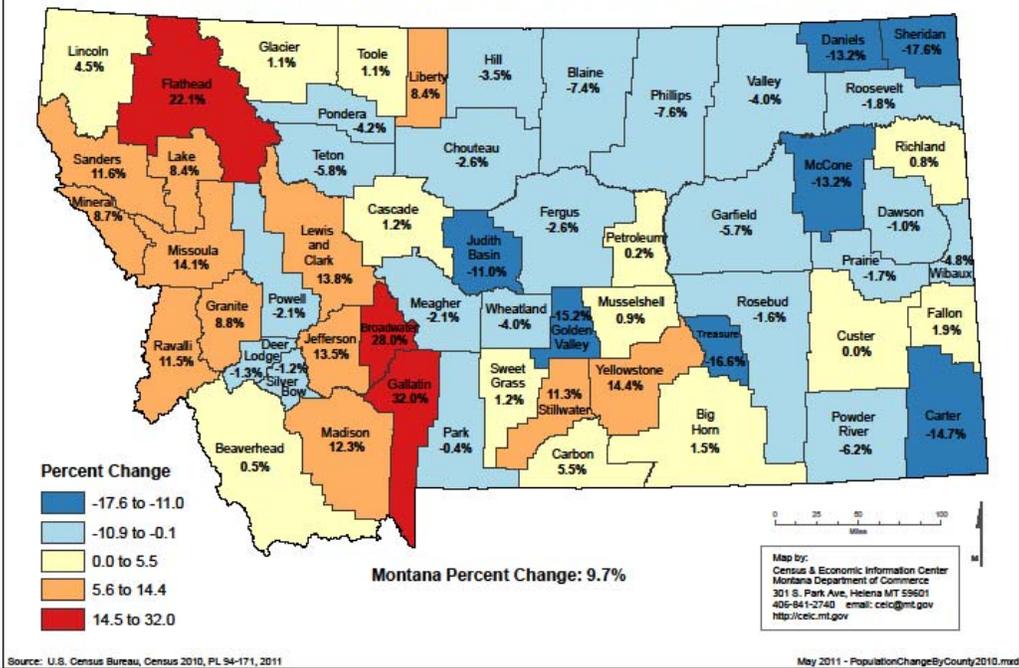
- ❖ Median Age in Montana, 2006-2010 Estimations
- ❖ Montana County Population, Population Density 2010
- ❖ Census 2010: Montana. Population Percent Change by County Census 2000-2010
- ❖ Average Wage Per Job, Montana 2009
- ❖ Percent American Indian by County, Montana - 2009
- ❖ Montana 2007 Health Insurance Coverage Status: Uninsured. Percent of County Population Under age 65 without Health Coverage



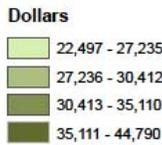
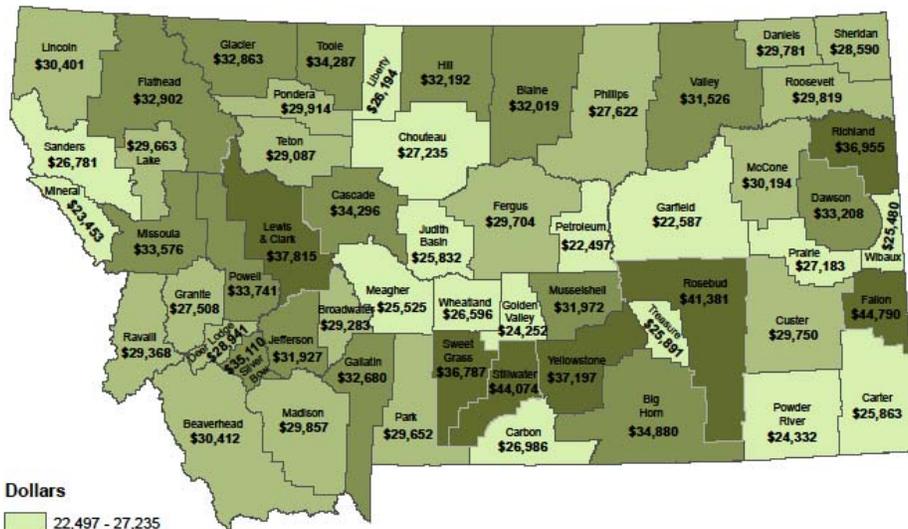
Montana County Population Population Density 2010



Census 2010: MONTANA Population Percent Change By County Census 2000 to Census 2010



Average Wage Per Job - Montana 2009



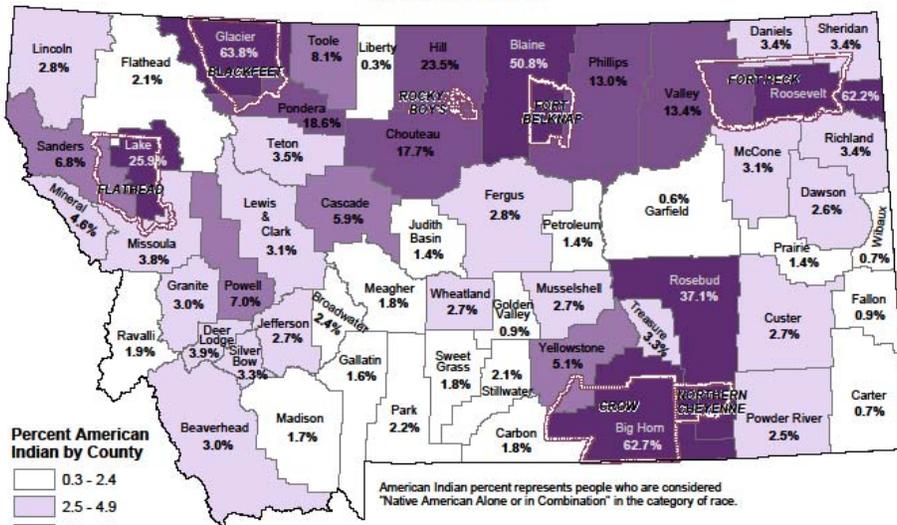
Montana Average Wage Per Job: \$33,918

Map by: Census & Economic Information Center
 Montana Department of Commerce
 301 S. Park Ave., Helena, MT 59601
 406-841-2740 email: ceic@mt.gov
 http://ceic.mt.gov

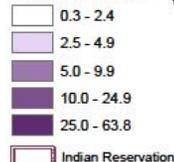
Source: U.S. Department of Commerce, Bureau of Economic Analysis, Regional Economic Information System, Local Area Personal Income, Table CA34, 2011

May 2011 - Wages09.mxd

Percent American Indian by County Montana - 2009



Percent American Indian by County



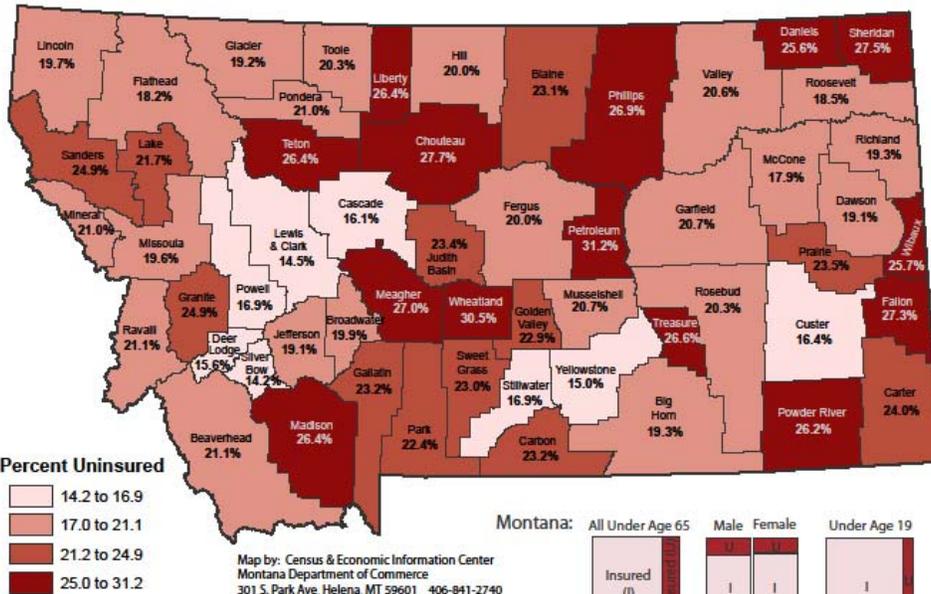
American Indian percent represents people who are considered "Native American Alone or in Combination" in the category of race.

Map by: Census & Economic Information Center
 Montana Department of Commerce
 301 S. Park Ave., Helena MT 59601
 406-841-2740 email: ceic@mt.gov
 http://ceic.mt.gov

Source: U.S. Census Bureau, Population Estimates Program, CO-EST2009-01data, June 10, 2010

IndianByCounty09.mxd - June 2010

Montana 2007 Health Insurance Coverage Status: Uninsured
 Percent of County Population Under Age 65 Without Health Coverage



Source: U.S. Census Bureau, Small Area Health Insurance Estimates 2007, Released July 2010.

SAHIE07.mxd - August 2010

Tables: Rankings: 56 counties on the targeted mental and behavioral health problems and consequences of the health problems

- ❖ **Prescription drug death** per 1,000 averaged 2008-2009; across 56 counties and 7 reservations.
- ❖ *Consequence of Prescription drug misuse/abuse: Drug arrest* per 1,000 residents averaged 2005-2011; across 56 counties and 7 reservations.
- ❖ **Suicide rate** per 100,000 averaged 2001-2010; across 56 counties and 7 reservations.
- ❖ *Consequence of underage and adult problem drinking: DUIs* per 1,000 residents averaged 2005-2011; across 56 counties and 7 reservations.
- ❖ *Consequence of underage drinking: Liquor law violations* per 1,000 residents averaged 2005-2011; across 56 counties and 7 reservations.
- ❖ *Consequence of underage and adult problem drinking: Percentage of car crashes involving alcohol* averaged 2005-2009; across 56 counties and 7 reservations.

These measures were collected for the fifty-six counties and include the seven reservations that traverse the counties. In addition to knowing the actual numbers/percent of each problem behavior in the respective counties, a composite severity score was calculated for each county.

Severity Score by County = suicide rate + rate of prescription drug deaths + drug arrest rate +DUI rate + rate of liquor law violations + % of car crashes involving drugs/alcohol

That is, each county was ranked 1 to 56 depending on how high the rate was, on each measure, in that county. The score was the sum of the rankings on each health problem. Using the score, counties were categorized as very high risk, high risk, moderate risk, low risk, and lowest risk. By ranking each county on each health problem, it made it easier to compare counties to each other and to understand what multiple public health problems existed within a county.

Ranking: A ranking of 1 means that the county has the highest rate across all 56 counties and is considered very high risk.

Prescription drug death per 1,000 averaged 2008-2009; across 56 counties and 7 reservations

County	Prescription drug death per 1,000 averaged 2008-2009	County risk ranking across all health problems	Population 2010	Reservations
MINERAL	1	Moderate	4,223	
PETROLEUM	2	High	494	
MUSSELSHELL	3	Moderate	4,538	
BROADWATER	4	Very High	5,612	
GOLDEN VALLEY	5	Moderate	884	
BEAVERHEAD	6	Very High	9,246	
DEER LODGE	7	Very High	9,298	
GRANITE	8	Lowest	3,079	
SHERIDAN	9	Very High	3,384	Ft. Peck
MISSOULA	10	Very High	109,299	Flathead
CHOUTEAU	11	Moderate	5,813	Rocky Boy's
ROOSEVELT	12	Very High	10,425	Ft. Peck
FERGUS	13	Moderate	11,586	
PARK	14	Moderate	15,636	
RAVALLI	15	High	40,212	
SILVER BOW	16	High	34,200	
HILL	17	Very High	16,096	Rocky Boy's
WIBAUX	18	Low	1,017	
MEAGHER	19	Lowest	1,891	
CARBON	20	Moderate	10,078	
SANDERS	21	Very High	11,413	Flathead
JEFFERSON	22	Lowest	11,406	
BIG HORN	23	Very High	12,865	N. Cheyenne & Crow
LINCOLN	24	Very High	19,687	
CASCADE	25	High	81,327	
RICHLAND-	26	Low	9,746	
GLACIER	27	High	13,399	Blackfeet
LAKE	28	High	28,746	Flathead
WHEATLAND	29	Moderate	2,168	
DAWSON	30	High	8,966	
YELLOWSTONE	31	Low	147,972	
ROSEBUD	32	High	9,233	N. Cheyenne
MADISON	33	Moderate	7,691	
STILLWATER	34	Low	9,117	
CARTER	35	Lowest	1,160	

County	Prescription drug death per 1,000 averaged 2008-2009	County risk ranking across all health problems	Population 2010	Reservations
LEWIS & CLARK	36	Moderate	63,395	
PHILLIPS	37	Low	4,253	Ft. Belknap
TETON	38	Lowest	6,073	
GALLATIN	39	Moderate	89,513	
TOOLE	40	Low	5,324	
POWELL	41	Lowest	7,027	
SWEET GRASS	42	Very High	3,651	
FLATHEAD	43	High	90,928	Flathead
LIBERTY	44	Lowest	2,339	
JUDITH BASIN	45	Low	2,072	
CUSTER	46	Moderate	11,699	
FALLON	47	Lowest	2,890	
BLAINE	48	Low	6,491	Ft. Belknap
VALLEY	49	Moderate	7,369	Ft. Peck
MCCONE	50	Low	1,734	
DANIELS	51	Lowest	1,751	Ft. Peck
PONDERA	52	Low	6,153	
POWDER RIVER	53	Lowest	1,743	
GARFIELD	54	Low	1,206	
TREASURE	55	Lowest	718	
PRAIRIE	56	Lowest	1,179	

Ft. Peck predominately in Valley and Roosevelt county

Crow predominate in Big Horn county

North Cheyenne predominately in Rosebud county

Ft. Belknap predominately in Blaine county

Rocky Boy's predominately in Hill county

Blackfeet in Glacier

Consequence of drug abuse: Drug arrests per 1,000 residents averaged 2005-2011; across 56 counties and 7 reservations

County	Drug arrest per 1,000 residents averaged 2005-2011	County risk ranking across all health problems	Population 2010	Reservations
TOOLE	1	Low	5,324	
HILL	2	Very High	16,096	Rocky Boy's
BROADWATER	3	Very High	5,612	
LINCOLN	4	Very High	19,687	
PETROLEUM	5	High	494	
DAWSON	6	High	8,966	
GALLATIN	7	Moderate	89,513	
FLATHEAD	8	High	90,928	Flathead
MISSOULA	9	Very High	109,299	Flathead
SILVER BOW	10	High	34,200	
VALLEY	11	Moderate	7,369	Ft. Peck
LAKE	12	High	28,746	Flathead
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GLACIER	20	High	13,399	Blackfeet
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WHEATLAND	22	Moderate	2,168	
RAVALLI	23	High	40,212	
CHOUTEAU	24	Moderate	5,813	Rocky Boy's
CARBON	25	Moderate	10,078	
DEER LODGE	26	Very High	9,298	
GOLDEN VALLEY	27	Moderate	884	
BIG HORN	28	Very High	12,865	N. Cheyenne & Crow
ROSEBUD	29	High	9,233	N. Cheyenne
MADISON	30	Moderate	7,691	
MUSSELSHELL	31	Moderate	4,538	
PHILLIPS	32	Low	4,253	Ft. Belknap
STILLWATER	33	Low	9,117	
POWELL	34	Lowest	7,027	

County	Drug arrest per 1,000 residents averaged 2005-2011	County risk ranking across all health problems	Population 2010	Reservations
CUSTER	35	Moderate	11,699	
JEFFERSON	36	Lowest	11,406	
MINERAL	37	Moderate	4,223	
ROOSEVELT	38	Very High	10,425	Ft. Peck
FERGUS	39	Moderate	11,586	
JUDITH BASIN	40	Low	2,072	
MEAGHER	41	Lowest	1,891	
PONDERA	42	Low	6,153	
WIBAUX	43	Low	1,017	
PRAIRIE	44	Lowest	1,179	
DANIELS	45	Lowest	1,751	Ft. Peck
CARTER	46	Lowest	1,160	
GARFIELD	47	Low	1,206	
TETON	48	Lowest	6,073	
FALLON	49	Lowest	2,890	
MCCONE	50	Low	1,734	
BLAINE	51	Low	6,491	Ft. Belknap
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LIBERTY	54	Lowest	2,339	
POWDER RIVER	55	Lowest	1,743	
TREASURE	56	Lowest	718	

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Rocky Boy's predominately in Hill county

Blackfeet in Glacier

Suicide rate per 100,000 averaged 2001-2010; across 56 counties and 7 reservations

County	Suicide rate per 100,000 averaged 2001-2010	County risk ranking across all health problems	Population 2010	Reservations
DEER LODGE	1	Very High	9,298	
CUSTER	2	Moderate	11,699	
JUDITH BASIN	3	Low	2,072	
PARK	4	Moderate	15,636	
ROOSEVELT	5	Very High	10,425	Ft. Peck
SANDERS	6	Very High	11,413	Flathead
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GLACIER	23	High	13,399	Blackfeet
LAKE	24	High	28,746	Flathead
FLATHEAD	25	High	90,928	Flathead
PETROLEUM	26	High	494	
BLAINE	27	Low	6,491	Ft. Belknap
CASCADE	28	High	81,327	
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HILL	34	Very High	16,096	Rocky Boy's
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FALLON	49	Lowest	2,890	
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TETON	51	Lowest	6,073	
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Consequence of underage and adult problem drinking: DUIs per 1,000 residents averaged 2005-2011; across 56 counties and 7 reservations

County	DUIs per 1,000 residents averaged 2005-2011	County risk ranking across all health problems	Population 2010	Reservations
SWEET GRASS	1	Very High	3,651	
HILL	2	Very High	16,096	Rocky Boy's
BIG HORN	3	Very High	12,865	N. Cheyenne & Crow
CASCADE	4	High	81,327	
MISSOULA	5	Very High	109,299	Flathead
DAWSON	6	High	8,966	
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TETON	44	Lowest	6,073	
MCCONE	45	Low	1,734	
CARTER	46	Lowest	1,160	
CHOUTEAU	47	Moderate	5,813	Rocky Boy's
PHILLIPS	48	Low	4,253	Ft. Belknap
YELLOWSTONE	49	Low	147,972	
TOOLE	50	Low	5,324	
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Blackfeet in Glacier

Consequence of underage drinking: Liquor Law Violations per 1,000 averaged 2005-2011; across 56 counties and 7 reservations. The vast majority are MIP Violations (Minor in Possession).

County	Liquor law violations per 1,000 averaged 2005-2011	County risk ranking across all health problems	Population 2010	Reservations
BEAVERHEAD	1	Very High	9,246	
MISSOULA	2	Very High	109,299	Flathead
HILL	3	Very High	16,096	Rocky Boy's
DAWSON	4	High	8,966	
VALLEY	5	Moderate	7,369	Ft. Peck
ROOSEVELT	6	Very High	10,425	Ft. Peck
CASCADE	7	High	81,327	
LEWIS & CLARK	8	Moderate	63,395	
BIG HORN	9	Very High	12,865	N. Cheyenne & Crow
CUSTER	10	Moderate	11,699	
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GARFIELD	12	Low	1,206	
WIBAUX	13	Low	1,017	
FLATHEAD	14	High	90,928	Flathead
SWEET GRASS	15	Very High	3,651	
PHILLIPS	16	Low	4,253	Ft. Belknap
ROSEBUD	17	High	9,233	N. Cheyenne
LINCOLN	18	Very High	19,687	
RICHLAND-	19	Low	9,746	
RAVALLI	20	High	40,212	
GALLATIN	21	Moderate	89,513	
STILLWATER	22	Low	9,117	
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PONDERA	31	Low	6,153	
DEER LODGE	32	Very High	9,298	

County	Liquor law violations per 1,000 averaged 2005-2011	County risk ranking across all health problems	Population 2010	Reservations
POWELL	33	Lowest	7,027	
BROADWATER	34	Very High	5,612	
WHEATLAND	35	Moderate	2,168	
FERGUS	36	Moderate	11,586	
SANDERS	37	Very High	11,413	Flathead
MADISON	38	Moderate	7,691	
JUDITH BASIN	39	Low	2,072	
CARTER	40	Lowest	1,160	
BLAINE	41	Low	6,491	Ft. Belknap
LAKE	42	High	28,746	Flathead
TOOLE	43	Low	5,324	
CARBON	44	Moderate	10,078	
JEFFERSON	45	Lowest	11,406	
GOLDEN VALLEY	46	Moderate	884	
MINERAL	47	Moderate	4,223	
PARK	48	Moderate	15,636	
GRANITE	49	Lowest	3,079	
MEAGHER	50	Lowest	1,891	
TETON	51	Lowest	6,073	
MUSSELSHELL	52	Moderate	4,538	
LIBERTY	53	Lowest	2,339	
PETROLEUM	54	High	494	
POWDER RIVER	55	Lowest	1,743	
TREASURE	56	Lowest	718	

Ft. Peck predominately in Valley and Roosevelt county

Crow predominate in Big Horn county

North Cheyenne predominately in Rosebud county

Ft. Belknap predominately in Blaine county

Rocky Boy's predominately in Hill county

Blackfeet in Glacier

Consequence of underage and adult problem drinking: Percentage of car crashes involving alcohol averaged 2005-2009; across 56 counties and 7 reservations

County	% of car crashes involving alcohol averaged 2005 - 2009	County risk ranking across all health problems	Population 2010	Reservations
ROOSEVELT	1	Very High	10,425	Ft. Peck
GARFIELD	2	Low	1,206	
GLACIER	3	High	13,399	Blackfeet
GOLDEN VALLEY	4	Moderate	884	
BIG HORN	5	Very High	12,865	N. Cheyenne & Crow
BLAINE	6	Low	6,491	Ft. Belknap
LAKE	7	High	28,746	Flathead
SANDERS	8	Very High	11,413	Flathead
CARBON	9	Moderate	10,078	
PETROLEUM	10	High	494	
DEER LODGE	11	Very High	9,298	
MUSSELSHELL	12	Moderate	4,538	
MADISON	13	Moderate	7,691	
WHEATLAND	14	Moderate	2,168	
MCCONE	15	Low	1,734	
BEAVERHEAD	16	Very High	9,246	
LINCOLN	17	Very High	19,687	
SHERIDAN	18	Very High	3,384	Ft. Peck
TOOLE	19	Low	5,324	
HILL	20	Very High	16,096	Rocky Boy's
PHILLIPS	21	Low	4,253	Ft. Belknap
PONDERA	22	Low	6,153	
VALLEY	23	Moderate	7,369	Ft. Peck
FLATHEAD	24	High	90,928	Flathead
MEAGHER	25	Lowest	1,891	
LIBERTY	26	Lowest	2,339	
SWEET GRASS	27	Very High	3,651	
WIBAUX	28	Low	1,017	
YELLOWSTONE	29	Low	147,972	
RICHLAND-	30	Low	9,746	
MISSOULA	31	Very High	109,299	Flathead
CHOUTEAU	32	Moderate	5,813	Rocky Boy's

County	% of car crashes involving alcohol averaged 2005 - 2009	County risk ranking across all health problems	Population 2010	Reservations
FALLON	33	Lowest	2,890	
BROADWATER	34	Very High	5,612	
FERGUS	35	Moderate	11,586	
JUDITH BASIN	36	Low	2,072	
GALLATIN	37	Moderate	89,513	
PRAIRIE	38	Lowest	1,179	
ROSEBUD	39	High	9,233	N. Cheyenne
PARK	40	Moderate	15,636	
POWDER RIVER	41	Lowest	1,743	
JEFFERSON	42	Lowest	11,406	
STILLWATER	43	Low	9,117	
CASCADE	44	High	81,327	
RAVALLI	45	High	40,212	
CUSTER	46	Moderate	11,699	
TETON	47	Lowest	6,073	
GRANITE	48	Lowest	3,079	
CARTER	49	Lowest	1,160	
DAWSON	50	High	8,966	
DANIELS	51	Lowest	1,751	Ft. Peck
LEWIS & CLARK	52	Moderate	63,395	
SILVER BOW	53	High	34,200	
TREASURE	54	Lowest	718	
MINERAL	55	Moderate	4,223	
POWELL	56	Lowest	7,027	

Ft. Peck predominately in Valley and Roosevelt county

Crow predominate in Big Horn county

North Cheyenne predominately in Rosebud county

Ft. Belknap predominately in Blaine county

Rocky Boy's predominately in Hill county

Blackfeet in Glacier

APPENDIX E: Epidemiological Workgroup Reports

Background and Methodology

In support of the Strategic Planning Enhancement Grant (SPE) Consortium, the Montana Epidemiological Workgroup undertook to assist in a statewide needs assessment by compiling available data on SPE areas of concern.

SPE areas of concern:

- Substance abuse and mental illness;
- Underage drinking and adult problem drinking;
- Suicide and attempted suicide with emphasis on high risk especially Military families, LGBTQ youth, or American Indians and Alaska Natives;
- Prescription drug misuse and abuse.

Initial Steps

A comprehensive list of all national and state agencies that collect Montana data pertinent to the SPE areas of concern was developed. It was agreed, that data sources must fit as many of the following criteria as possible to be included in the database:

- *Centralized and consistent source:* The measure must be consistent, i.e. the method or means of collecting and organizing data should be relatively unchanged over time.
- *State-level and regional breakdowns:* The measure must be available from a centralized, state or regional data source.
- *Validity:* The measure must meet basic criteria for validity, i.e. the data should accurately measure the specific construct.
- *Periodic collection:* The measure should be available for the past three to five years, preferably on an annual or at least biennial basis.
- *Sensitivity:* For monitoring, the measure must be sufficiently sensitive to detect change over time that might be associated with changes in alcohol, tobacco or illicit drug use/abuse.
- *Culturally competent:* The measure must be available in disaggregated form to reflect different demographic and geographic breakdowns.

Data sources include:

- 1) Department of Public Health & Human Services (DPHHS)
 - a) Addictive & Mental Disorders Division (AMDD)
 - b) Montana Vital Statistics Analysis Unit (MT VSAU)
 - c) Behavioral Risk Factor Surveillance Survey (BRFSS)
 - d) Prevention Needs Assessment survey (PNA)
 - e) Hospital Discharge Data System (HDDS)
- 2) Office of Public Instruction
 - a) Youth Risk Behavior Survey (YRBS)
- 3) Montana Supreme Court (MTSC)
 - a) District Court/Youth Court (MTYC)
- 4) Montana Board of Crime Control (MTBCC)
- 5) Montana Department of Transportation (MDT)
- 6) Substance Abuse & Mental Health Services Administration
 - a) National Survey on Drug Use & Health (NSDUH)

- b) Treatment Episode Data Set (TEDS)
 - c) National Survey of Substance Abuse Treatment Services (N-SSATS)
- 7) American College Health Association
- a) National College Health Assessment (ACHA-NCHA)
- 8) National Survey of Family Growth (NSFG)

Other data sources not used for the database but used in the additional data sections:

- a) Prescription Drug Abuse Awareness Program
- b) State Crime Lab
- c) Drug Abuse Warning Network

Databases associated with chosen data sources were evaluated for their immediate relevance to Montana’s SPE and indicators were then chosen and a SPE database developed. Indicators were collected for 2006/2007 and 2009/2010 to show trending in the data.

Data base elements collected from DPHHS Addictive and Mental Disorders Division reflect data from the treatment facilities listed below. These indicators were not scored as they summarized such things as demographics and length of stay and were used to fill out the picture of what is going on in Montana.

- Montana Chemical Dependency Center;
- Montana State Hospital; and
- Montana Mental Health Nursing Center.

Indicators collected and reported by the National Survey of Substance Abuse Treatment Services are shown as coming from “all Montana facilities”. This means: “The National Survey of Substance Abuse Treatment Services (N-SSATS) is designed to collect information from all facilities in the United States, both public and private, that provide substance abuse treatment. In Montana, 53 substance abuse treatment facilities were included in the 2010 N-SSATS.”

Ranking of Indicators

The Montana Epidemiological Workgroup ranked the final list of indicators based upon the following equally weighted criteria:

- Change in Montana 2006/2007 rate to Montana 2009/2010 rate
- Montana Trend
- Annual # persons in Montana

The scoring scheme used for each indicator was:

- 5 points = high (i.e. this is a high priority indicator)
- 3 points = medium (i.e. this a medium level priority)
- 1 point = low (i.e. this is a low level priority)

The data cells where data was not available were not scored. After scoring each column, individuals averaged the scores for each indicator. Scored spreadsheets were collected and a master sheet was compiled averaging all scored sheets. This enabled the group to determine an initial prioritized list of SPE areas of concern. It is important to note that some areas of concern had many more indicators available than other areas; such as alcohol versus prescription drugs.

Data Snap Shots

Three data snap shots were developed to report on the ranking of problems as scored by the workgroup and then integrated with other data components such as mental health data that are not appropriate for scoring but give a more

significant picture of what is going on around the state. Three broad age groupings were determined to be the most appropriate way to present the findings. These age groupings, as much as possible, corresponded with the age groups for which data is collected. Unfortunately there was some overlap in ages in all data snap shots because of the differing formats of data collection. Additional data information that was not in the SPE database was included where available and where appropriate.

- High school/teenagers: Includes 8th through 12th grade, and under 18 years of age not necessarily high school.
- Young adults/University Student: Includes university students and those under 25 years of age not necessarily at university.
- Adults: Indicators include the following age breakdowns: 17 years old and up, 21 – 25 years old and all ages

An additional data snap shot was developed on the SPE area of concern covering suicide and attempted suicide:

- Suicide and attempted suicide (high risk especially Military families, LGBTQ youth, or American Indians and Alaska Natives)

Data Challenges

Substance abuse and mental illness

- No data links or cross-tabs with alcohol and drug abuse;
- Limited number of measures available.

Underage drinking and adult problem drinking

- Very few data linkages to mental health and suicides;
- Lack of age breakdowns on age and drinking/driving.

Suicide and attempted suicide with emphasis on high risk especially Military families, LGBTQ youth, or American Indians and Alaska Natives

- Very little data making connection between suicides and these groups;
- Only national data available on LGBTQ youth;
- Due to confidentiality issues, Public Health and Safety Division guidelines require that no data is publically released if the frequencies of cell sizes is less than five or calculation of rates are based on fewer than 20 events.

Observations and Conclusions

Strategic Planning Enhancement Grant (SPE) areas of concern:

Below is the table showing differences in priority ranking of SPE areas of concern over the three big age groupings after being scored by the Epidemiological Workgroup.

Area of Concern	High school/teenagers	Young adults/University Student	Adults
Suicide and attempted suicide	1	3**	1
Underage drinking and adult problem drinking	2	1	3
Substance abuse and mental illness	3	2	2
Prescription drug misuse and abuse*	4	4	4

Epidemiological Workgroup: Ranked by highest to lowest scores by area of concern and age groups.

Caveats to rankings:

*Prescription drug misuse and abuse came out with a low ranking but the Epidemiological Workgroup expressed concern that this could be misleading because of recent increasing numbers of prescription drug abuse and misuse.

**The suicide and attempted suicide rank of 3rd in the young adult/university student age group may reflect a lack of indicators specific to these ages.

Suicide and attempted suicide

All Montanans

- Suicide and attempted suicide was the highest scored SPE area of concern among both high school/teenagers and adults.
- Where trend data was available for suicide measures the rates/number had increased.
- From 2006 – 2010, the average suicide rates per 100,000 population for all races was highest among the 26 and older age group (27), then among the 19 – 25 age group (24.7), followed by 10 and older (24.3), the lowest rate was among the 10 – 18 year olds (8.7).

Military families

- An average of 43 Military personnel in Montana committed suicide each year between 2003 and 2009.
- Veterans diagnosed with PTSD appear less at risk for suicide than veterans without that diagnosis.

LGBTQ youth.

- LGBTQ youth are subjected to bullying by their cohorts at alarmingly high rates.
- LGBTQ youth had high rates of major depression, generalized anxiety disorder and substance use or dependence.
- Attempted suicide rates among LGBTQ youth are estimated to be 23% higher than their peers with opposite-sex orientation.

American Indians and Alaska Natives

- In all measures suicide rates among American Indians and Alaska Natives were higher than any other group.
- From 2006 – 2010, the average suicide rates per 100,000 population were higher for American Indians/Alaskan Natives races over all age groups compared to other races.
- The average suicide rate per 100,000 population among American Indian/Alaskan Native young adults aged 19 – 25 was over twice that of their white cohort.

Underage drinking and adult problem drinking

- Underage drinking and adult problem drinking was the highest scored SPE area of concern among young adults.
- Underage drinking and adult problem drinking was the next highest scored SPE area of concern among high school/teenagers.
- Alcohol abuse indicators trended flat or decreased.
- There was an increase in the rate of children in grades 8 – 12 viewing drinking regularly as a negative or thinking that alcohol was hard to obtain.
- Alcohol/Drug related vehicle crashes as a percent of all crashes decreased.

Substance abuse and mental illness

- Measures to link substance abuse and mental illness were mostly unavailable making it necessary to find surrogate indicators.
- Most of the indicators for mental illness were for adults and few for the high school/teenager or young adults.

- There was an increase in the rate of children in grades 8 – 12 viewing marijuana as harmful or thinking illegal drugs (cocaine, LSD or amphetamines) were hard to obtain.

Prescription drug misuse and abuse

- Many measures on prescription drugs have trended upwards compared to alcohol indicators that have remained flat or gone down.
- The number of people reported in prescription drug consumption or consequence indicators is considerably smaller than the number of people reported in alcohol consumption or consequence indicators making this a difference in the scale of the problems.

Prescription drug misuse and abuse

- No connections with alcohol and other types of drug abuse
- State Crime Lab data does not have age breakdowns

Data Caveats and Other Influences:

- Some data is not available on websites and often researchers have to go to the data collection agency to obtain special tabulations.
- Some law enforcement data such as DUI, citations and convictions depend on existing and changing laws, state and local resources available for enforcement; likewise, local community awareness of and commitment to dealing with the problems associated with alcohol and drug abuse which influences enforcement.

Data on prescription drug misuse and abuse is less available using the data source requirements listed above. However as much as possible information gleaned from other sources has been included in the data snapshots to provide as total a picture as possible.

Snapshot Reports

SUICIDE AND ATTEMPTED SUICIDE

The Strategic Planning Enhancement Grant (SPE) identified suicide and attempted suicide as a one of four areas of concern; with emphasis placed on high risk groups, especially Military families, LGBTQ youth, or American Indians and Alaska Natives.

LGBTQ youth

No data sources used in the SPE Needs Assessment Database had Montana-specific statistics on suicide or attempted suicide among lesbian, gay, bisexual, transgender/transsexual/two-spirited, queer/questioning (LGBTQ) youth.

Montana Data:

- The National College of Health Assessment provided data on sexual orientation amongst University of Montana students, an age cohort not considered “youth”.
 - 4% of male UM students reported having male sexual partners
 - 2% of female UM students reported having female sexual partners
- The 2010 National Survey of Family Growth provided Montana data on ages 18 – 44 which does not include “youth”.
 - 2% of Montana males between the ages of 18 – 44 self-identified as homosexual
 - 1% of Montana females between the ages of 18 – 44 self-identified as homosexual
- The 2000 Census provided Montana-specific data on the sexual orientation within the general population:
 - For all ages, there are approximately 1,200 same-sex couples in Montana, which ranks Montana 48th in the nation. This number is considered to be significantly lower than the actual number, especially since this number does not include youth. (U.S. Census Bureau, Census 2000)

- Montana Strategic Suicide Prevention Plan—2011
 - Alcohol and drug impairment, a sense of hopelessness, underlying mental illness, and a societal stigma against depression, all contribute to the high rate of youth suicide in Montana.

National Data:

National data can be found in the Montana Strategic Suicide Prevention Plan—2011 and other national studies.

- Research concludes that high rates of “major depression, generalized anxiety disorder and substance use or dependence” persist in lesbian and gay youth. (American Psychologist)
- Nationally 42% of gay and lesbian youth who were studied had thoughts of suicide at some time. 25% had thoughts of suicide in the past year, and 48% said thoughts of suicide were related to their sexual orientation. (Centre for Suicide Prevention 2003)
- Youth with same-sex orientation are 23 times more likely than their opposite-sex peers to attempt suicide.
- Approximately 15% of youth who reported suicide attempts also reported same-sex attraction or relationships.
- These youth also presented as higher risk for alcohol abuse and depression
(Russel, S.T. & Joyner, K., 2001, Centre for Suicide Prevention, 2003)
- 75.4% of LGBT high school students reported hearing remarks such as “faggot” or “dyke” frequently or often at school.
- 89.2% of LGBT high school students reported hearing “that’s so gay” or “you’re so gay” (often used to indicate that someone or something is stupid or worthless) frequently or often at school.
- 18.6% of LGBT high school students reported hearing homophobic remarks from their teachers or other school staff.
- 74.2% of LGBT high school students in the survey reported feeling unsafe in school because of personal characteristics, such as their sexual orientation, gender or religion, 64.3% reported feeling unsafe at school because of their sexual orientation specifically, and 40.7% felt unsafe because of how they expressed their gender.
- 64.1% of LGBT high school students reported that they had been verbally harassed at least some of the time in school in the past year because of their sexual orientation and 45.5% because of their gender expression.
- 37.8% of LGBT high school students had experienced physical harassment at school on the basis of sexual orientation and 26.1% on the basis of their gender expression.
- 17.6% of LGBT high school students had been physically assaulted because of their sexual orientation and 11.8% because of their gender expression.

(Gay, Lesbian and Straight Education Network, 2005 National School Climate Survey)

American Indians and Alaska Natives (ALL AGES)

- Between 2000 and 2009, the highest rate of suicide in Montana was among American Indians (24.11 per 100,000) followed by Caucasians (19.95 per 100,000).
- Among American Indians/Alaska Natives ages 15- to 34-years, suicide is the second leading cause of death.
- Suicide rates among American Indian/Alaskan Native adolescents and young adults ages 15 to 34 (21.4 per 100,000) are 1.9 times higher than the national average for that age group (11.5 per 100,000).
- Between 2000 and 2009, there were 138 suicides by American Indians, compared to 1,713 by Caucasians. However, Caucasians constitute 90.5% of the population while American Indians only constitute approximately 6.4%.

(Montana Strategic Suicide Prevention Plan—2011)

- From 2006 – 2010, the average suicide rates per 100,000 population were higher for American Indians/Alaskan Natives races than all other age groups. It was highest among the 19 – 25 age group (54.3),

then among the 10 – 18 year olds (33.4), followed by 10 and older (31.8), the lowest rate was among the 26 and older age group (25.3).

Age	All races	White	American Indian/Alaska Native	Other or Unknown
10 – 18	8.7	6.0	33.4	7.1
19 – 25	24.7	21.5	54.3	39.9
10 and older	24.3	23.5	31.8	40.6
26 and older	27.0	26.8	25.3	54.4

Average suicide rate per 100,000 by age; 2006 - 2010 (Montana Vital Statistics Analysis Unit)

Youth Risk Behavior Survey (YRBS) Grades 8, 10 and 12

YRBS Findings	Hispanic/Latino	American Indian	White
% of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	31.1%	30.9%	24.2%
% of students who seriously considered attempting suicide during the past 12 months	23.3%	21.2%	14.2%
% of students who made a plan about how they would attempt suicide during the past 12 months	18.7%	15.1%	11.5%
% of students who actually attempted suicide one or more times during the past 12 months	9.8%	11.9%	5.6%
% of students who made a suicide attempt during the past 12 months that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse	5.2%	5.2%	1.8%

Source: Youth Risk Behavior Survey (2011)

Military families

- The VA estimated that in 2005, the suicide rate per 100,000 veterans among men ages 18-29 was 44.99, but jumped to 56.77 in 2007.
- In Montana, between 2003 and 2009, there were 347 suicides by Montana veterans of all ages, giving us a rate of approximately 46 per 100,000.
- Montana has more than 100,000 veterans or nearly one person in every 10.
(Montana Mental Health Oversight Advisory Council)
- Veterans diagnosed with depression in the 18 to 44 year old group were at most risk for suicide at a rate of 95.0 suicides per 100,000 compared to 45 -65 year olds whose rate was 77.9 per 100,000.

- Veterans who also had a diagnosis of post-traumatic stress disorder (PTSD) were less likely to commit suicide (68.2 per 100,000) compared to depressed veterans without this disorder (90.7 per 100,000).
(Montana Strategic Suicide Prevention Plan - 2011)
- Nationally, Army Reserve National Guard veterans aged 26 – 30 years old had the highest number of suicides among all age groups.
- Twenty-five 26-30 year olds committed suicide in 2011 compared to the next highest number of 12 among the 31 to 35 year olds.
- There were more suicides among Army Reserve National Guard personnel who had never been deployed compared to those in theatre or returning veterans.

(Army Reserve National Guard)

HIGH SCHOOL/TEENAGERS

Includes 8th through 12th grade, and under 18 years of age not necessarily in high school

Suicide and attempted suicide: AVERAGE SCORE = 3.60

- 3.74 Attempted suicide one or more times during past 12 months
- 3.59 Children considered attempting suicide in past 12 months
- 3.47 Completed Suicides, ages 10-17

Additional Data

- From 2001 - 2010, fewer than five children under 17 committed suicide using Fentanyl or other synthetic narcotics representing 66.6% of all children under 17 committing suicide using some type of drug.
- Sixty-eight percent (68%) of suicides among children under the age of 17 did not use alcohol or drugs to commit suicide.
- Average suicide rates over 2006-2010 are broken down by race among children ages 10 – 18. These show rates of 8.7 suicides per 100,000 population for all races; 6 for whites, 33.4 for American Indian/Alaskan Natives and 7.1 for other or unknown race.

(Montana Vital Statistics Analysis Unit)

Underage drinking and adult problem drinking: AVERAGE SCORE = 3.58

- 4.01 Children having one or more drinks of alcohol in past 30 days
- 4.00 Kids who had more than a sip or two of alcohol before age 12
- 3.67 Children who think there's moderate to great risk of harming themselves if they have one or two alcoholic drinks nearly every day*
- 3.67 Children binge drinking one or more times in past 30 days
- 3.34 Children who think it's hard or very hard for kids to get alcoholic beverages*
- 3.26 Children driving when drinking alcohol one or more times in past 30 days
- 3.13 Children seeing drinking alcohol regularly as wrong or very wrong

*Indicators where the trend has risen, representing an improvement.

Substance abuse and mental illness: AVERAGE SCORE = 3.25

- 3.81 Clients under age 18 in all Montana facilities*
- 3.06 Children seeing using illegal drugs like cocaine, LSD or marijuana as wrong or very wrong
- 3.01 Children using marijuana one or more times during lifetime
- 3.01 Children seeing smoking marijuana as wrong or very wrong
- 3.01 Children thinking there's moderate to great risk of harming themselves if they smoke marijuana regularly

* As collected and reported by the National Survey of Substance Abuse Treatment Services. "The National Survey of Substance Abuse Treatment Services (N-SSATS) is designed to collect information from all facilities in the United States, both public and private, that provide substance abuse treatment. In Montana, 53 substance abuse treatment facilities were included in the 2010 N-SSATS."

**This measure is affected by outside biases; different Youth Courts districts have different practices., individual judges and probation officers decide what drug test to be used and how often. Most often, the terms of the probation include some level of drug testing. Unless a case goes formal (e.g., drug court) judges have little to do with determining the scope of drug testing. Funding is not an issue.

Additional Data:

- Thirty-three percent of all Medicaid youth 5 years old and younger was provided with Mental Health Services in SFY10, representing 4,035 children or 6.5% of ALL Montana kids 5 and under. (Children's Mental Health Bureau)

Prescription drug misuse and abuse

No prescription drug misuse and abuse indicators scored above the 2.99 cut off. The two highest scored indicators for the HIGH SCHOOL/TEENAGER cohort were:

- 2.93 Clients under age 18 in all substance abuse treatment facilities
- 2.73 Youth court referrals: Dangerous Drugs

Additional Data:

- Youth aged 18 and under accounted for 22.4 % of all drug related arrests. (Montana Incident-Based Reporting System)
- In 2010, 27 children between the ages of 12 and 17 were hospitalized for drug and/or alcohol poisoning. (Hospital Discharge Data System)

YOUNG ADULTS/UNIVERSITY STUDENTS

Includes university students and those under 25 years of age not necessarily in university

Underage drinking and adult problem drinking AVERAGE SCORE = 3.38

- 3.60 Students having 5 or more alcoholic drinks last time they drank
- 3.39 Drove after binge drinking
- 3.40 Misdemeanor/felony cases filed: Minor in Possession
- 3.33 Liquor law violations: Underage drinking related
- 3.20 Binge drinking, past 2 weeks

Substance abuse and mental illness

No substance abuse and mental illness indicators scored above the 2.99 cut off. The two highest scored indicators for the ADULT/UNIVERSITY STUDENTS group were:

- 2.13 Used marijuana one or more days during past 30 days
- 2.10 Currently taking medication for depression

Suicide and attempted suicide

No suicide and attempted suicide indicators scored above the 2.99 cut off. The two highest scored indicators for the YOUNG ADULT/UNIVERSITY STUDENTS group were:

- 2.27 Male students attempting suicide, past year (NCHA)
- 2.20 Female students seriously considering suicide, past year (NCHA)

Additional Data:

The National College Health Assessment (NCHA), reports on only University of Montana students. This report also shows that:

- 10% of male students and 11% of female students seriously considered suicide in the past year.
 - 1% of both male and female students attempted suicide in the past year.
- National College Health Assessment
- Average suicide rates over 2006-2010 are broken down by race among young adults ages 19 – 25. These show rates of 24.7 suicides per 100,000 population for all races; 21.5 for whites, 54.3 for American Indian/Alaskan Natives and 39.9 for other or unknown race. (Montana Vital Statistics Analysis Unit)

Data provided by the Montana Vital Statistics Analysis Unit on method of suicide reported for adults over 17 years. Thus some of these incidents pertain to the young adult cohort but are not broken down to report specifics. However some of the numbers reported in the following would include this age cohort.

- From 2001 – 2010, 236 adults over the age of 17 committed suicide using some type of drug and/or other biological substances representing 12.6% of all adults over 17 who committed suicide.
- Eighty-seven percent (87.2%) of suicides among adults over the age of 17 did not use alcohol or drugs to commit suicide.

Prescription drug misuse and abuse

No prescription drug misuse and abuse indicators scored above the 2.99 cut off. The two highest scored indicators for the YOUNG ADULT/UNIVERSITY STUDENTS group were:

- 1.67 Received alcohol/drug use prevention information from the University
(There were no other indicators in the database for this measure and this age group.)

Additional Data:

- In 2010, 402 people over the age of 18 were hospitalized for drug and/or alcohol poisoning (Hospital Discharge Data System)
- From 2001 – 2010, 70 adults over the age of 17 committed suicide using one of the following drugs: Morphine, Oxycodone, Hydrocodone, Methadone, Other Synthetic Narcotics, Fentanyl, Pethidine, Other and Unspecified Narcotics. This represents 27.8% of those adults over 17 who committed suicide using some type of drug. (Montana Vital Statistics Analysis Unit)

ADULTS

Indicators include the following age breakdowns: all ages, over 26, over 18 and over 17 years old.

Suicide and attempted suicide* AVERAGE SCORE = 3.97

- 4.37 Suicides, all ages (number)
- 4.37 Suicides, ages 18+
- 4.13 Suicides, all ages (rate per 100,000)
- 3.87 Attempted suicide one or more times in past 12 months (subset of line 93)
- 3.13 Hospitalizations for suicide attempts, ages 18+

Additional Data:

- From 2001 – 2010, 236 adults over the age of 17 committed suicide using some type of drug and/or other biological substances representing 12.6% of all adults over 17 who committed suicide.
- From 2003 – 2010, 27% of 1,585 suicide deaths involved alcohol or drugs.
- From 2001 – 2010, 87.2% of suicides among adults over the age of 17 did not use alcohol or drugs to commit suicide.
- Annual suicide rates from 2005 through 2010 show little to no change in number of suicide involving drugs and alcohol.
- Suicide has ranked as the 7th or 8th leading cause of death for Montanans for more than two decades.
- Average suicide rates over 2006-2010 are broken down by race among all Montanans 10 years old and older. These show rates of 24.3 suicides per 100,000 population for all races; 23.5 for whites, 31.8 for American Indian/Alaskan Natives and 40.6 for other or unknown race.
- Average suicide rates over 2006-2010 are broken down by race among adults over age 26 years. These show rates of 27 suicides per 100,000 population for all races; 26.8 for whites, 25.3 for American Indian/Alaskan Natives and 54.4 for other or unknown race.

(Montana Office of Vital Statistics)

Substance abuse and mental illness AVERAGE SCORE = 3.54

- 3.79 Illicit drug use, past month
- 3.74 Adults treated for alcohol abuse w/secondary drug
- 3.59 Needing but not receiving treatment for illicit drug use
- 3.53 Total facilities with substance abuse and mental health treatment services*
- 3.53 All clients in treatment in Montana facilities**
- 3.07 Any mental illness, past year

* As collected and reported by the National Survey of Substance Abuse Treatment Services. The number of facilities with substance abuse and mental health treatment services in Montana rose from 11 in 2007 to 23 in 2010.

** As collected and reported by the National Survey of Substance Abuse Treatment Services. The rise in the number of treatment centers is reflected in this indicator going from 474 in 2007 to 1693 in 2010.

Additional Data

Montana Facility (2010 data)	Average Daily Population (trend since 2007)	Average Age	% of patients w/co-occurring disorders	Median length of stay (days)
MT Chemical Dependency Center	52 (up)	34	92%	34
MT State Hospital	189 (up)	44	55%	40
MT Mental Health Nursing Center	82 (up)	62	40%	3.2 (years)

DPHHS Addictive and Mental Disorders Division

Additional Data:

- 12.46% of Montana’s adult population has serious psychological distress and approximately 9% of Montana adolescents and adults have major depressive episodes.

- Individuals with serious mental illness (SMI) constitute 6-8% of the U.S. population, but account for several times that proportion of the 32,000 suicides that occur each year in the country
(Montana Strategic Suicide Prevention Plan - 2011)

Underage drinking and adult problem drinking AVERAGE SCORE = 3.50

4.07	Needing but not receiving treatment for alcohol use
4.00	Drive motor vehicle after binge drinking
3.86	Binge drinking, adults (past 30 days)
3.73	Alcohol/Drug related crashes
3.73	DUI offenses
3.67	Adult alcohol dependence or abuse, past year
3.46	Adults driving after drinking too much at least once in past 30 day
3.40	DUI convictions
3.21	Adult alcohol dependence, past year
3.20	Convictions per 1,000 population
3.07	Misdemeanor/felony cases filed: DUI--Alcohol
3.06	Adults treated for alcohol abuse only
2.99	Alcohol-related fatalities (BAC=0.01+)

Additional Data:

- Binge drinking rates for males of all ages is 22.6% compared to 11.4% for all females.

Additional Data on young adults (2010):

- The rate of fatal alcohol crashes per 10,000 licensed drivers of all ages was 1.3, for 20-24 year old it was 3.1. Young adults (20-24) are 3 times more likely to be in fatal alcohol crashes compared to all ages. (Montana Department of Transportation)
- Drivers 21 – 24 years of age accounted for 15% of all drivers in fatal alcohol crashes BUT represent only 6% of all licensed drivers. (Montana Department of Transportation)
- Binge drinking rates for 18 – 24 year olds was 22.9% compared to 17% for all ages. (Behavioral Risk Factor Surveillance Survey)
- Binge drinking rates for 25 – 34 year olds was 25.9% compared to 17% for all ages. (Behavioral Risk Factor Surveillance Survey)

Prescription drug misuse and abuse

No prescription drug misuse and abuse indicators scored above the 2.99 cut off. The two highest scored indicators for the ADULT cohort were:

- 2.94 Non-medical pain reliever use, past year
- 2.93 Misdemeanor/felony cases filed: DUI--Any drug

However, in the 2.99 to 2.46 scoring range there were 31 indicators and of these 31, 14 of them were adult prescription drug misuse and abuse indicators (45%).

Additional Data:

- The number of drugs other than alcohol found in DUI cases in Montana has risen every year between 2007 and 2009.
- Cannabis was the leading drug found in the 2009 DUI cases (231).
- Of the 15 top drugs found in 2009 DUI cases, 9 were depressants, 4 were narcotic analgesics and 2 were stimulants.

- Thirty-two percent of fatal vehicle crashes involved drugs, with 1/3rd involving more than one drug category (depressant, narcotic and stimulants).
(Department of Justice, Forensic Science Division)
- In 2010, 402 people over the age of 18 were hospitalized for drug and/or alcohol poisoning (Hospital Discharge Data System)
- From 2001 – 2010, 70 adults over the age of 17 committed suicide using one of the following drugs: Morphine, Oxycodone, Hydrocodone, Methadone, Other Synthetic Narcotics, Fentanyl, Pethidine, Other and Unspecified Narcotics. This represents 27.8% of those adults over 17 who committed suicide. (Montana Office of Vital Statistics)

Additional Data on young adults (2010):

- 18 – 24 year olds accounted for 37.7% of all drug related arrests. (Montana Incident-Based Reporting System)

Interviews on Seven Reservations in Montana: Prevention is Everyone's Business

Patty Stevens and Natale` Adorni

March to May 2012

**This report records the insights and personal experiences of those involved
in health promotion efforts related to preventing:**

Suicide and Attempted Suicide

Consequences of Underage Drinking

Consequences of Adult Problem Drinking

and

Prescription Drug Misuse/Abuse

**Funded by the Substance Abuse Health Services Administration (SAMHSA)
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Interviews on Seven Reservations: Prevention is Everyone's Business

Patty Stevens and Natale` Adorni

Purpose of the Interviews: These interviews were conducted under the auspices of the Strategic Prevention Enhancement Grant (SPE). This planning grant was awarded to the Addictive and Mental Disorders Division, within the Montana Department of Public Health and Human Services, to mobilize state agencies and tribal entities to better plan for and coordinate prevention activities to address four specific health areas. The four areas were: 1) to build *emotional health*; 2) to prevent and reduce the *consequences of underage and adult problem drinking*; 3) to reduce *prescription drug misuse and abuse* and 4) to *prevent suicide and attempted suicide* in the general population and populations at-risk including American Indians, Military families, and Lesbian, Gay, Bi-sexual, Transgender and Questioning (LGBTQ) populations.

The planning activities were under the purview of the SPE Consortium consisting of twelve state agencies and three tribal entities. Tribal participation in the Consortium fell to four members representing two of the reservations (The Confederated Salish and Kootenai Tribes of the Flathead Reservation and the Rocky Boy's Indian Reservation) and the Montana/Wyoming Tribal Leaders Council¹.

In order to further enhance the knowledge about how the targeted public health problems impacted the reservations and what prevention efforts were occurring in Indian Country, the Consortium requested in-person interviews be conducted with groups and individuals across the seven reservations. It was also hoped that through this process relationships would emerge that could be fostered over time and result in useful collaboration for all parties.

Interviewers: The grant supported the work of two interviewers, Patty Stevens and Natale` Adorni. Patty is a member of the Interagency Coordinating Committee (ICC) working group whose mission is to create and sustain a coordinated, comprehensive system of prevention services in the state of Montana. Patty is also an enrolled member of the Confederated Salish and Kootenai Tribes of Montana. At the time of these interviews, Natale` was a Montana Center for Substance Abuse and Prevention (CSAP) Fellow at the Department of Public Health and Human Services and has considerable experience working with local communities in rural and frontier Montana to enhance prevention efforts as well as improving care for at-risk youth and adults.

Process: Prior to the interviews, Patty and Natale` attended the *Community Readiness Training for Indian Health Services*, in Billings, MT where treatment professionals from across the state were gathered. At the meeting, Patty and Natale` outlined the purpose of the interviews, the reservations they intended to visit and what they hoped to identify (overall successes/barriers and emerging trends). As a result of this meeting, a list of possible contacts was generated. This created an opportunity to begin connecting with the behavioral healthcare workers, to share information about the planning grant and quickly identify important stakeholders with the knowledge and experience about prevention efforts on the reservations.

In some cases, interviews resulted from referrals from other interviewees, they occurred spontaneously, and were not necessarily always conducted with experts in any particular field,

¹ The Tribal Leaders Council represents all of the tribes and provides a means of communication with tribal leadership.

but were held with respected community members. At the conclusion of each interview, inquiries were made to identify elders, leaders, community members and professionals who could be interviewed.

Reservations Visited: Blackfeet, Crow, Flathead, Fort Belknap, Fort Peck, Northern Cheyenne and Rocky Boy's. Over 2000 miles were covered in the course of conducting these interviews taking a month to complete. A total of **76 interviews** were conducted with a broad array of professionals from schools, hospitals, treatment facilities, housing authorities, prevention programs, social services, as well as Elders, leaders and community members.

Interviewees were Asked: 1) to describe their prevention efforts or health promotion efforts related to preventing: *suicide, underage drinking, adult problem drinking, prescription drug abuse and mental health issues*; 2) what prevention strategies/activities (that targeted the health problems) worked well in the communities; 3) what environmental conditions (community, school, family, friends) helped prevent the targeted health problems; 4) what environmental conditions contributed to the risk of the targeted health problems; what resources were used for prevention efforts (including workforce, community awareness and support, sound knowledge of prevention theory, practices, programs, vast practical experience, knowledge of community politics, policies, finances, other); and 5) how their prevention work connected to the prevention work carried out at the state-level. The questions were used to guide the conversations and the resulting stories, from the interviewees, illustrate what is happening on the respective reservations.

Montana and the Seven Reservations

Montana is the fourth largest state in the country with 147,138 square miles. It is a rugged, rural state with a sparse population; Montana's population reached 1 million people in 2011. The state is composed of predominately Caucasians, 89.9 %; about 11 percent higher than the national average. The remaining population includes: 6.4% American Indians (5th highest in U.S.) , 3.5% Hispanic and .5% African American (lowest proportion in the U.S.).

Much of Montana is considered *Frontier* rather than rural. According to the dictionary, frontier is defined as "the farthest area of land on which people live and work, before the country becomes wild and deserted. Based on a study from the USDA Economic Research Service, frontier and remote is also described as a territory characterized by some combination of low population size and a high degree of geographic remoteness (<http://www.ers.usda.gov/data-products/frontier-and-remote-area-codes.aspx>). Montana contains 56 counties, of which 45 qualify as *frontier* counties. The reservations are located within fifteen of these frontier counties.

Montana is home to seven Indian Reservations, with the majority of the 53,000 American Indian populations living on these reservations. The seven reservations are: Blackfeet, Crow, Flathead, Fort Belknap, Fort Peck, Northern Cheyenne and Rocky Boy's. Montana is also home to the Little Shell Tribe which is made up of 4,500 members located in Cascade County. The tribe is recognized by the state but not the federal government so they do not receive federal support. The *Little Shell Chippewa Tribe* does not have reserved land and the members of the tribe live throughout the state. No interviews were conducted with tribal members.

Tribal nations are diverse. Each tribe has unique cultures, languages, traditions, histories and geographic conditions. The largest tribal organizations in Montana include the Blackfeet Nation,

the Crow Tribe, and the Fort Peck Tribes with a total lands covering 13,188 square miles (8,440,147 acres).

The impact of these geographic realities, on the lives of residents, emerged during the interviews. For example, they talked about the large distances from and lack of easy access to mental health and chemical dependency treatment services/professionals; the lack of adequate transportation and poor to non-existent cell phone coverage. Faced with this reality, prevention and treatment professionals are required to be not only passionate, creative and innovative but also able to identify and integrate existing community resources and treatment modalities to meet their clients need.

Historically, the needs of communities were met through building partnerships and coordinating services. However, with the rise of prescription drug misuse and abuse, alcoholism and completed suicides, it has been necessary to access services from outside agencies. As one of the treatment professionals at Crow Agency stated, “We are left with the job of “band-aiding” people in crisis until we can set up an appointment in Billings.” As the interviews revealed, local prevention, treatment and mental health staff working on reservations, were referring clients to Montana’s larger cities, Billings, Missoula, Great Falls, Bozeman, Butte-Silver Bow and Helena.

Blackfeet Reservation

The Blackfeet Reservation covers 1.5 million acres (3,000 square miles) and is considered a frontier community. It has a population of about 10,000, including 8,500 enrolled Blackfeet, several hundred Blackfeet descendants’ and Indians from other tribes, and a few hundred non-Indians. About half of the members live on the reservation. The Blackfeet Reservation is located in northwestern Montana along the eastern slopes of the Rocky Mountains. It is bordered on the north by Canada and on the west by Glacier National Park. The Tribal headquarters and Blackfeet Community College are located in Browning.

Blackfeet Tribal Chief, Earl Old Person, states one of the main issues facing the tribe today are “the high unemployment rate and looking at ways to create permanent employment opportunities rather than relying on government programs for employment.”

Revenue for tribal members is derived from agriculture, livestock production, timber, light industry, tourism, and construction. The leading employers on the reservation are the Indian Health Service, School District No. 9, the Blackfeet Tribe, and the Bureau of Indian Affairs. Local craftsmen increase their income by selling crafts to the summer tourists. Much of the labor force depends on firefighting and other seasonal type jobs. According to the Montana Department of Labor and Industry, 2012, the 2011 average unemployment rate on the Blackfeet Reservation was at 16.6%.

For more information, please visit: <http://www.blackfeetnation.com/about-the-blackfeet/the-blackfeet-today.html>

Crow Reservation

The Crow Reservation is the largest reservation in Montana, encompassing 2.2 million acres of rolling upland plains, the Wolf, Bighorn and Pryor Mountains, and the bottomlands of the Bighorn River, Little Bighorn River and Pryor Creek. The reservation is home to 8,143 (71.7%) of the 11,357 enrolled Apsáalooke tribal members. About half live on the reservation. The reservation is located in south-central Montana and is considered a frontier community. It is

bordered on the south by Wyoming and on the east by the Northern Cheyenne Reservation. The northwestern boundary is about 10 miles from Billings. The tribal headquarters and Little Big Horn College are located in Crow Agency.

The economy of the Crow Reservation rests largely upon government services to the residents, and some employment in agriculture, farming and ranching, particularly in spring and summer. According to the Montana Department of Labor and Industry, 2012, the 2011 average unemployment rate on the Crow Reservation was at 23.6%.

For more information, please visit: <http://www.crowtribe.com/pop.htm>

Flathead Reservation

The Flathead Reservation, home to the Confederated Salish, Kootenai and Pend d'Oreille Tribes, covers 1.39 million acres. Fifty-eight percent is Indian owned, including the first tribally designated and managed wilderness area of 93,000 acres. Much of the tribal land is in various forms of natural management. There are 7,923 enrolled members. About half live on the reservation. The reservation is located in northwestern Montana between Missoula and Flathead Lake. The reservation includes the southern half of Flathead Lake. The tribal headquarters and Salish Kootenai College are located in Pablo.

The Tribes have traditionally been the largest employers on the reservation. Other employers include the K-12 school districts and the Salish Kootenai College, which houses the Tribal Business Assistance Center. This office provides workshops related to business management, creating a business infrastructure and entrepreneurship. According to the Montana Department of Labor and Industry, 2012, the 2011 average unemployment rate on the Flathead Reservation was at 14.0%.

For more information, please visit: <http://www.cskt.org/>

Fort Belknap Reservation

The Fort Belknap Indian Reservation is home to the Gros Ventre and the Assiniboine Tribes and is located forty miles south of the Canadian border and twenty miles north of the Missouri River, which is the route of the Lewis and Clark Expedition. Fort Belknap Indian Reservation is the fourth largest Indian reservation in Montana and is another frontier community. It encompasses an area consisting of 675,147 acres, which extends approximately 28 miles east, and west and 35 miles north and south. Approximately 4,921 members live on or near the reservation. The tribal headquarters and Fort Belknap Community College are located in Fort Belknap.

The principal source of employment is agriculturally-related. According to the Montana Department of Labor and Industry, 2012, the 2011 average unemployment rate on the Fort Belknap Reservation was at 14.9%.

For more information, please visit: http://visitmt.com/places_to_go/indian_nations/nakoda-aaninin-fort-belknap/

Fort Peck Reservation

The Fort Peck Reservation covers 2.1 million acres of which there are an estimated 11,786 enrolled tribal members with about half of the members living on the reservation. Fort Peck is home to two separate Indian nations, the Assiniboine and the Sioux Tribes, each composed of numerous bands. The reservation is in the north eastern corner of Montana 40 miles west of

North Dakota and 50 miles south of Canada. The southern border is the Missouri River. This is considered a frontier community. The tribal headquarters and Fort Peck Community College are located in Poplar.

In addition to agriculture, the industrial park in Poplar is one of the largest employers on the reservation and houses an assortment of enterprises such as production sewing and metal fabrication. Other important contributors to the economy include an electronics manufacturer, farming, ranching, and oil extraction. According to the Montana Department of Labor and Industry, 2012, the 2011 average unemployment rate on the Fort Peck Reservation was at 11.1%.

For more information, please visit: <http://www.fortpecktribes.org/>

Northern Cheyenne Reservation

The Northern Cheyenne Reservation covers 445,000 acres located in southeastern Montana near Colstrip, Montana. This mineral rich reservation is home to over 9,300 Northern Cheyenne enrolled tribal members with about half living on the reservation. The Northern Cheyenne Reservation is in southeastern Montana. It is bounded on the east by the Tongue River and on the west by the Crow Reservation. This is a frontier community. The tribal headquarters and Chief Dull Knife College are located in Lama Deer. The major employers include the St. Labre Indian School, the federal government, tribal government, power companies and construction companies. The education system, farming, ranching and small businesses contribute to the economy. According to the Montana Department of Labor and Industry, 2012, the 2011 average unemployment rate on the Northern Cheyenne Reservation was at 20.5%.

For more information, please visit:

<http://www.bia.gov/WhoWeAre/RegionalOffices/RockyMountain/WeAre/NorthernCheyenne/index.htm>

The Rocky Boy's Reservation

The Rocky Boy's Reservation covers 130,000 acres. There are approximately 5,656 Chippewa Cree enrolled members with about half living on the reservation. The reservation is located in north central Montana and is bordered on the west by US Highway 87 and on the east by the Bears Paw Mountains. The Rocky Boy's Reservation is the smallest reservation in Montana and the last to be established. The reservation is split by Hill County covering the northeast and Choteau County covering the southwest portion of the tribal lands. There is no town site on the reservation, is truly frontier in every sense of the word. The community of Rocky Boy's includes tribal headquarters and Stone Child College.

Major employers include the Chippewa-Cree Health Board, the Chippewa-Cree Tribal Office, Rocky Boy Schools, Stone Child College and Box Elder Schools. According to the Montana Department of Labor and Industry, 2012, the 2011 average unemployment rate on the Rocky Boy's Reservation was at 15.6%.

For more information, please visit: <http://www.rockyboy.org/Site%20Map/Info%20Page.htm>

RESULTS OF THE INTERVIEWS

The following results illustrate how the seven reservation communities have a wealth of traditions and stories that guide them in discussing prevention efforts that meet the needs of their members. Discussions around prevention and prevention efforts need to be considered within the cultural context of the respective reservations.

The stories are organized by categories such as Protective Factors, Prevention Efforts, and Environmental Risk Factors and illustrate the major themes that emerged during the interviews. We acknowledge this is not an exhaustive compilation of what is happening in Indian Country. However, it is a summary of what is happening on each of the reservations using the words of the interviewees.

A number of themes emerged from the interviews that support what is reported in the literature on tribal experiences across the United States.

Themes: 1) Culture *plays a significant role in preventing public health problems* and it's essential to see the connections between community, culture and prevention. For example, a reoccurring theme across reservations was the role of cultural connectedness as a protective factor. This factor is well supported in the literature. For example, "One of the strongest factors that protect Native Youth and young adults is their sense of belonging to their culture and community; conversely loss of culture can reduce resiliency and well-being. Protective factors help a person stay safely on the correct path. It is often the Elders and adults, and sometimes the role of older peers, to guide the young along their life's path and help them avoid, or at least cope with, some of the roadblocks that appear" (p. 8)². "For example, in a situation when a suicide has occurred, the possibility of suicide contagion seems to be decreased by a healing process that involves the role of Elders and youth in decision-making, adult role models and the use of traditional healing practices" (p. 15).

Other examples of protective factors include the use of indigenous language as a marker of cultural persistence and strength (p. 16), and spiritual continuity as evidenced through strong spiritual beliefs and practices that promote survival (p. 16). Spiritual beliefs, traditional values, and health methods promote spiritual and cultural continuity, ensuring that young people have a valued role in preserving their heritage. They also encourage and support the acquisition of life skills and coping skills that help prepare youth to live successfully in a bicultural world (p. 18).

2) *Exposure to historical trauma is a risk factor associated with public health problems.* Again the literature recognizes this as a significant risk factor for American Indian communities throughout the United States. "All Native families have a collective history of trauma and abuse. As a result, many parents struggle every day to pass on to the next generation what they themselves may never have received in terms of nurturing or a sense of belonging. Historical trauma is the cumulative exposure of traumatic events that affects an individual and continues to affect subsequent generations. Trauma never affects just one person, one family, one generation or even one community" (p.12). "A trauma-informed plan would be one in which all of its components have been considered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addiction services" (p. 12).

"Nurturing and protecting children is a basic aspect of these cultures, although this aspect may have been threatened over time as a result of historical trauma, boarding schools, imposed social services, alcoholism and poverty, traditional family values have survived and will help

² U.S. Dept of HHS. To Live to See the Great Day that Dawns: Preventing Suicide American Indian and Alaska Native Youth and Young Adults. DHHS Publication SMA (10)-4480, CMHS-NSPL-0196. 2010. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

strengthen youth. Culturally sensitive programs to strengthen family ties can be effective prevention effort” (p.15).

3) *A community’s sense of having some control over its daily life can be empowering and contribute to the community’s sense of general well-being.* Some interviewees emphasized the value of taking local responsibility and not relying on others. This value is also supported in the national literature as a protective factor within communities.

This report presents the stories, through the lens and experiences of the interviewees, that emerged during the brief interviews.

Protective Factors Associated with Reducing/Preventing the Risk of the Targeted Public Health Problems

These factors included, but were not limited to:

- ❖ Embracing traditional cultural practices, beliefs, norms and values, languages, rituals
- ❖ Peer/community support for avoiding substance abuse
- ❖ Commitment by the communities to keep the culture, traditions and languages alive
- ❖ Close family/home ties
- ❖ Embracing spiritual beliefs
- ❖ Respectful communication between youth and parents.

The following stories illustrate the role of these protective factors.

Emphasizing the *need to immerse in its culture*, on Fort Belknap it was said, "There is a Cree component that is taught in the public school that is teaching the background of our culture and our beliefs. They need to expand and strengthen this. The people practice their cultural religion here; they use peyote. They have a Sundance. Each Tribe holds its own event." He continued, "They *have evidence based programs* such as Positive Indian Parenting and Honoring Our Children by Honoring Our Traditions. Grandparents have a lot of influence."

One professional on Rocky Boy’s talked about the importance of maintaining sobriety and through her efforts and by her example, she brings hope to future generations. She stated, “I live in Rocky Boy because it’s beautiful. My mother’s here. I love my job and it helps me stay sober. *We help each other stay sober.* I’ve had some people say that Rocky is a big black hole that sucks them in. When in reality it’s their substance abuse that is the big black hole. When they decide to make that change, they have a whole different outlook.”

One of the last professionals we spoke to on Rocky Boy’s added, “I love it here too. My kids are in school here. It’s in my blood. My children won’t go anywhere else. I love it in the summertime. My mom is here. All the family is here. It doesn’t matter if I come from Billings or Great Falls, once I see the Bear Paw Mountains, *I know I’m home.*”

In each community we visited there was a consensus that in order for sustainable change to occur, *a commitment must come from within the community* itself. As an example, a prevention coordinator from Northern Cheyenne stated, “In Cheyenne, we live for each other. We have the ability to make a difference. You always draw upon your experience to help others! In Cheyenne, if you’re corrected you always talk about that.” He emphasized both *community and*

individual responsibility when implementing change. Adding, “A person needs to communicate one's needs effectively in both Indian/Non-Indian cultures.” When addressing the needs of those bullied and vulnerable he said, “You take up for people that can't take up for themselves. There is an organized media campaign to address this issue on our reservation.”

Results from the interviews revealed Native youth may be subjected to additional hazards that increase their risk for alcohol and substance abuse. These are lack of cultural identity; historical trauma; and low self-esteem. In order to combat these identified hazards, on Fort Belknap, the Meth Suicide Prevention Coordinator/Oversight Planting Seeds of Hope emphasized the need for cultural distinctiveness. She said, “*If we get our people back to touch base on their culture, it helps them.* It helps them a lot. We go into our schools and teach our traditional games. I and my coworkers are certified cultural trainers and we go in and teach our kids cultural games and their meaning and background behind them. Double ball, shinny, atlatl. You take double ball and you get a group of Jr. high kids and they're going to want to knock each other down and play hard, play rough. You set them down beforehand and explain why we played it and this is the respect of it. What made me come to the conclusion that it was our culture because without our culture, we don't have anything. It don't matter if I go across the bridge over here and I'm talking to a non-native kid, they've lived here long enough and they are around the rez enough and they're best friends with rez kids, even though they may be non-Indian, they're still connected somehow to this reservation and culture. When you sit down and play the games with them, they have just as much respect for our games as they would themselves.”

She continued, “We've been very fortunate to have our own people, our cultural teachers in our schools that have helped a lot. We have someone in the Lodge Pole Elementary, the high school and Jr. High out at Hays, and we have staff here at Harlem High School. They are cultural teachers. They are actual certified teachers and have gotten their cultural endorsements.”

Traditionally, families have both provided support and advocated for the needs of their members. However, it appears social conditions, such as alcoholism, are eroding this mechanism. From those interviewed, *in order to survive on the reservation, it may be more necessary to learn to advocate for one's self.* An example of this is best demonstrated in one professional's personal story. “I've been sober 23 years. I was born and raised in Browning but lived on and off the reservation until I was 18. My father was a raging alcoholic and I was a poster child for dysfunction.” He continued, “My son didn't graduate from high school. He was presented with a lot of social challenges – not academic. My son told a photo journalist that someday he wanted to be a counselor just like his Dad. When asked why, he said ‘because he helps people.’ ”

Tribal members are more likely to go to those who are respected for advice and help versus those who are not. For example, in Northern Cheyenne we learned tribal members generally respect those families and Elders who have knowledge, life experience and perseverance. *These rich relational resources have great potential to impact and ultimately shape and change community norms.* Faced with the public health issues of prescription drugs and alcohol abuse, those interviewed expressed *a willingness to listen to proposing environmental program changes, but only when presented in culturally appropriate ways.*

One coordinator stated, “You pick your battles. I come from a whole different perspective. I don't fight. I stand for what I know resonates in the deepest part of me and I'm not going to push up against anything because the natural law says it's going to push back and I don't want that anymore. So what do we stand for? We stand for the youth.” He added, “I wasn't raised

traditional, I wasn't raised in that environment and I never learned how to speak Cheyenne. Our ceremonial things were to be feared rather than embraced. So until my mom married into a very traditional family, and I'm so grateful for that, its bringing into the present now and how can we learn to incorporate that into our being. It isn't about these intellectual diatribes; *it's about what resonates here.*"

The impact *community support systems* can have on individuals engaged in self-destructive behavior is best illustrated in the following story. Disclosing she contemplated committing suicide as a youth, one professional shared her personal struggles growing up as a youth on the reservation. "I was scared to commit suicide. I was taught in the churches that if you committed suicide you would go to hell. I didn't try it. I always thought about it. I thought it was the easier way. I witnessed physical abuse of my mom almost on a daily basis. There was no holidays or birthdays without a full blown fight." She continued, "For sure I'm an exception. There are not many who have God in their lives. I talk to as many people as I can because I have a full time job, I'm a mom and a wife and so I do a lot. Social media has helped a ton. Even just this morning, I posted that I had abuse in my background and that I had every excuse to fail but God's given me every excuse to succeed. I even talk about suicide on there. I talk about it a lot because no one talks about it. I'm very passionate about it. There are some out there my age that are like me but there's a lot of excuse making. I always thought that way for a long time. I'm like this because I witnessed abuse growing up. I have a lot of dysfunctional coping today mechanisms that might not have been out in the open, it might not have been drugs or alcohol, but it's still dysfunction and it could have wrongly affected my family, my kids. I've just now found a lot of freedom this past year after serving God for 10 years. It's not something that happens overnight. You just gotta keep going."

Today many popular, non-tribal cultural norms and values are evident in the tribal school environment. This is best exemplified in the following example. On the Blackfeet Reservation, unlike a half a century ago, a large percentage of Blackfeet are fluent English speakers. Several of the schools on the reservation are administered by a locally elected school board, under the Board of Public Education, and subject to school laws. A Browning High School Counselor stated, "*If students of whatever race or culture are disconnected from their traditional values they are likely to pick up on unhealthy values.*" He added, "Our kids are also barraged by popular culture through television, movies and the Internet."

Emphasizing the importance of creating a healthy environment in order for youth to flourish, a professional also from Blackfeet stated, "While academic knowledge and test scores are important, it is students behavior towards others that is of vital importance because it is a determinant of how individuals use the knowledge they have gained." He added, "*Parents, extended family and the environment conditions are critical components to laying the groundwork for a healthy community.*" "We need to look at the entire family and community, not just the individual to blame."

A common theme throughout the interviews was the importance of giving and sharing personal interaction with one another. A Blackfeet Tribal Member relayed, "Harmony in body, mind and spirit is at the core. *A person has to be in a state of wellness in order to be able to relate to himself and his people.*" In contrast this member defined the concept of "unwellness" as disharmony in body, mind, and spirit.

Common spiritual beliefs include the following:

- American Indians believe in a Supreme Creator. In this belief system there are lesser beings also.
- Man is a three-fold being made up of a body, mind, and spirit.
- Plants and animals, like humans, are part of the spirit world. The spirit world exists side-by-side and intermingles with the physical world.
- The spirit existed before it came into a physical body and will exist after the body dies.
- Illness affects the mind and spirit as well as the body.
- Wellness is harmony in body, mind, or spirit.
- Each of us is responsible for our own wellness.

Prevention Efforts

An important prevention tool, acknowledged across the reservations, was the significance of returning to and in some cases reintroducing culture to people of all generations. For example at Browning, a community based worker stated, "If we valued our culture we would have fewer problems. We are losing a lot and losing our language is our biggest loss. We need to value our language. This will lead to better coping skills and a connection with identity. *Identity is key to preventing suicide along with other addictions.*"

We interviewed a young professional from the Healthy Heart Project on the Crow Reservation. She was both a nurse and case Manager. She stated, "We've had some pretty tragic things happen. The one I can remember was a little less than a year ago. A mental health patient that wasn't getting the care he needed, I think he was schizophrenic, murdered his Grandma. I have one person that I stay in contact with through Facebook that was contemplating suicide. *Faith has a lot to do with it.* That's probably the main reason why I'm in nursing because of the helping part of it and there is also the spiritual health that is included. I wasn't going to finish nursing school because I thought that I wouldn't be able to use what I thought I had to offer. After talking to one of my instructors during nursing school when I was thinking about quitting and going into Christian Counseling, she said you get to do a lot of it and it's actually one of the aspects of nursing care. I was so glad that I stayed in the nursing program."

Given the assignment of *promoting positive cultural norms*, one data collection professional explained, "You have to have some type of information to give out to people that they can read and absorb. You have to have a hook to catch people. *What is one thing that people have here that they want more than anything? It's their identity.* People realize, they say I'm Cheyenne but what is a Cheyenne? How do they live? How do they treat each other? What is their history? What do they believe? To me, you give them this; they will have a life. If you ask people here, what do you have here? You'll probably get a laugh. They think it's a joke or something. Very few of them will tell you it's the people. That's a really hard kind of realization because you realize where the people are at. If you ask the elder people what's going on? What happened? What do you see? They will tell you so much. It has everything to do with people not being taught or implementing what they say they are. The Cheyenne, we live for each other. We live for respect out of what we were given as a nation to survive. We are one of the only northern banks tribe, through a covenant, that is tied to a regent. The laws that we have, we are the only tribe that lives in that regent that has those laws."

The Healthy Heart Case Manager at Crow said, “*We need to work together with other programs.* We did a Crow Fitness Center Open House where we tried to tell them all the resources that are available. The Fitness Center took the lead and all the programs had about 15 minutes where they talked about their programs. We’ll have it from 10-2; we’ll have lunch for the community. It was pretty successful. IHS helped by getting out this mass mailing to everyone. There was no social media advertising. The only list they sent out was the diabetic registry which was over a 1000. So here’s the problem, when someone was getting some pre-diabetic training, they got added to the registry. They weren’t actually diabetics. So people were coming in saying, ‘I’m not a diabetic, why did I get this letter? Is there something I don’t know?’ That’s when they knew they needed to work on the registry. So it went from 1100 back down to 900.”

Examples of Effective Prevention Strategies and Practice-Based Evidence Activities

There are a wide variety of culture-based practices being used across the reservations; the following are some examples.

On Fort Belknap a Chemical Dependency Center staffer stated, “Most of the kids that come in for activities are involved in their culture. We have another person that does prevention activities. *She gets them busy doing community service.* She’ll have those help elders. We have our Cultural Coordinator for the youth who takes kids to the *sweat house*. He coordinates our ‘Language & Roots’ on Tuesday in all three communities through the CDC (Chemical Dependency Counseling) Program. There is a lot of emphasis on *language revitalization*. There is the Assiniboine language on Tuesdays and Gros Ventre on Thursdays. Those programs provide dinners. They make hand drums, drum sticks, gourds, moccasins, hair ties, etc. Our hope is to get sewing machines in here for dance regalia and shawls. Our services are equally provided in the three communities. We hope to have sweats at her place for the girls in the near future.” She uses the *Matrix Model for Teens and Young Adults*. The center has a Culture Night, Movie Night and swimming pool.

A former councilman on Fort Belknap noted, “What is positive is that more kids are finding their culture again. There are a lot of singing groups. *Kids are starting to sing and dance again.* They’re *starting to feel pride in themselves again.*” He continued, “I have a grandson that is at the Denver March Pow Wow singing. That’s what saved him. He doesn’t drink or smoke in spite of what his parents are doing. His mom is a pill user and his dad is abusive. Grandpa and Grandma were the same way. I think that (culture) is going to be the Savior.”

From the Northern Cheyenne, "One of the things we talked about was doing a beadwork class. That was one of the activities that I wanted to do. The designs we use all promote healthy living. They all promote a disciplined way of life. I look at the system that can be developed and it all boils down to having *a system, a lifestyle, a community system, that is going to promote a healthy lifestyle and environment.*” *Promoting individual’s to take personal responsibility of their actions.*

On Crow Agency, an example of a positive and effective community prevention activity occurs during the third week in August during the Chichaxxaasua Crow Fair Celebration and Pow Wow. According to the official website, this event is *viewed as the largest family reunion in the world*, stating Apsáalooke/Crow People are famous for their cultural vitality. Over 10,000 Crow people live in the encampment of over 1,700 teepees and 1,200 tents. Crow families move their households including their horses to the camp. The Tepee Capital of the World features a daily parade of the Apsáalooke/Crow People and their horses in full regalia, cars and flatbed trucks

bedecked with beadwork and attire, an afternoon of all Indian rodeo and Indian relay races and daily drumming, singing and dancing.

Each year the Blackfeet Nation's Annual North American Indian Days are held in Browning. Tipis, tents and RVs decorate the Pow Wow grounds for four days of contest dancing and games. During the Pow Wow, *no alcohol is sold on the reservation (including grocery stores) and bars are closed.*

On the Flathead Reservation, a Salish couple living in St. Ignatius recognized that a lot of the young people had no exposure to horses, nor had they slept in a tipi, fished or gone into the mountains. *They wanted children to have fun and be in a safe environment free from alcohol and drugs (tobacco included).* So they started acquiring horses and discussing their ideas with others who wanted to help. Each year 75-100 youth and families come to their home to sleep in tepees and ride horses. Guests also keep busy swimming, hiking, cooking and learning cultural activities and survival skills. The couple wants to have 4 camps a year with the primary focus to be with horses, to hunt, gather berries and roots and tan hides. There is no charge to participants, no registration process, and no one is turned away.

Youth can also be important shapers and models of positive community norms and values for their peers and adults. One of the enrolled members of the Confederated Salish and Kootenai Tribes described a newly formed Indian youth group that calls themselves, *Yoyoot Skwikwimlt*, which translates to “Strong Young People.” Their purpose is dedicated to Indian youth so they can better themselves by knowing who they are as Indian people. The group recognizes that the youth don’t know who they are in life as Indian people. Some of them are going down a road that their ancestors never intended them to follow. They want youth to go on and be successful and know who they are and where they come from. *The founder is now 19 years old and is the youngest fluent speaker of the Salish language.* He teaches the Salish Language and the traditional values of the Salish people, along with history, hunting, beadwork, storytelling, drying meat, digging bitterroot, camas bake, berry picking, powwows and cooking. The group is not expert in these areas and seeks guidance from knowledgeable Salish Elders. *Once they learn themselves, they teach others.*” In discussions with these youth group members, aged 12 to 19, each member reported no history with drugs or alcohol. While most youth may say that they have nothing to do, this group is quite the opposite. As individuals, they report *keeping busy with school, activities and family.*

Highlighting his culture and his people, in Browning a young man by the name of John Davis took a unique route to his badge of honor. "I was the first Blackfeet to ever talk on this radio," Davis said. "This is my coup story." Davis, a 21-year-old Blackfeet Community College student, is among the volunteers who have made FM 107.5 a force to be reckoned with in Browning. In the Blackfeet language, the station is *Ksistsikam ayikinaan*. That translates to ‘voice from nowhere,’ but you can call it Thunder Radio. At 30-watts, the community radio station doesn't reach too far beyond Browning, but its impact is growing.” He continued, “The Blackfeet people have our own accent so I guess they enjoy that it sounds like them. The DJs are from the faith-based and school sectors. Everyone seems to have one important thing in common - they have a positive outlook on life.” *His radio program is reportedly transmitting a positive energy to its listeners.*

In Lame Deer, the Second Season program works with a group of young men, youth, who are on the verge of getting into trouble. The program takes them to different events and *gets the youth*

participating in the community. According to the professional interviewed, “*These kids are learning respect and they are speaking out.* They are very articulate. I don’t know that it’s a last chance.” This professional also told us of an event entitled: “Time To Become One.” It was held at the *2nd Annual Native American Cultural Awareness Conference.*

At Crow Agency we asked, “If you could do anything for your community to help them, and there was no issue about anything, what would you do?” Our professional responded by stating she would start a *support group* in Lodge Grass. “The reason we’re starting something in Lodge Grass is because a young lady just approached me at a basketball game and said that I had no idea that the things I was saying (Facebook posting) were helping her. I didn’t even know she was on there. She said, ‘Can you please think about coming here?’ Shortly after that I was asked by somebody else to help with something there and the perfect opportunity came up. My husband is very supportive of me. He’s not as loud about his faith but he supports it. He understands it.” Her husband watches their children in support of her work.

With the goal to prevent the onset and reduce the progression of substance abuse, underage drinking and suicide, the Fort Belknap Meth Suicide Prevention Coordinator stated, “My position is *education and awareness.* What I do is go into the schools to train our teachers in suicide prevention and over the summer with the TANF (Temporary Assistance to Need Families), we also train our teenagers with QPR (Question, Persuade and Referral). This project builds resilience and facilitates recovery in the community.”

As was evident on all reservations, tribal members on Fort Belknap appeared to be open to the concept of the supernatural and a higher power having a large impact and in their lives especially when it came to treatment success. One individual stated, “*We value the importance of an individual’s spiritual connection* and sweats are part of the culture. Also, we have three churches here. All are well attended. We have the Assembly of God, Sacred Heart and Baptist Church.”

On the Flathead Reservation, the *Suicide Prevention Program runs a series of groups for ages 14-24 years.* There is also Seeking Safety, an evidence-based program, which does activities with veterans, Second Circle Lodge youth, and Salish Kootenai College students. There are *weekly groups for veterans, family and survivors* who lost a family member to suicide because, “There is a need to talk about it in a safe environment.”

There are many examples of prevention activities occurring on the Flathead Reservation. The following illustrate the comprehensive nature of the public health prevention programs and coordinated prevention efforts. For example, a Parent Partnership Advocate helps individuals navigate through the mental health system, working with both adults and youth. He also runs a course entitled: *Mindfulness*, a cognitive based therapy for those with recurrent suicidal behaviors.

Another professional *facilitates a women's group with college age students that focuses on preventing and reducing high risk behaviors, and empowering the participants to make healthy choices.* She explains, that “With risky behavior, participants are usually under the influence. There have been a lot of IV drug users recently. They do a lot of counseling with HIV stuff.” This interviewee also works with hepatitis prevention training programs for nurses in Montana and Idaho. Her peer organizes presentations on and off the reservation, talking about “protecting yourself.”

A health education professional who manages the tribal fitness centers, stated, “I’m always looking at prevention. My focus is on the kids and *fighting obesity diabetes*. I work closely with all aspects of Tribal Health.” She added, “The reservation also promotes the *Safe on All Roads Program and Buckle-Up Montana*. We know that it doesn't work that easy on the other reservations. A lot of ours is prevention. *Our big push is the car seats* too. This is a state program and now is under the umbrella of Tribal Health. On the state-level, the Flathead Reservation has been the most successful in prevention and they also work well with the county health department.” Another example of *coordinated efforts with diverse programs in the community is the work carried out under the Tribal Incentive Grant*.

The program coordinator for the Fatherhood Program described a parenting program entitled *Parents as Teachers (PAT)* that builds parenting and life skills. The demand for this program is high; one staff member has a caseload of 48 clients. “We operate on federal grants and no state funding. My staff believes in collaborating with others.” The project is funded to provide for 125 clients. “Our caseload is about 170 as of September 1, 2012.” The program addresses a number of interconnecting risk factors that can be associated with poor mental and behavioral health such as unemployment, trauma, and inadequate life skills. For example, the program provides financial literacy programs, domestic violence training, parenting classes, and provides jobs or can help participants get jobs. “Everyone has to pass a background and drug test and then be subjected to random tests. They have a Work Placement Specialist currently knocking on the doors of the private sector. There is a Home Construction crew where they provide labor on the various projects. There is also a certified auto mechanics program. Cultural identity is held once a week.” The Tribal Lands Department contracts with his clients for their fencing project.

The Program Manager for Behavioral Health on the Flathead Reservation believes that people employed are less likely to be “out there partying hardy and it’s important to promote personal responsibility.” The programs offered by the Behavioral Health Center are in demand. “We have 135 clients and are only supposed to have 125. We are a 3-year program. If a client is in the program this year, they can't be in the next round. Each year has to be an unduplicated count.”

From her perspective, “Treatment is an opportunity to be preventive.” They have had emergency on-call coverage for suicide prevention for the last 30 plus years.” This center also has an agreement with the University of Montana that employs two doctoral students. “They do evaluations for us, analyze data and then present it. They make sure everyone gets a follow-up appointment. With underage drinking and driving, we do a *Minor’s in Possession (MIP) Program* as well as provides intensive outpatient for adolescents. She sees a lot of kids.”

The Behavioral Health Center also provides intervention for adults with alcohol-related problems. “We use the *Prime for Life*. It's a 4-week course that is held 3 hours a week. It's a nice program. [Addressing] adult problem drinking is what we do all day.” She added, “Alcohol misuse is still a big issue. We have meth and domestic violence monies that *focus on Depression Anxiety and Anger (DAA)*.” *For prescription drug abuse, we have DURT (Drug Utilization Review Team)*, a program where any provider can do a referral and this allows for information and medical records to be gathered and a team put together to make recommendations [if they believe the client to be getting multiple scripts from different sources, although there is no data to indicate whether this is helping to address the problem]. *Medicated Assisted Treatment (MAT) is used for people to help manage craving*; typically, Suboxone is prescribed. We also employ a staff addressing client treatment needs through the *Access to Recovery (ATR) program*.”

According to most individuals interviewed from all seven reservations, prescription drugs abuse is an escalating problem without ideal solutions or effective programs, other than DURT. Other interviewees expressed concern about the high number of clients seeking help because they were getting addicted to Suboxone.

Environmental Factors that Enhance the Effectiveness of Prevention Efforts

Youth involvement was identified as an important prevention strategy used by the reservations. For example on the Blackfeet Reservation, “There is a youth coalition group that is starting up. It's called the 'Blackfeet Youth Coalition’”.

Another supportive environmental condition on the Blackfeet Reservation is the commitment by the Blackfeet Community College to “promote and advance the *Nii-tsi-ta-pi* values and way of knowing through high quality, accessible academic and vocational education programs and services.” The core values promoted by the College are: *Tsi-ksi-ka-ta-pi-wa-tsin* – Blackfeet Way of Knowing: Blackfeet Culture/Spirituality in philosophy, thought, and action; *Nin-na-wa-tsin* – Being a Leader: Professionalism, Integrity, and Responsibility in human interaction; *Iniyimm* – Respect: Respect for ones self, all other people, all ideas and each thing in the natural world; *Ni-ta-pi-pa-ta-pi-tsin* – Living in a Good Way: Honest in all thoughts and actions; *Ii-yi-kah-kii-ma-tsin* – Trying Hard: Commitment, Dedication, Sincerity in the pursuit of all our goals; *Aoh-kan-otah-tomo* – Accepting Everyone: Embracing the unique talents and contributions of each individual and *Ii-ta-mii-pa-ta-pi-yoip* – Happy Living: Humor, laughter and enjoyment of life (<http://bfcc.edu/about.php#vision>). This demonstrates *broad community support and commitment for promoting tribal values and tribal pride*.

Stressing the importance of collaboration between state and tribal law enforcement agencies, one individual from the Blackfeet Housing-Community and Economic Development stated, "Now we have a *fairly good working relationship with law enforcement*. We've come a long way and have built relationships with the Glacier County Commissioners. Before, we didn't have cross-jurisdictional deputized officers. Now it's in code." She added, “We previously had safety checkpoints that were very effective. The incentives were very effective especially during our grant Montana Community Change Project (MTCCP). It reinforced good behavior.”

Fort Peck Reservation is also working with law enforcement to promote an important environmental change, the use of seat belts. The Fort Peck Reservation has a Primary Seatbelt Law that is enforced with the collaboration of tribal and state law enforcement officials. These officials conduct Safety Checkpoints/High Visibility Enforcement Operations during holidays and share data from vehicle crashes.

Fort Belknap, addresses substance misuse and abuse by *encouraging programs, policy change and supportive environmental practices, through Education and Safety Programs and locally driven Ordinances*. The professionals note, “It's hard to get the young people to not drink and drive. You hear a lot from the young kids that there's nothing to do. I work part-time with the Safe On All Roads (SOAR) Program and Fitness Center. There's a big push for seat belts and addressing underage drinking and driving. It's hard to get people to change their behaviors.” In order to better understand the community’s level of readiness for change, she used funding from the Department of Transportation to conduct a survey with over a 1,000 people between the ages of 18-34 years of age. The results identified priorities that could be targeted in the change process.

In order to better understand the nature and extent of consumption (i.e., underage drinking and prescription drugs misuse/abuse), on the Flathead Reservation, “Ronan School wrote a comprehensive grant a few years ago for emergency response. It was a reservation wide plan. It was similar to fire drills. There was a protocol, intervention, prevention, aftercare.”

Environmental Risk Factors Contributing to the Targeted Public Health Problems

A recurring theme that emerged from the interviews was that *Prescription Drug and Alcohol Abuse are #1 in misuse and abuse*. “They seem to go hand in hand (alcohol and prescription drugs). Addicts/dealers are waiting outside of hospital emergency rooms and paying patients top dollar for prescription narcotics.” This message was consistently heard from schools, the faith-based community, health, treatment/recovery facilities and social service sectors across the seven reservations. Professionals recognized this as a public health crisis.

Risk factors in the tribal communities included: *high poverty; high unemployment; loss of culture, identity and value; and increased criminal activity associated with prescription drug abuse*. The loss of culture, identity and values was consistently identified as a risk to public health and the restoration and reinforcement of cultural traditions was perceived of as potent protective factors. When youth or adults are disconnected from their culture, it leads to increases in incidents of suicide, domestic abuse, sexual crimes, unplanned pregnancy, school dropout, unemployment, substance abuse and misuse.

Another risk factor that negatively impacts the health and safety of tribal communities is *criminal activity*. The capacity to deal effectively with crime is challenged by a number of factors. The quality and quantity of law enforcement personnel to address criminal activity is variable. Some reservations found it difficult to adequately compensate their officers which results in low retention rates and impacts the professional behavior of those who officers who remain.

In addition, on some reservations, *cross jurisdictional “turf issues” exist and law enforcement is compromised*. One professional stated, “During the project (MTCCP – Montana Community Change Project), cross jurisdiction was a big obstacle. Here we have to work with all three: Tribal/State/Federal. There are a lot of barriers to access the federal data. So how did we get the school data? We got it because one of the tribal members was a brother to a school official.” State/Federal law enforcement agencies recognize that increasingly more types of crime have migrated across tribal nation lines and effective law enforcement requires the cooperation of disparate agencies across organizational and jurisdictional boundaries. This is especially evident when it comes to combating illegal drug trafficking, specifically, prescription drugs, and violent crimes on the reservations. Those reservations with cross jurisdictional agreements address even common problems more efficiently and effectively. Also, many tribal departments are too small to dedicate resources to specific areas. When state and tribal law enforcement cooperate together, manpower is more efficiently distributed, it is more cost effective, and response/investigation time is improved, culminating in better service to the communities.

The Fort Peck Reservation is also subject to an increased public health problem – the number of crashes involving serious bodily harm – with risk factors related to a *rapid increase in population and volume of traffic*. As a result of the Bakken Oil Boom approximately 35,000 persons were reported to have relocated in Eastern Montana/Williston, North Dakota in the last year. The (CHSP) Comprehensive Highway Safety Plan, Emphasis Area has identified high crash Severity Corridors on Fort Peck, due to an increased number of commercial vehicles

involved in crashes. Fort Peck Indian Reservation statistics showed there were a total of 50 crashes resulting in serious bodily injury. This number is expected to continue to rise with the increased population and volume of traffic using the highways. A related concern is the relationship between seat belt usage and injury from crashes. Based on recent studies, on the Fort Peck Indian Reservation the current seat belt usage rate ranges from 22-52 percent. The data also show that 58% of the crash victims who needed hospitalization were not wearing a seat belt. [Source: Harborview Injury Prevention and Research Center, Montana Highway Patrol, Indian Health Services, and Fort Peck Injury Prevention Program.]

Professionals interviewed in the areas of domestic abuse, mental health and chemical dependency services expressed *frustration with the tribal court system* around inconsistencies related to individual accountability, sentencing and mandated treatment. The outcome can be missed opportunities to intervene early and interrupt the destructive cycle and for individuals to receive treatment and support to recovery. For example, at Rocky Boy's a professional stated, "There are about 13 children in foster care and 8 in the Family Preservation Program. There are lists upon lists of (ICWA) Indian Child Welfare Act inquiries. There are 11 pending and 9 active cases. Placement for these children is usually in family or kinship foster care."

Patty and Natale' provide some informational background about the courts. "In general, tribal governments do not have the 'separation of powers' that calls for an independent judiciary. This can affect consistency in sentencing. How independent a tribal court is from a tribal council depends greatly on the method of selecting judges, council tradition and the character of the individual judge. Tribal judges generally are not attorneys, but some tribes do require preparation for the office by administering judicial qualification exams. Tribal court judges all receive judicial training while serving in office. Overall, most tribal governments are organized in much the same way as state and local governments. Legislative authority is vested in an elected body often referred to as a tribal council; although it can be known by other names, such as business committee, community council, or executive board. The council members can be elected either by district or at large. In some instances the members are nominated by district but are elected at large. The council governs the internal affairs of the tribe with one important exception --some tribal resolutions and ordinances may be subject to review by the Secretary of the Interior. In some instances, the secretary may veto power over tribal ordinances. However, a tribe may opt out of this review requirement if the tribe's constitution does not include the requirement."

The single common environmental factor, identified across the reservations, that impacted health of the communities was *geographic isolation*. The frontier conditions, in part, inhibit access to resources, treatment professionals, and support from the state. Access issues are further exacerbated by challenges associated with transportation and poor cell phone coverage. These factors directly affect timely access to and the standard of care available for those in serious need. Unfortunately access to prescription drugs such as OxyContin and Vicodin are more easily available and people are self-medicating in order to cope.

Geographic isolation can interact with individual risk factors such as depression, trauma, identity issues and result in *physical/emotional isolation* and further misuse and abuse of drugs and alcohol. For example, with youth who choose to socially isolate themselves, meaning, in some cases, staying home from school for days, not talking with friends or acquaintances, and generally avoiding contact with other people, there were increased episodes of substance abuse and suicide. It was reported these individuals used drugs and alcohol to mask problems, "shut

down” or “feel numb.” While there was no universal and all-encompassing explanation for drug and alcohol abuse among the reservations, treatment professionals agree, “When a person feels depressed, inadequate or anxious, it can lead to further isolation, loneliness and depression. It can be very difficult to break this cycle, but breaking this cycle is very necessary for recovery. We never give up hope.”

“When traditional Native values clash with the values of the dominant society, cultural conflict results. Native youth can easily be caught in a no-man's land of confusion and fuzzy self-image. Besides coping with the normal challenges of adolescence, Native youth must also deal with their identity as Indians. In this effort they face a microcosm of all the problems with which their culture struggles.” Chief Earl Old Person stated, “I once heard a Governor in Montana say we are for the majority. I told him, what about the minority? We are the minority.”

Not surprisingly, interviews exposed *greater incidents of self-destructive behavior on those reservations with recurrences of high unemployment rates and living in impoverishment.* We learned from professionals, isolation, fear, guilt, shame, depression, anger, irritability, and other symptoms were typically connected to the identification of post-traumatic stress. One professional from a Blackfeet Reservation Treatment Center noted that young adults are masking their trauma with the increased use of alcohol and prescription medication, up to and including completed suicide.

Chief Earl Old Person talked about Native peoples' *history of oppression (historical trauma)* and how present situations can increase the risk of trauma on Reservations. He cited the following personal example. As an elementary child in boarding school, he reflected back on an incident when he along with other Native children were told to line up in the school yard. He said they were told people from the federal government were going to scrape their eyes for DNA samples. Without questioning further, he along with the other children complied. He stated “no one ever saw the final report.” He attributed damage to his eye sight and the need to wear sunglasses to this incident.

Chief Earl Old Person recalls his childhood experiences as positive in spite of this incident adding, "My parents tried to give us other things that others had within the school. I used to tell my dad that it wasn't necessary. Kids used to have letterman sweaters with things that you've earned. They wanted to get me one. The important thing was that I learned something; I didn't have to display it. Those are some of the things, some changes. Today the kids have everything and they want something more. But on the other hand, there's some that don't have anything. So I think there's a lot of things that's causing our young people to come to the point they think there is no one that really wants to help." He added, *“choices concerning alcohol and substance abuse are tied in some way to self-esteem and at the root of this is the breakdown of the family unit.* Many youth today are living and coping with someone else's trauma in the home.”

A member of the Salish Community also recalled childhood incidences of trauma that had a profound impact on her. As a child, she remembers spending summers with her grandmother who would frequently bathe her in a small round wash tub. The purpose, “she was scrubbing the Indian off me.” She also recalled as a child not being able to go to town with her grandmother, unlike her sister, because her skin was too dark. She concluded with two school incidents. “My 4th Grade teacher told my friend not to trade shoes with me because Indians have germs. I also witnessed my brother's 1st grade teacher grabbing his long hair and saying, ‘That's what this long hair is good for.’”

Meeting the mental health and substance abuse needs of reservation communities is sometimes challenging for providers, the client, family members and friends. The following story illustrates some of the challenges.

While in the process of completing this report, interviewer Stevens encountered the problem of prescription drug abuse and its consequences through a firsthand experience.

A young woman called Stevens for help with her addiction to prescription drugs. She wanted to go to inpatient treatment. She was “sick” and could not make herself “feel better”. She mentioned being afraid of losing her child. She knew Stevens’ home was known to be drug and alcohol free, and it would be a safe place. Not knowing anything about this problem, Stevens did not know where to start. It was Friday, and a phone call was made to Tribal Health. No one was at work that day who could help. The next call was to the tribal jail for the on-call mental health person. The on-call worker was asked if it was possible to get into a place to detox. She was directed to the emergency rooms at the local hospitals. The worker was unsure of whether or not she would be covered under Tribal Health if she went to a local hospital. The intake person at the local hospital said, “they didn’t have a way to detox someone” and referred her to Missoula, a community several miles away.

While waiting in the Missoula hospital 30-45 minutes, the young woman “wanted to just forget about it because it was taking too long.” Interviewer Stevens asked to accompany the young woman, so she could get an understanding of the process. When meeting with the nurse, the young woman shared her problem and requested inpatient treatment. After being seen, the young woman returned to the waiting room, where she waited for two more hours, again wanting to leave. Finally, she was called and was brought into another room where she changed into hospital clothing. After another hour of time passed, the young woman finally met with a Mental Health Worker and revealed that she was “depressed,” had “stomach cramps”, and had thoughts of suicide but did not know how she would “do it”.

By the time her wait was over, the young woman was seen and was prescribed **five** medications that would help with withdrawal symptoms. Prior to leaving the hospital, a Mental Health Worker told her that she was doing exactly what she should be doing, and the next steps were to get in and see a counselor and be evaluated. He told her that she needed to put herself in a lockdown type of environment so that she would not be tempted to use while she detoxed. The worker then made a phone call to Turning Point, a local chemical dependency treatment provider, to get more information. The worker advised the young woman to go to Tribal Health to see how long it would take to get an assessment, as the option at Turning Point was to have an assessment the following Tuesday at 7am. Tribal Health might be a quicker turn around, although being the weekend, options were limited.

The young woman returned to Stevens’ home, and for the next two days, she had difficulty sleeping and was quite restless and experienced a lot of anxiety. The young woman repeatedly said she was “really tired” and that her body “never ached so bad”. Stevens helped care for her baby when the young woman seemed overwhelmed. The young woman made several phone calls to friends and told them what she was doing and the importance of “getting clean” for her child. Additionally, she made a trip to her own home once each day for the following three days to get some of her belongings, and that of her baby.

On Monday, day 4, the young woman contacted Tribal Health, only to find that it would be **several weeks** to get an assessment done. Stevens agreed to pay the \$25 assessment charge at Turning Point as the young woman could be seen the following day yet lacked the resources to pay the cost of the assessment. The young woman started feeling better and began recanting her desire for inpatient treatments, stating, “I will take my baby and run if they tell me I have to go to inpatient treatment. I can’t be away from my baby that long.” She began to rationalize why it was best for her to do intensive outpatient treatment, and second guessed what was going to happen.

On Tuesday, day 5, the young woman went to Turning Point and had her assessment done. She also went to her mother’s home and told her what was happening.

On Wednesday, day 6, the young woman went to a group meeting, and when she returned to Stevens’ home, she said she “wanted to sleep in her own bed” [indicating that she would leave for the night] and return the next day. Stevens asked her about what the counselor said. The young woman said that he asked her about what she wanted, and said something to the effect that he would rather have her smoking pot than using drugs. The comment started a big discussion and Stevens asked the young woman, “Are you using again?” The young woman replied, “I’m not going to lie, I’ve smoked pot every day when I would leave and go to my house.” She left and would return to Stevens’ home the following day.

On Thursday, day 7, the young woman called Stevens and said that she had forgotten her prescriptions and was having a hard time. She said she would go to Stevens’ house because she needed help with her child. Upon being confronted about possible relapse, the young woman denied the allegation.

On Day 10, Stevens’ contacted the young woman, who reported being clean and feeling good although “bored just sitting at home.”

On Day 11, the young woman’s counselor called Stevens’ and suggested ways for others to provide support.

During the course of these days, the young woman admitted to six years of “use”. She began snorting the pills as a way to get high. She admits that she started smoking the drugs within the last three months even though she thought she “would never do that”. The young woman reached out for help because she felt “worthless” and had been “without” for a couple of days and was in withdrawal. She added, “You’d be surprised about the number of people in your circle that use.”

This was Stevens’ first encounter with someone, addicted to prescription drugs, who was reaching out for help. *As a result of the event, it was evident that there was no clear path or ideal solution for those who live on reservations. You have to know how to navigate the system, to ask the right questions of the providers and the individual, to be able to answer questions to aid someone seeking help, to confront someone when necessary, and to get connected to resources.*

Status of the Public Health Problems on the Reservations: What we Learned

Alcohol and drug abuse in Native families and communities is a public health crisis on our reservations. The abuse of substances hurts all tribal members, not only the abuser but his/her family, friends and associates as well. The negative effects of alcohol and substance abuse are physical, mental, emotional, and spiritual. Alcoholism and substance abuse appears to be multi-generational.

According to the professionals interviewed, presently, it is affecting 3-4 generations and will affect many more generations to come if it is not opposed. Alcohol abuse is only the tip of the iceberg. Prescription medication misuse and abuse trails closely behind. All professionals agreed. Those who abuse only do so to submerge and mask the problems. Alcoholism often co-exists on reservations with certain other specific emotional and behavioral problems like depression, self-hate, cultural shame, stress-related acting out, including completed suicides.

From the interviews conducted, alcohol abuse is reported to be widespread on all seven reservations. Further, it is perceived that American Indians use and abuse alcohol and other drugs at younger ages, and at higher rates, than other ethnic groups.

Promoting change can be challenging. One prevention specialist at Lame Deer related, “Rather than anybody saying anything at all, they just won’t say it. The one’s that do say something, they say, ‘well they did this, and they did that and so who are they to talk about that?’ That’s an issue there in itself. *How do we get people to talk about the issues that are really important here?* What she was talking about even just saying it like that, “I’ve said that to some people before.” I’ve said, ‘Hey, this doesn’t exist in our culture’. That he, who has sinned, cast the first stone because you always draw upon your experiences to help others. That’s important. How do we get people to understand that? The large part is getting them to buy into that ethic to live by, because people are afraid. They’re so afraid and you see it in the numbers that we have in substance abuse. That is evident that the fear we have and who are the people here that are living a vibrant life? Which of our people are just trying to skim the lines and not get involved in things?”

People that really do have the knowledge and the technical abilities to really make changes and recognizing our resources and where can we get these people to really discuss issues. An example, they had this at Fort Robinson, these grandchildren of these people that survived under the slaughters of our people got up and they told this history and they just talked about it. Now one of these guys goes and does a run over there. He takes these kids over there and they do that to a couple of these sites. This is something our Elders always said, ‘Don’t go to places where suicides were committed. Don’t go there.’ They used to burn those areas. They literally burned up the house if there was a suicide there. If there was a murder, they’d burn it. That doesn’t happen today. It seems like a lot of these things have kind of fallen out of the memory. When we bring this up to people, they say, “Yes, I remember that.” The reasoning behind those kinds of things, getting people to understand why these things are happening, what it represents. That type of buy in, it’s difficult to get people to see that.”

Another professional stated, “*We need to bring attention to self-accountability. It starts at home. Here they have issues with school authority. There are high truancy problems. It’s clear that kids are falling off at sophomore year.*”

“Many people are dealing with the *issues of oppression vs. suppression* .and you wonder why people drink. *The essence of the problem goes back to historical trauma*. Putting a Band-Aid on an aching wound does not work. Unless we get over that specific thing, we can’t do all of these things. How well is that going to work? It has to do with dealing with people’s feelings and being honest and talking about the kinds of abuse that happened. This is really what happened and how do we move forward with it? Many of us this has happened to, until we come to recognize that it isn’t specifically about the victimization because the majority of us recognize that, but what are the steps in moving forward? We get either those persons who accuse others and point their fingers at others or simply shut their mouths and say nothing.” He continued, “Elders always said, “You never go to places where our people were slaughtered, murdered or committed suicide.”

A mental health professional from Northern Cheyenne stated, “Here there are two sets, we have modern mainstream values and law and order codes. We still have our own ancestral values. All that information is becoming lost. *We’re trying to live two separate ways*. So we’re always caught up in this other way, they’ll automatically revert to this other way, saying I have this right, I have that right. I would say they don’t know how to maintain or how to be accountable and at the same time be accountable to the community. I listen to what is being said and I’m the same way. This is a life experience and you realize that you want to move forward. I’m sure of what our ancestors would have wanted. With their history, and what they did, that’s what permeates throughout me. These stories that they talked about, they really invoked on the moral and principles associated with it. Like talking about where certain laws came from and where certain traditions come from. That information isn’t available. When you’re trying to help promote something within the youth or these young people that you’ll talk to, automatically someone will come along and say that person doesn’t know anything, they’re too young, they don’t know. I asked these people, what do you think will change for our people when they move back to their identity and that everything to do with preserving their identity and everything to do with what could be done with it, the healthy part of it. Working together and improving our community. One guy said, ‘I always think about that.’ Not until we lose everything and these people say, ‘Here, there saying I’m Cheyenne but they don’t know what it means and they’re gonna wanna learn. I’d say we’re at the bottom.’”

How do you bring a methodical understanding to the causes and consequences of risk taking behavior? One Northern Cheyenne professional stated, “A guy gets thrown in jail for domestic violence. He fights in there. Maybe he’s even sent to prison. He becomes more motivated and learns all these other skills while in there and he is going to be worse when he gets out. (Historically), versus going before the society and they say, hey if you do that again, we’re going come back here and we’re going to whip you. He’ll think about that. Let’s say he tests that. He does it again and they bring him back and they do whip him. That was how we stopped things from happening. People have criticized that way. I said if you can find me an example where we locked somebody in a tepee and it worked. *The biggest point is incorporating the cultural teachings that would promote them to do their best.*”

One of the more troubling indicators of the toll depression takes on American Indians is reflected in the reported completed suicides. The professionals we spoke to indicated *suicide on the reservations was one of the leading causes of death for American Indians especially those between the ages of 15 to 24 years old.*

On Rocky Boy's a community member stated, "*Prescription drugs are a big issue at Rocky Boy too. I had cancer a year ago and they put me on prescription drugs. Before I could even get to the clinic for my appointment I had three people approach me and ask me if they could buy the drugs the doctors were going to prescribe me. Once it gets out that you're sick, you're a target for drug dealers.*"

On Flathead Reservation a treatment professional reported, "Our facility is restricted to 30 clients, not anywhere near where it needs to be to touch the issue. There is no campaign to do awareness – they are funded at 40% of the need in behavioral health and chemical dependency is 1% of the IHS (Indian Health Services) budget."

On Fort Belknap we heard it *should be up to the tribal governments to recognize their responsibility for ensuring that the needs of their people with substance abuse and mental health frailties are being met.* This individual also proposed greater involvement from tribal health clinics, tribal educational institutions and any other tribal organizations which serve the whole tribe. This tribal member spoke directly to practical issues outlining barriers such as treatment professionals not keeping regular office hours for those clients seeking help, extraordinary staff turnover, lack of accessible rehabilitation services, inconsistent access to or lack of access to transportation and lastly poor cellphone coverage.

Tribal/State/Federal Association

Linked to stimulating the individual cultures and identities, there has been a *call for self-sufficiency in addressing the economic and social health of the reservations.* A housing authority representative stated, "We need to create more opportunity. We need to see that the Federal Government will not help us long term. We need to get away from looking to the Federal Government to support us. It's not good for the Indian people." At the Northern Cheyenne Reservation, it was also noted, that "Federal funding is not an issue. We need to be more resourceful independent of the government."

The Bureau of Indian Affairs (BIA) does not play any part in the workings of the tribal government. While on some reservations the Bureau maintains a significant presence, the BIA is not involved in tribal governmental decision making.

We learned that tribal members who live off of their home reservation maintain tribal membership and benefits. However, to access those benefits (i.e., health care) or to exercise their membership rights (i.e., voting in tribal elections) they may have to return to their home reservations. There may be benefits, such as higher education scholarships, that they are eligible for by returning to the reservations. Tribal services and benefits for off-reservation members vary from tribe to tribe.

Raising Future Generations

The *connection between economic well-being and family well-being* was a theme that emerged from the interviews. This connection is explained by a member of the Blackfeet tribe, "What we know is whether or not parents work outside of the home dramatically affects all these areas. When parents are employed in the workforce, it is less likely that parents will call the school and tell them their kid is sick. In the mornings, they'll say let's get going, I need to get to work. A parent working and feeling like they are a contributing member of society dramatically affects community's teens, school dropout rate, depression/suicide, substance abuse, and criminal

activity. It also reduces their likelihood to get in trouble by just hanging out. You know what they say about idle hands.”

One message heard consistently was the *importance of “family.”* Family is defined as biological parents, their children plus grandparents, aunts and uncles. Grandparents are often viewed as key decision-makers and play a central role in the “child-rearing” of especially young children. Other members of extended family may also assume childcare responsibilities and may discipline children. Aunts may be called “mother,” uncles may be called “father.” A child’s cousins may be viewed as his or her brothers and sisters. One tribal member emphasized the importance of finding strength within the family unit itself. “We have allowed ourselves to be totally dependent on tribal programs. Who is there to support the parents? In our society, it’s the uncles and the auntie’s.”

Family support systems play a significant role in guiding each family member and future generations. This appeared very important because the American Indian culture is centered on the family, and family relationships contribute to and shape individual choices. A staff from the Crystal Creek Lodge Treatment Center in Browning stated, “Being a grandmother, I raised my grandchildren, it’s the Indian way. My daughter passed away from this disease.” *Lack of family support may be a source of stress.*

Temporarily employed at the Fort Belknap Tribal Health Center, a former tribal health director/former councilman acknowledged, “One of the most positive factors here is family. Family is really big!”

When intervention is necessary, we learned it is important to protect, mentor to and request that all “family” members participate in the decision making for those relatives encountering or engaging in high risk behaviors. A Northern Cheyenne program director with mental health services said, “One of the things in high school that I was taught by my grandmother was that you take up for people who can’t take up for themselves. In high school I was really defensive of people who were picked on. I had a friend that was gay and he came up to me years later and said I always wanted to tell you thank you for treating me so good through high school. You always respected me. You didn’t tease me. I said, ‘That is how I was raised.’ There’s no difference in how people are and the way that they live. Maybe there are some of those kids that are out there that are like that but how many kids actually have that training or that understanding. I couldn’t tell you. Who’s teaching our kids that? I went through a whole process of rewriting the culture and I tell people that because I know what it’s like to be re-educated. I know what it’s like to do something that I didn’t have the right to do or assuming that I did, or making a mistake. That’s something that we talk about in Cheyenne. The overall Judah-Christian society that we’re acclimated to doesn’t do that. If you’ve done something wrong, you don’t speak about it. You don’t tell anybody else about it. I see that a lot when it comes to preserving our culture.”

With an emphasis on the *importance of mentoring*, a Northern Cheyenne program director added, “When I was a young man, I was in the Marine Corps. I wanted to fight. I had two guys that had taken me through ceremonies who were both combat veterans in Vietnam. When I’ve worked with youth in the past who’ve wanted to learn about Cheyenne history and culture, they always ask me, ‘Why are we doing that today?’ I always tell them, you have to tolerate that. Imagine going through life like that. You have to tolerate, tolerate, tolerate. I had a friend that is doing a student exchange, we’re always talking about issues or his experiences with his kids and

I was doing a little research myself with the Japanese culture. They've been successful in maintaining their culture and incorporating it into modern society. We are so unsuccessful at that. How do we get our families here to understand that this is what is really needed? If we use those principles and those values and incorporate them and make them so that they meet today so that we can be just as successful. *It's about identity. Today, what they are learning in the schools contradicts what they are learning at home.*"

On the Rocky Boy's Reservation a community member stated, "*Elders in the community are making a difference.* That's true. I'm evidence of one of those people. I've been sober now for 10 years in April. I had to change my whole life. I'm really worried about the kids on our reservation today. When I got sober I had to change the people I hung out with and my whole social life. I even had to bring my own beverages just in case all people had was alcohol at their house. Now it's people like me that are raising the grandkids and teaching them a better way. The most positive thing about Rocky is we are the most educated tribe. When I graduated in 80 there were only two of us that graduated from college with a BA. Now there are lots of kids that have a Masters and I know of a few that have or are working on their PhD's. That's my perception."

A tobacco prevention specialist in Lame Deer stated, "We have had three *Gathering of Native American's* (GONA's) in the two last years. Sitting in the groups with people, the bottom line is they want something different, they haven't used, and they don't have anybody supervising them, or walking with them as they're making those changes. It's like you get on a bike and you go down this road and you see this other path and you say, I can't do this because it's unfamiliar and you slide back into the same behavior and how many people are willing to be honest enough to say that you're sliding back into the same behavior. Know that I'm here and you can call me and I'll walk with you on this new trail even though I know that you're a little scared. It's about having a support system because isn't it a part of what we've been taught along the way and it goes so totally against who we are as tribal people that you need to be independent, pull yourself up by your bootstraps. Think about the harshness of that. That's pretty harsh. *In a tribal society, it's like, "here, let's do this" and you walk through that process.* My estimation is that it goes back to historical trauma because something in our knowing that this doesn't resonate with us."

Acknowledging the *significance of spiritual connectedness*, a professional stated, "I got involved in the church at about 16. *I was searching for something to help.* I didn't do any drugs. It's crazy because I lived on the reservation for a long time and then I moved to Billings to the really scary area. I was offered drugs but I was scared of disappointing my mom. She was a really great mom. She was a single parent and brought a step-father into the home where a lot of things happened and so she was not healthy in her mind. She was the best mom you could ask for but she had her issues. She was raised by two alcoholic parents and basically an orphan. She had her issues where she allowed a dangerous person to come into our home and didn't take into account how it was affecting us. We had the cops at our house every week. I have one younger brother. We grew up in the same home and he coped with it in every wrong way you could cope with anything. He is trying to fightit. I don't know. It's such a mystery to me because we lived in the same house. This step dad was his biological father. I have a sister that is 16 years younger than me. She's 14. She had to grow up in that environment a lot longer than I had too. My step dad is her biological father. She deals with a lot of anger and is sort of coming out of it right now. I see a lot of changes. Good changes. She is getting involved with the church. She

had a situation at school where this girl was taking advantage of her and putting her through so much. We told her to stay away from her but don't dislike her. Don't do any of that. Forgive her. You can love her and you don't need to talk bad about her. We talked to her about boundaries. She's doing better but she had like continual migraine headaches. They can't find a medical reason for it. A lot of it could be mental because she was exposed to that physical abuse of the parents which is so not healthy for her. I just hated the fact that she was growing up in that environment. I was so glad to have gotten out of there. I lived in that kind of environment and did not want that for my kids. I did everything I could to keep them out of what I had to go through. They know nothing of dysfunction whatsoever."

A common theme from those interviewed, "Ultimately individuals choose their life path." A tribal member stated, "But for sure, God played a role in it. This is the crazy part. We were the most dysfunctional family you could think of but we were in church all the time. My abusive step dad was like almost like a preacher. He also had mental health issues. I was offered drugs. I was suicidal when I was younger. I mean really suicidal. At 16, my mom let me move in with my auntie. I found this group called the Christian Club and there was an older woman there who was a mentor. She talked me through things. She was like a mom to all us kids. I had a great mom, with issues, but who doesn't? I got involved in that group when I was 16 and actually met my husband in that group. I still had tons of dysfunction in my life from being exposed to all that ugly stuff."

She continued, "At 19, I was already pregnant with my first daughter, not yet married, scared to go to church, you should be married before you have a child. That's what I was told all my life. Finally, I was waiting for my boyfriend to join with me but I waited a whole year. I knew I needed to make that decision for myself and my child, so I went by myself. So for the first two years I said why I am even coming to church because my mind is so messed up? But I stuck it out and kept at it, and now I'm totally different. When I was 16 and suicidal, I didn't talk to anyone about it."

The former councilman on Fort Belknap noted, "*What is positive is that kids are finding their culture again.* There are a lot of singing groups. Kids are starting to sing and dance again. They're starting to feel pride in themselves again. He has a grandson that is at the Denver March Pow Wow singing. That's what saved him. He doesn't drink or smoke in spite of his parents. His mom is a pill user and his dad is abusive. Grandpa and grandma were the same way. "I think that [culture] is going to be the Savior."

An example of a cultural institution that plays an important role in shaping youth is the *Cuts Wood School*, on the Blackfeet Reservation. This school immerses its students in their Blackfeet language both as a goal in itself and a means of transmitting cultural values. According to the Director, "the school has found content that is taught in Blackfeet becomes part of English knowledge as well. In addition to academics and language, values are also emphasized. The Cuts Wood School avoids competition, 'a form of violence,' as well as hierarchal concepts, ranking, and punitive designations."

Encouraging, Common Emerging Trends

Encouraging news, treatment professionals, formal and informal leaders on our Reservations acknowledge alcohol and substance abuse exists, understand the need to make sustainable changes, and report they are taking steps themselves to eliminate abuse. Native people and their

communities are becoming increasingly confident that their members can reject abuse, and, more importantly, can continue to reject it in the future. Those interviewed recognized *the only way to conquer alcohol and substance abuse is for the tribal people themselves to take the initiative to become involved and provide direction to their communities.*

We heard, in its struggle against abuse, *a tribal community's most valuable resource is its own people.* Allies in this cause include parents and families, school personnel, social service providers, and primary and mental health care providers. In addition, court, law enforcement and tribal government personnel can provide valuable assistance.

Tribal traditions and spiritual values are also being recognized as a vital resource. These *cultural traditions, including language and values articulate promise, renew hope and foster coping skills.* Those involved on the front lines understand they cannot create change alone. It is incumbent on all individuals in their community to take part in the effort against alcohol and substance abuse. As one professional stated, “They need to feel involved and must believe that they have planned and own the effort.” Another stated, “My ancestors are what motivate me. I took the time to learn from elders before they died and learned their way of life. Meth has gone down, so has prescription drugs/marijuana.” He specified, individual drug abuse/addiction is perceived to be self-induced by individuals who are basically just not taking care of themselves. There are low suicide rates because of our cultural beliefs. Elders speak up to the young people about strong cultural norm, but not necessarily social accountability. If they commit suicide, we tell them they are not going on to see their relatives in the next life.”

Community workers we interviewed, both formal and informal also *believe that youth will make better choices about their lives if youngsters know more about and take a more active part in their tribal culture, especially their language.* Youth achieve positive self-esteem that comes with belonging to something larger than them.

We learned *cross-generational communication will be an essential piece to implementing sustainable change in the fight of addressing substance abuse, mental health issues and suicide.* As Chief Old Person stated, “I think you need to communicate. I was talking to a youth in Washington, D.C.; there was a National Youth Conference. I sat next to him and he told me, “You know we are afraid to talk to the elders, afraid that they might not accept us.” I was telling him, “I think the elders are afraid to talk to you people too. They’re afraid you’re not going to listen. Why don’t you come together? Make an effort. Find out how you get comfortable. The elders have some wisdom. You folks, you have some things you can help the elders with. Maybe there is something you might want to tell them.”

Creating Change for the Future: Culture is Prevention

Each Indian reservation visited had a different culture. The extent of cultural involvement and practices also varied from tribe to tribe as it did with each individual. There is however, agreement that the *best means for fighting alcohol abuse in a Native community is one that the community cultivates itself.* This approach has the key advantage of belonging to those it aims to help. Change requires partnership and the passion of others in order to make the largest positive impact.

There was consensus, among those interviewed, that *Native adolescents who identify with their culture were far less likely to be involved in alcohol use than those who lack this sense of identity.* All professionals agreed it was important for youth to have clear and positive standards

for behaviors through family supervision and discipline; family and peer norms that discourage alcohol and drug use; academic achievement; meaningful opportunities to feel a part of the community; and most importantly strong relationships within the family and between parents/caregivers. *It is critical for the community environment to control access to alcohol and drugs by developing healthy norms and values and to recognize that policies and laws need to be consistently enforced by the criminal justice system.*

A site coordinator in Lame Deer talked about the *importance of partnering with existing prevention efforts in the community*. He said, “That’s what we try to do. We’re having a basketball camp in August and Tobacco Prevention can come in and do their talks. Try to maximize the unique opportunities that we have. Like the Town Hall meetings. We’re supposed to be setting up an underage drinking event for next month. Crows sing Cheyenne Sundance songs. Crows have taken Cheyenne ceremonies and do them there. We’ve watched them over the years take Cheyenne songs, Cheyenne protocols and do them at Crow. That’s the cultural norm in any society that’s been assimilated. We have that ethic where that’s still very strong. These elders used to speak about it. Elders were very adamant and spoke up to the young people about them making changes to things. In our society, one of the main cultural laws is that you can’t change anything and you can’t add anything. You have to do things the way they were meant to be done. If you don’t adhere to that, there’s a consequence. It’s a law that’s supposed to have a social response but it doesn’t anymore. The accountability that’s associated with the person’s health. Like for instance, people make an observation that a person two years ago was walking around, going about his business, trying to sell parts of the ceremony and today he’s in a wheelchair and in really bad health. That’s the things we have here. The thing with suicide is that when a person commits suicide they are not going to go on and see their people on the other side. For some people, that’s a major factor. I think that’s probably it. Substance abuse is being used instead of that choice.

Common Threads for the Future - A Comprehensive Community Approach

The interviews revealed that community support is necessary when effecting long-term sustainable change. Each community expressed knowing what change approach was needed to meet their needs. For some communities the approach involved sharing information and supporting one another in their prevention efforts. For other communities, interviewees talked about the value of a more formalized approach that involved considerable collaboration and commitment from the community in order to pursue and achieve a shared vision.

At the conclusion of the interviews, Natale’ and Patty considered the content of the interviews, discussed possible next steps and as a result, they have offered some opportunities and suggested strategies that could be used to inspire/promote healthy lifestyles. An overarching theme of their suggestions is the importance of bringing together the best of both culturally-based approaches and western evidence-based prevention methods to create and structure a system for addressing the multiple public health problems.

The opportunities and strategies align with the first four steps in the Strategic Prevention Framework Model (SPF) model, with particular emphasis on ensuring cultural competence. The following figure depicts all five steps: 1) Profile population needs, resources and readiness to address needs and gaps; 2) Mobilize and/or build capacity to address needs; 3) Develop a comprehensive strategic plan; 4) Implement evidence-based prevention programs and activities; and 5) Monitor, evaluate, sustain, and improve or replace those that fail.



Opportunities and strategies that align with the first four steps of the model:

- **Profile population needs, resources and readiness:** *Identify risk and protective factors that are present at all levels: community, family, and individual levels;*
- **Mobilize capacity to address needs:** *Interviews revealed that an individual's tribal pride is reinforced when a community promotes an alcohol and drug-free lifestyle that includes the sweat lodge, pow-wows, graduation ceremonies and other traditional practices.*
- **Mobilize capacity to address needs:** *Promote consistent and widespread messages about the negative consequences of substance abuse and the need for prevention;*
- **Mobilize capacity to address needs:** *Work on changing any community norms, values, policies and perceptions that support substance abuse;*
- **Mobilize capacity to address needs:** *Create broad-based support by involving a wide spectrum of individuals, groups, and organizations;*
- **Mobilize capacity to address needs:** *Encourage newly formed coalition team members to identify and work with individual prevention efforts, already existing in their community;*
- **Mobilize and build capacity to meet needs:** *Promote youth involvement in prevention efforts with the support of respected Elders. For example, the use of weekly peer support groups can build buy-in from the youth sector. Here students can share thoughts and feelings, in a protected environment that promotes tribal culture, and encourages development of healthy attitudes about life, including those that counter the pro-social norms around the use of substances. An essential component of this process is the involvement of Tribal Elders who could potentially facilitate and monitor these group activities, lending their expertise and guidance. Ultimately this cross-generational exchange has potential to open up the channels of communication between these two persuasive generations.*
- **Reservations develop a comprehensive strategic plan that meets their specific needs and context:** *Inform, educate, and empower people by developing a tribal sponsored plan that*

promotes positive health choices and supports emotional health, and counters alcohol or substance abuse in their communities.

- **Implement culturally-based, evidence-based programs/strategies:** *Identify and integrate new prevention strategies and partner with existing organizations and institutions.*
- **Implement culturally-based, evidence-based programs/strategies:** Promote the use of culturally-based activities that provide youth with opportunities to have fun without substances, sustain their cultural heritage, and build self-esteem with the support of positive adult role models.

Concluding Remarks

When reflecting on this extraordinary and valuable experience, Natale' and Patty, concluded that "There is a heightened sense of community awareness in the field that prevention is the key to changing environmental conditions surrounding: underage drinking, adult problem drinking, prescription drug abuse and mental illness."

For reservation communities, the key to prevention is to hold onto or re-embrace their culture. It was quite clear that each Tribe felt it was vital to pass on their customs and traditions. Using the words of one tribal member, "Teaching our people to know where they came from and getting back to honoring our culture, maintain our language, traditions and values is the most powerful tool we can use to combat the issues we face on our reservations."

Interviewer Stevens stated, "We always have hope. If we (Native Americans) give up hope, we die." A quote from a treatment professional on the Blackfoot Reservation sums up the strength and hope future, "*There are a lot of great people out there who are working in the trenches who have great hope for future generations, this in spite of overwhelming cultural circumstances, they go to work every day with great hope to make a difference. The most important thing to understand is the belief that each of us is responsible for our own wellness.*"

APPENDIX G: ACEs and the relationship to the SPE and the planning process

Vicki Turner

Several members of the SPE Consortium, who are concurrent members of the ICC, have recently engaged in discussions to learn and understand Adverse Childhood Experiences (ACEs), and how a broad range of early childhood traumatic stressors impacts a lifetime of consequences, and the importance of investing in primary prevention programs to reduce ACEs.

ACEs affect the developmental trajectory. They are defined as stressful or traumatic experiences, including abuse, neglect and a range of household dysfunction such as parental substance abuse, mental health problems, divorce, parental battery and incarceration. Child abuse and neglect in this context is inclusive of physical abuse, sexual abuse, emotional abuse, physical neglect and emotional neglect. Indicators of family dysfunction include mentally ill, depressed or suicidal person in the home, drug addicted or alcoholic family member, witnessing domestic violence against the mother, parental discord indicated by divorce, separation, and/or abandonment, and incarceration of any family member.

ACEs have a cumulative effect, and chronic exposure to multiple adversities that have lifelong consequences, may often start long after the exposure. Stressful and traumatic childhood experiences are a common pathway to emotional, social, and cognitive impairments that lead to increase risk of unhealthy behaviors, violence, disease, victimization, and premature mortality.

The theoretical basis for the ACEs research takes a lifespan approach, which is an important component of the Strategic Prevention Framework (SPF). Biological processes that occur when children are exposed to stressful events can disrupt early development of the central nervous system. These physiologic changes may impede a child's ability to cope with negative or disruptive emotions leading to emotional and cognitive impairment. Over time, and often during adolescence, the child adopts coping mechanisms, many of which are harmful such as alcohol and tobacco use. Eventually, this contributes to disease disability and social problems in work and premature mortality.

The original ACEs study was conducted in 1996 via a questionnaire mailed to 13,494 adults who had completed a standardized medical evaluation at a large HMO; 9,508 responded for a 71% response rate. A second survey was done in 1998, and individuals who responded were added to the first survey and all were followed over time to monitor mortality, morbidity, outpatient visits, ER visits and pharmacy use.

Research from the ACEs study has demonstrated a strong relationship between ACEs and initiation of drug and alcohol use in childhood and adolescence, and the impact persists into adulthood and continue to predict problem drinking behavior and illicit drug use. According to the study authors, responses to underage drinking will not be effective unless they help youth recognize and cope with stressors of abuse, domestic violence and other adverse experiences. Further the study indicates that ACEs have a powerful graded relationship to the risk of suicide attempts, both in adolescence and adulthood. Bridging to physical health, the cascade effects of ACEs increase the risk for obesity, diabetes, high blood pressure and heart disease.

The ACEs study and the results bring together a unifying context that brings together brain development science, the adverse childhood experience, positive adaptations in the individual, family, community domains coupled with societal resilience and capacity for transformative improvements, and the systems science to address how we see our current reality, and how this can point to higher leveraging solutions.

The relevance of ACEs in context of the SPE planning process, is dually beneficial in that members of the ICC align the programs and services that unify the framework, and can provide the leadership to assure efforts are clearly linked to strategic goals, the work reflects meaningful collaboration, and resources are leveraged and efforts have meaningful impact. ACEs is easily understood and provides common ground for results-based decisions in that intermediate and long-term outcomes are clear and results are useful and credible, stakeholders engage in dialogue that is data driven, and the focus is on reduction of a particular "at-risk behavior" and a positive trend in the rate of that behavior. When ACEs are reduced, the impact predicts a simultaneous reduction across generations in alcohol and heavy drinking,

cardiovascular disease, cancer, separation/divorce, life dissatisfaction, mental health conditions, hopelessness, mental health treatment, anxiety, and HIV risk.

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