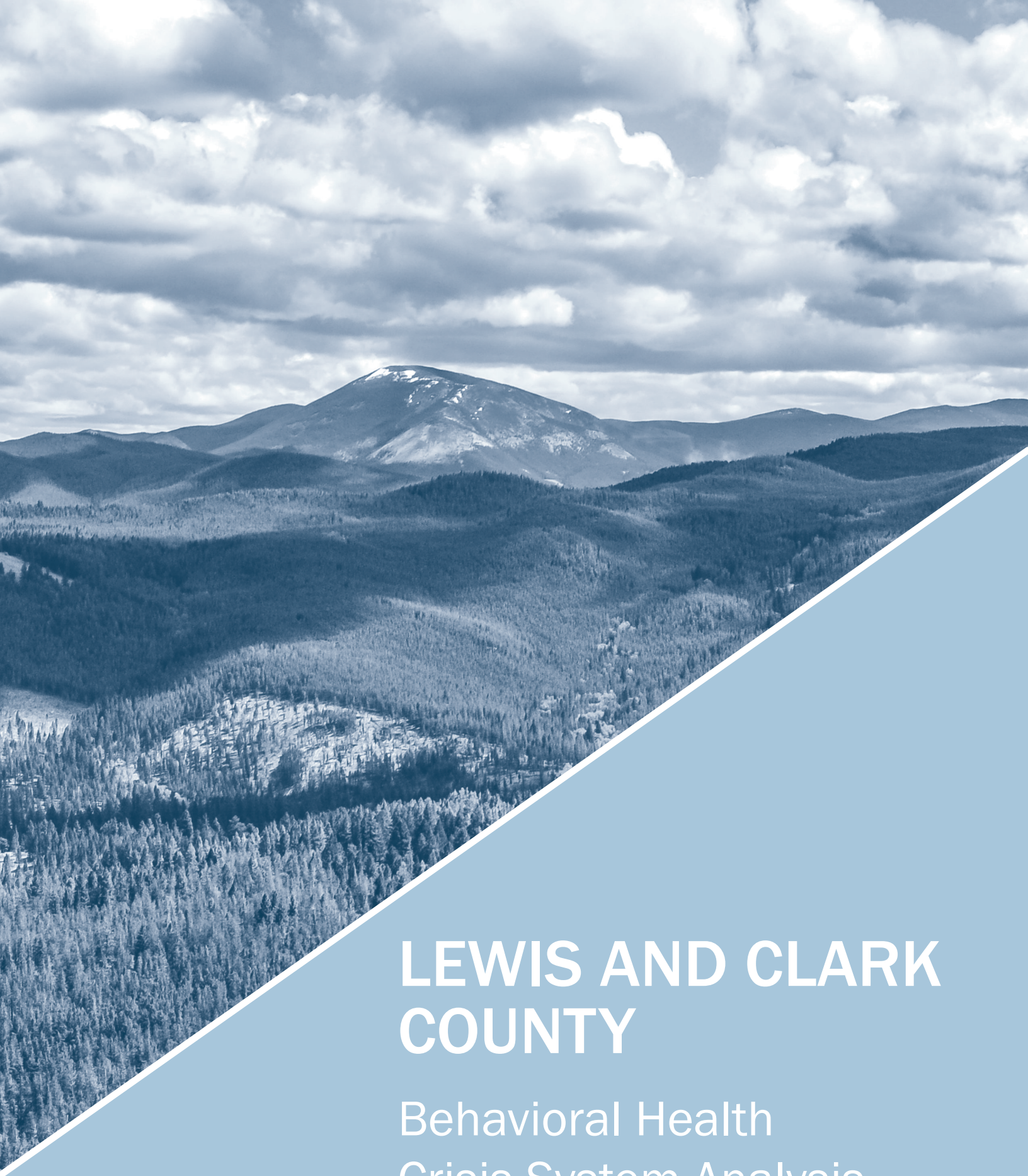

LEWIS AND CLARK COUNTY

Behavioral Health Crisis System Analysis

AUTHOR INFORMATION AND ACKNOWLEDGMENTS

This report was written by Kristal Jones, Kate Salemo, and Brandn Green (JG Research & Evaluation) for Lewis and Clark County.

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DEFINITIONS

Crisis Intervention Team (CIT): A program for law enforcement and other first responders that provides training on how to de-escalate situations involving mental health and substance use crises and then connect individuals in crisis to the proper services (CIT International)

Crisis Response Team (CRT): A mobile crisis intervention service solely made up of mental health professionals and/or paraprofessionals (peer support specialists, behavioral health aides); the service "helps individuals experiencing crisis get relief quickly and resolve the crisis situation when possible;" it also "provides appropriate care while avoiding unnecessary law enforcement involvement, emergency department use, and hospitalization" (Substance Abuse and Mental Health Services Administration)

Community Crisis Response (CCR): A mobile crisis co-responder program that embeds a mental health professional with law enforcement officials to work on scene with an individual in crisis; law enforcement provides a legal response while the mental health professional provides crisis de-escalation and connects a client with mental health resources

Behavioral health crisis: Any situation in which an individual is a danger to themselves or others and/or is unable to care for themselves or function effectively in the community (National Alliance on Mental Illness)

Behavioral health diagnosis: Any formal diagnosis that includes a substance use or overdose, mental illness, self-harm, or suicide-related diagnosis

Behavioral health visit: Any inpatient or outpatient visit to a clinical professional that involves a primary, secondary or tertiary diagnosis classified as a behavioral health diagnosis

Impression (for incidents): The way EMS, law enforcement and other non-clinical professionals characterize the cause of incidents to which they respond. This is not a diagnosis but is truly an impression based on their interaction with the individuals involved in the incident

Mental health crisis: Any situation in which an individual is a danger to themselves or others and/or is unable to care for themselves or function effectively in the community and where the primary cause of a crisis or emergency is a mental, behavioral, or neurodevelopmental condition

Mental illness: A mental, behavioral, or emotional disorder (National Institute of Mental Health)

Missed opportunity: A behavioral health crisis that could have benefited from an intervention but an intervention never took place during that crisis

Self-harm: A purposeful act to hurt one's physical body, which could be with or without the intent to die

Serious mental illness: A mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (National Institute of Mental Health)

Severe disabling mental illness: A person who is 18 or more years of age who has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder in the past 12 months or has recurrent suicidal ideation with the past 12 months, a history of suicide attempts, or a specific plan for completing suicide; and has a primary diagnosis of a set of mental health conditions (MT Medicaid)

Substance use crisis: Any situation in which an individual is a danger to themselves or others and/or is unable to care for themselves or function effectively in the community and where the primary cause of a crisis or emergency is the misuse of a substance

Suicide ideation or threat: A situation in which an individual thinks about, considers, or plans for suicide (Crosby et al. 2011)

Suicide attempt: A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior (Crosby et al. 2011)

INTRODUCTION

An ideal community-wide behavioral healthcare system would be able to respond to individuals in need of services in a timely, efficient, and appropriate manner. Within a community-wide behavioral healthcare system, crisis and emergency response services fill a key niche. In moments of crisis, response system actors meet people in a period where they have lost control and must be able to quickly assess, respond, and stabilize. Effective response to a behavioral health care crisis requires distinctive response mechanisms, with a clear delineation about roles and responsibilities across call centers, law enforcement, emergency medical services, crisis response teams, behavioral health care providers, hospitals, and judges.

This analysis is intended to support the Behavioral Health System Improvement Leadership Team in their efforts to enhance the crisis response system in Lewis and Clark County. The report was developed in collaboration with leadership from Lewis and Clark Public Health.

For the crisis redesign project in Lewis and Clark County, a behavioral health crisis is viewed as escalation of a client's behavioral health situation in interaction with a sequential set of responses from actors in the system. This study defines a behavioral health crisis as any situation in which an individual is a danger to themselves or others and/or is unable to care for themselves or function effectively in the community (National Alliance on Mental Illness). A behavioral health crisis is an adverse event that has been caused by substance use, an untreated or mismanaged mental health disorder, or a combination of the two. For this report, we focus on those crises that are caused either directly by substance use or related to a mental health diagnosis, or the co-occurrence of both.

Substance use crisis – The primary cause of a crisis or emergency is the misuse of a substance

Mental health crisis – The primary cause of a crisis or emergency is a mental, behavioral, or neurodevelopmental condition

Suicide ideation, suicide attempt, and self-harm – The primary cause of a crisis is thinking about, considering or planning for suicide, or undertaking non-fatal self-injurious behavior with or without the intent to die

GOALS OF THIS REPORT

Goal 1: Provide an inventory of organizations that engage with those who are experiencing a behavioral health crisis in Lewis and Clark County

Goal 2: Develop an understanding of the relative volume of demand put on the Lewis and Clark County crisis system by each of the three types of behavioral health crisis.

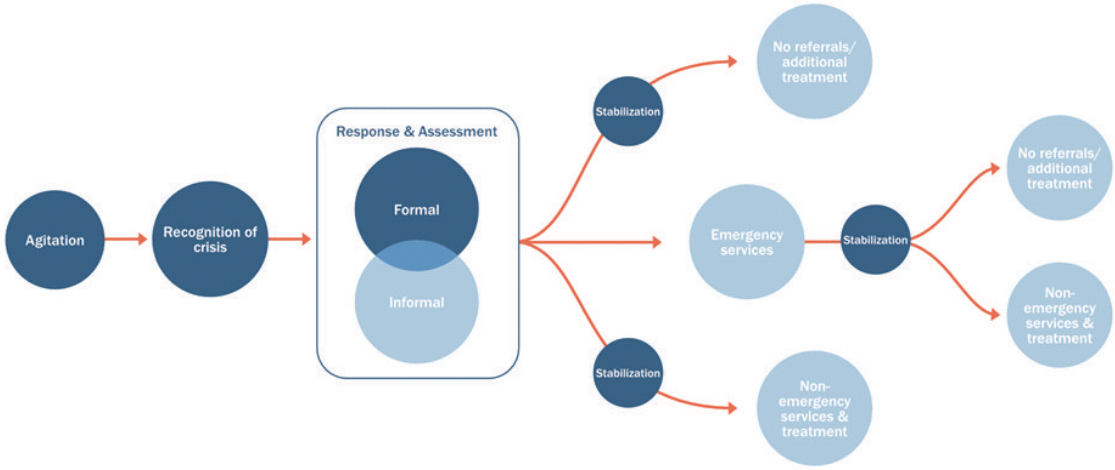
Goal 3: Depict the relative burden for responding that is placed on different organizations that provide behavioral health crisis services throughout a crisis process.

DEFINING THE CRISIS RESPONSE SYSTEM

Each of the individual goals of this report contribute to the primary goal of enhancing the crisis response system in Lewis and Clark County. The primary driver of this effort is to identify opportunities for adjusting current practices or developing new interventions or treatment options that can decrease the overall costs of providing crisis services while ensuring access to the appropriate level of care in a timely manner and improving client outcomes over time.

Although a crisis moment is by definition unpredictable, there is a general pathway along which an individual in crisis engages with the crisis response system, as outlined in Figure 1. An individual first is agitated and someone, either the individual themselves or a family member, friend, or bystander, recognizes that agitation has shifted into crisis. Following the recognition, there is an initial response and assessment, where either a formal assessment is conducted by a professional, or an informal assessment is completed by the individual themselves, or a family member, friend or bystander. This step is the first opportunity for an individual to engage with the crisis response system. Here, an individual may reach out to a professional for an assessment by calling 911, calling a crisis line such as Help Center 211, or reaching out a non-crisis medical or behavioral health provider. Professionals conducting an assessment for an individual in crisis include law enforcement, EMS, mobile crisis teams, a mental health professional, or a trained crisis line worker.

Figure 1: General pathways of a crisis



At each stage in the crisis pathway, the individual in crisis is interacting with others, including friends, family members, and bystanders who share the social space as well as officials acting in their capacity in the medical, public safety or legal systems. Once someone becomes agitated, they enter a pre-crisis moment where subsequent decisions made by both this individual and their immediate social group begin the process of engagement with the crisis response system. The moment when agitation escalates to crisis is the stage at which external actors become engaged.

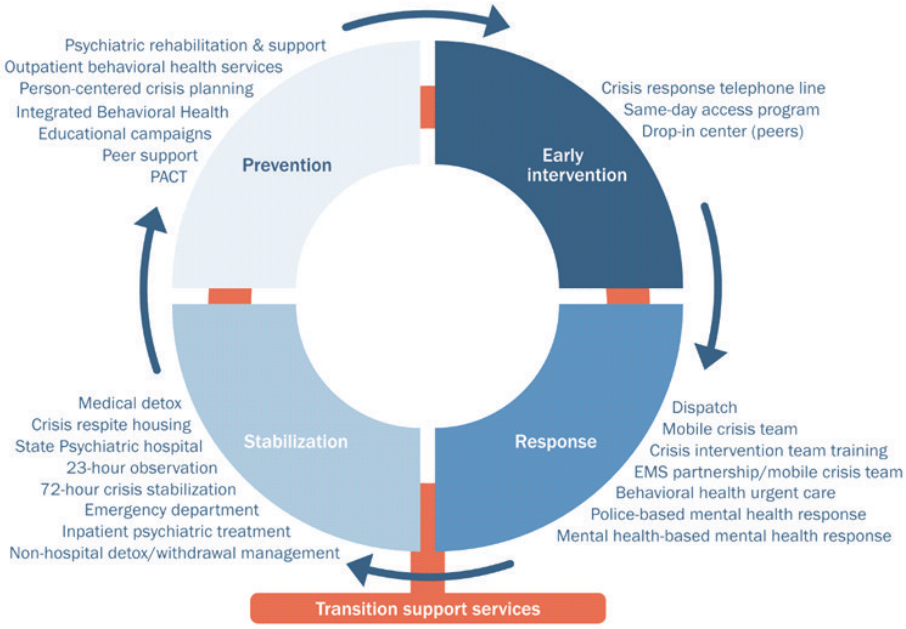
From the moment where external actors are engaged, there are three possible pathways:

1. The individual is stabilized by the initial responders without further treatment or referrals
2. The individual is stabilized by the initial responders and referred to continuing behavioral health care
3. The individual receives emergency crisis services and treatment in order to stabilize, then either is referred to continuing behavioral health treatment or receives no further treatment or referrals

At the end of one of these options, the immediate crisis is resolved, though an individual may experience multiple crises, and thereby reengaged with the crisis pathway. The crisis response system must assist in managing how individuals move through this pathway in order to 1) direct the individual to the most appropriate services, and 2) mitigate future crises. The analysis presented in this report is bounded and focused on the crisis response system and does not attempt to quantify the behavioral health care continuum for those who may need post-crisis treatment or access to ongoing services.

Figure 2 outlines the behavioral health crisis continuum, adding detail to the general pathway of a crisis and depicting how a crisis system can optimally function. The crisis continuum has four main stages: early intervention, response, stabilization, and prevention. Early intervention services function to intervene before a crisis becomes an emergency and assist in directing an individual to the appropriate crisis response. Response involves the services that provide direct care or assessment to an individual in crisis. Stabilization includes any service that assists the individual in de-escalating the crisis. Prevention services aim to support those who are at higher risk of experiencing a crisis and to link them with supports to minimize the likelihood of a crisis, including behavioral health treatment. Each of these four stages are linked by transition support services (such as warm hand-offs, peer support, and timely coordination across services), emphasizing the importance of ensuring that an individual who has entered a crisis moves from one stage to another seamlessly.

Figure 2: Behavioral health crisis continuum



Note: Adapted from Crisis Solutions North Carolina's Crisis Services Continuum.

There are a few basic goals of the crisis response system, which we have derived from the concepts in Figure 1 and Figure 2 as well as some components of SAMHSA's National Guidelines for Behavioral Health Crisis Care. These goals are important in developing a crisis system that functions effectively and efficiently:

1. Coordinate all crisis services by generating effective transition support services and establishing a "no wrong door" policy
2. Increase the number of formal or professional assessments conducted for an individual in crisis
3. Ensure that actors within the crisis response system can guide an individual to the appropriate service at any point along the crisis pathway
4. Create safeguards so that an individual never ends a crisis without referrals or additional treatment

The four main components of the behavioral health crisis continuum (early intervention, response, stabilization, and prevention) are used to organize this report, with a section for each component. The analysis focuses primarily on three types of crises: substance use, mental health, and suicide ideation or attempt and self-harm. Specific elements of the behavioral health crisis continuum are relevant for one or more types of behavioral health crisis, and all behavioral health crises require some type of engagement at each point on the continuum. By examining the relative burden of crises and response patterns by crisis type and continuum stage within the county, this report can further support the Behavioral Health System Improvement Leadership Team by identifying elements of the system that are in need of enhancement or revision.

CURRENT CRISIS RESOURCES

Table 1 is a list of the organizations that are providing behavioral health crisis services in Lewis and Clark County. This list was developed based on the SIM mapping exercise completed in summer 2020 by the Behavioral Health System Improvement Leadership Team. Data from a subset of these organizations is included in the analytical portion of this report (see Table 2 below).

Table 1. Inventory of organizations engaged with behavioral health crisis continuum of care in Lewis and Clark County

Organizations engaged in the behavioral health crisis continuum of care in Lewis and Clark County	
211 Crisis Call Lines	PureView Health Center
LCC 911 Dispatch	Center for Mental Health
LCC Pretrial Services	Instar Community Services
LCC Detention Center	Youth Dynamics
EMS (St. Peter's Health Ambulance Service)	Aware
Montana Board of Crime Control	Journey Home (WMMHC)
LCC County Attorney	Intermountain
St. Peter's Health Mobile Crisis Response Team	Helena Indian Alliance
St. Peter's Health ED, Inpatient and Outpatient claims	Florence Crittenton
Medicaid	YWCA
Shodair Children's Hospital	Boyd Andrew Community Services
Montana State Hospital	Our Place Drop-In Center
Montana Chemical Dependency Center	God's Love/Our Place Street Outreach
Treatment Court	MT Peer Network

METHODOLOGY

During the first phase of this project, the research team compiled a list of the community's behavioral health resources and organized them by stage of crisis and by crisis type: substance use and overdose, mental illness, and suicide ideation or attempt and self-harm (Goal 1). In the second phase of the project, the team identified and requested administrative and secondary data sets that could be analyzed to understand how crisis resources in Lewis and Clark County are being utilized and what types of behavioral health crises are the most common and most severe (Goal 2). In the third phase of the project, the team analyzed the data sets and developed an understanding about both the relative volume of different types of behavioral health crises and relative service utilization among organizations working somewhere along the behavioral health crisis services continuum (Goal 3).

Data were provided to the project team in two forms: either as aggregated totals created by the organization or as de-identified, incident- or claim-level records. For aggregated totals, we report the totals as provided to our project team. For incident- or claim-level data, our team reviewed each data set for data quality, addressed data errors, and produced descriptive statistics. All analysis was completed in RStudio. Table 2 describes the data source, time period, level of aggregation, and basic details about each of the datasets used in this analysis.

Table 2: Data sources to be used in analysis

Early intervention	Prevention
211 Crisis Call Lines	**PureView Health Center**
Response	**Helena Indian Alliance**
LCC 911 Dispatch	**St. Peter's Health Outpatient Services**
Montana Board of Crime Control	**Shodair Children's Hospital Outpatient Services**
EMS (St. Peter's Health Ambulance Service)	**Center for Mental Health**
St. Peter's Health Mobile Crisis Response Team	**Instar Community Services**
Instar Community Services	**Boyd Andrew Community Services**
Stabilization	**Florence Crittenton**
St. Peter's Health ED and Inpatient Services	**Good Samaritan drop-in center and street outreach**
Shodair Children's Hospital	**Youth Dynamics**
Montana State Hospital	Aware
Montana Chemical Dependency Center	Intermountain
LCC County Attorney	YWCA
LCC Criminal Justice Servics	Treatment Court
Journey Home (WMMHC)	

Notes: Data from organizations in bold are included in this report. Data was requested from all organizations but was not received for those not in bold.

During the first phase of this project, the research team drew on SIM mapping done in 2020 in Lewis and Clark County to compile a list of the community's behavioral health resources and organized them by stage of crisis and by crisis type: substance use and overdose, mental illness, and suicide ideation or attempt and self-harm (Goal 1). In the second phase of the project, the team identified and requested administrative and secondary data sets that could be analyzed to understand how crisis resources in Lewis and Clark County are being utilized and what types of behavioral health crises are the most common and most severe (Goal 2). In the third phase of the project, the team will be analyzing the data sets and developed an understanding about both the relative volume of different types of behavioral health crises and relative service utilization among organizations working somewhere along the behavioral health crisis services continuum (Goal 3).

Data are being provided to the project team in two forms: either as aggregated totals created by the organization or as de-identified, incident- or claim-level records. For aggregated totals, we report the totals as provided to our project team. For incident- or claim-level data, our team reviewed each data set for data quality, addressed data errors, and produced descriptive statistics. Using aggregated totals provides a general picture of the relative volume and demand on the Lewis and Clark County behavioral health crisis system and has certain limitations. Ideally, we would have had client, incident, or claim-level data for each data source to enable a more precise analysis. For example, with client-level data, we could understand characteristics of individuals receiving certain diagnoses, model and quantify repeat visits from the same individual, or model precisely how individuals flow through the crisis system.

LIMITATIONS

All assessments have limitations. This assessment was limited by a lack of deidentified, individual-level records for each organization that provides crisis services, as well as variation in the completeness of data collection and reporting efforts within organizations. Additional limitations include a lack of detail about the financing of crisis services, as well as the general challenge in trying to produce specific estimates about the population of need in Lewis and Clark County. While noting these limitations, the data provided by participating organizations as well as the feedback provided by the Behavioral Health System Improvement Leadership Team has been invaluable and offers distinctive and important insights for improving understanding about the crisis response system within Lewis and Clark County.

The majority of data used in this report is based upon diagnosed behavioral health conditions, organized by stage of the crisis continuum. Additional insight about performance or quality of care internal to each organization was beyond the scope of this project. Examples of questions about organizational performance include wait times in the emergency department for patients and time spent by law enforcement in the emergency department as patients receive an assessment. Subsequent iterations of this report may include performance information, but it is dependent upon the provision of these data. There may be value in building research plans within the Behavioral Health System Improvement Leadership Team or other Helena-based coalitions to answer these additional questions about performance and quality.

RESULTS

PREVALENCE ESTIMATES OF BEHAVIORAL HEALTH DIAGNOSES

Estimates of the prevalence of serious mental illness (SMI), serious disability mental illness (SDMI), serious emotional disturbance (SED), and substance use disorders (SUD) are limited at the county-level due to a general lack of comprehensive population-level surveillance data. The most commonly utilized data sources for these estimates are the Behavioral Risk Factor Surveillance Survey (BRFSS) and the National Survey on Drug Use and Health (NSDUH). BRFSS is a self-report, telephone-based survey and contains limited questions related to SMI or SUD. NSDUH is an interview-based survey that utilizes clinical criteria to establish the prevalence of SMI and/or SUD. In this report, we rely on the NSDUH estimates and downscaling for the state of Montana as the more precise surveillance survey for assessing current and potential load.

Recognizing the data collection caveats, we have included prevalence estimates in Lewis and Clark County with the state-level percentages from NSDUH, which provide the best available estimates of these conditions within a population. The total population age 12+ is 59,541 in Lewis and Clark County (US Census 2020). The general estimates in Table 3 provide a rough guide to characterizing diagnosable behavioral health conditions in the county and potential treatment needs. It is important to note that a behavioral health crisis can occur among those who would not meet the diagnostic criteria applied by SAMHSA to produce the NSDUH population estimates; therefore, these numbers are likely to be an underrepresentation of the true population of those who may need crisis services in the county.

Table 3: NSDUH Based Prevalence Estimates for Lewis and Clark County 2020 age 12+

Outcome	Montana prevalence estimates - % of population (2018-2019)	Estimated prevalence for Lewis and Clark County residents ages 12 and older – total number (2018-2019)
Past Month Binge Alcohol Use	29.42%	17,517
Any Mental Illness in Past Year	20.81%	12,390
Received Mental Health Services in Past Year	17.56%	10,455
Past Month Illicit Drug Use	16.77%	9,985
Needing But Not Receiving Treatment for Substance Use	9.59%	5,710
Alcohol Use Disorder in Past Year	7.92%	4,716
Serious Mental Illness* in Past Year	5.19%	3,090
Had Serious Thoughts of Suicide in Past Year	4.63%	2,757
Past Year Misuse of Pain Relievers	4.41%	2,626
Past Month Illicit Drug Use Other than Marijuana	3.79%	2,257
Illicit Drug Use Disorder in Past Year	3.4%	2,024
Needing But Not Receiving Treatment for Illicit Drug Use	2.89%	1,721
Past Year Methamphetamine Use	1.53%	911
Past year Heroin Use	0.39%	232

*Notes: Column 3 is calculated by multiplying the percentage by the number of individuals ages 12 and older in Lewis and Clark County. The population estimate for this age group is 59,541 in 2019. Note that column 2 is an estimate for all regions across Montana, and these regions are heterogeneous; the estimate presented in column 3 is not precise because of this heterogeneity. *Serious mental illness (SMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID), which is based on the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). SMI includes individuals with diagnoses resulting in serious functional impairment.*

The population estimates suggest a few things about the population of individuals who may be in need of crisis services. First, the most common substance use behavior that may contribute to a crisis in Montana is alcohol, and there is an estimated population of 17,517 individuals who were likely to have engaged in binge drinking within the past month. The majority of illicit substance use is marijuana, a substance with changing legal status in Montana, a change that may have impacts on both law enforcement and the crisis response system.

In addition to the prevalence estimates that can be generated by utilizing estimates from statewide surveillance surveys, we also use data on Medicaid clients to understand the prevalence of behavioral health needs in Lewis and Clark County. Utilizing Medicaid data provides a highly accurate look at recent trends in diagnoses, procedures and services provided, for a subset of the total population. A recent statewide analysis of Medicaid data found that 37% of Medicaid expansion clients had a behavioral health diagnosis. If we take this rate to be average for the whole Medicaid population, and estimate the Medicaid population in Lewis and Clark County, the data in Table 4 shows that the rate of behavioral health needs in the county is roughly the same as across the state within the Medicaid population.

Table 4. Medicaid clients with behavioral health diagnosis by diagnosis category, 2016-2020

Diagnosis category	2016		2017		2018		2019		2020	
	N	% of total	N	% of total	N	% of total	N	% of total	N	% of total
Total clients with any behavioral health diagnosis	4793	100%	5680	100%	6558	100%	6785	100%	6349	100%
Any Mental Illness	4463	93%	5220	92%	5922	90%	6064	89%	5729	90%
Serious Mental Illness	4005	84%	4711	83%	5403	82%	5587	82%	5307	84%
Substance Abuse & Overdose	1048	22%	1415	25%	1835	28%	2181	32%	1973	31%
Suicide & Self-harm	309	6%	424	7%	472	7%	516	8%	466	7%
Violence	115	2%	183	3%	194	3%	266	4%	248	4%

Notes: Serious mental illness is a subset of any mental illness. The data include any Lewis and Clark County resident that has a Medicaid claim with a behavioral health diagnosis in 2016-2020.

Table 4 shows almost all Medicaid clients with a behavioral health diagnosis have a mental illness diagnosis, and a substantial minority have a co-occurring substance use disorder. Substance abuse and overdose diagnoses increased by over 40% in the time period of 2016 to 2020 (from 22% of clients in 2016 to 31% of clients in 2020). This could be due to increased need among clients and it could also be due to increased capacity of state-approved treatment providers in Lewis and Clark County, meaning that more Medicaid clients had access to SUD services and thus to a diagnosis.

Table 5. Prevalence of specific substances in SUD diagnoses among Medicaid clients, 2020

Substance	Patients	% of SUD patients
Alcohol	891	45.16
Cannabis	715	36.24
Stimulants	711	36.04
Opioids	484	24.53
Other Substances	457	23.16
Sedatives	77	3.90
Cocaine	26	1.32
Hallucinogens	12	0.61

Notes: The data include any Lewis and Clark County resident that has a Medicaid claim with a substance use diagnosis in 2020. A patient can be included in more than one substance category.

[1]MCHF and Mannatt. (2021). *Medicaid in Montana: Issue spotlight*. https://mthcf.org/wp-content/uploads/2021/06/MHCF-Behavioral-Health-Report_6.30.21-FINAL.pdf.

[2]Lewis and Clark County is home to roughly 6.4% of the state population, and if we assume that the same proportion of total Medicaid clients (265,000 in 2020 according to the MHCF/Mannatt report) reside in Lewis and Clark County, then there were roughly 17,000 Medicaid clients in 2020, about 37% of which had a behavioral health diagnosis.

Table 5 shows the prevalence of specific substances among individuals with diagnoses of SUD and highlights the dominance of alcohol as the most common substance diagnosed (almost half, 45%, of Medicaid clients with an SUD diagnosis). Cannabis and stimulants are each present in just over one-third (36%) of all individuals with any SUD diagnosis. Individuals with any SUD diagnosis can have more than one substance included in their set of diagnoses, and the numbers in Table 5 also highlights the prevalence of polysubstance use.

Table 6. Age group distribution for Medicaid patients with a given behavioral health diagnosis (2020)

Age group	Substance use & overdose (%)	Any mental illness (%)	Serious mental illness (%)	Suicide & self-harm (%)
0-10	3.04	9.21	6.79	3.19
10-17	6.03	17.05	16.31	30.21
18-19	3.68	3.87	3.98	8.30
20-29	20.59	16.28	16.96	19.79
30-39	27.01	18.96	19.72	13.83
40-49	18.58	13.16	13.75	12.77
50-59	14.31	11.89	12.50	7.66
60+	6.76	9.58	9.99	4.26
Total	100%	100%	100%	100%

Notes: Serious mental illness is a subset of any mental illness. The data include any Lewis and Clark County resident that has a Medicaid claim with a behavioral health diagnosis in 2020.

Table 6 shows the age distribution of Medicaid clients with diagnoses in each behavioral health category. Of particular note is the high proportion of suicide and self-harm diagnoses that come from individuals in the 10-17 age range, which points to a clear need for ongoing support for adolescent behavioral health care specifically focused on preventing crises characterized by suicide or self-harm. Medicaid clients in Lewis and Clark County with SUD are concentrated in the 20-49 age range – two-thirds (66%) of clients with a SUD diagnosis fall into this age range. Any mental health and serious mental illness are more consistently distributed throughout the client population from age 10 and up.

EARLY INTERVENTION

The early intervention stage of the crisis services continuum serves as a way to mediate before a crisis becomes an emergency by de-escalating an individual in crisis. At the early intervention stage, there is a critical opportunity for directing an individual to the appropriate crisis response.

Crisis phone lines are one of the primary early intervention resources for an individual that is in crisis or nearing crisis. There are three regional crisis lines that serve Lewis and Clark County: 211 Great Falls, the Help Center (Bozeman), and Voices of Hope (Great Falls). In addition, the statewide suicide hotline, Lifeline, received calls from Lewis and Clark County residents and routes them to either the Help Center or Voice of Hope. Table 7 shows that about half of calls to hotlines from Lewis and Clark County residents are to the Help Center, and another one-third of calls are to the Lifeline. Only the Lifeline calls are consistently annotated as being about a crisis situation, so it is difficult to identify the proportion of total calls that pertain to an immediate crisis.

Table 7. Total annual calls to hotlines from Lewis and Clark County residents, 2018-2020

Hotline	Total calls			Crisis calls (% of total)		
	2018	2019	2020	2018	2019	2020
211 Great Falls	137	100	138			
Help Center (Bozeman)	706	892	936			
Voices of Hope (Great Falls)	331	221	79			
Lifeline (state suicide hotline)	476	597	625	42%	38%	40%

Notes: 211, Help Center and Voices of Hope calls are dialed directly to those hotline numbers, and Lifeline calls are to a state hotline and routed to either the Help Center or Voices of Hope. Only Lifeline calls have consistent reporting on whether the call is a crisis.

Of calls to the Lifeline, about 40% (or 250 calls in 2020) are categorized as an immediate crisis. The numbers in Table 7 suggest as a proportion of total calls, around 14% of calls to any hotline from Lewis and Clark County residents are related to an immediate suicide crisis.

Table 8. Primary presenting issue for calls to hotlines, 2018-2020 (combined)

Primary presenting issue	Calls	% of all calls with a presenting issue listed
Mental health	787	42%
Relationships	369	20%
Suicide	319	17%
Basic needs	207	11%
Substance	95	5%
Health	41	2%
Abuse	34	2%
Legal	24	1%
Sexual assault	10	1%

Notes: Data are from 2018 through 2020. One call can have many presenting issues. Each of the presenting issues listed here has subcategories, so each presenting issue can have multiple sub-issues. Not all calls have a presenting issue listed. Relationship issues include domestic violence, and further breaking down this category can help identify the crisis situations within the category.

Table 8 shows the most common primary presenting issue for any call from a Lewis and Clark County resident to any of the hotlines serving them, whether or not the call is categorized as a crisis. Primary presenting issues are mutually exclusive (only one can be listed per call). The figures in Table 8 suggest that almost two-thirds (64%) of hotline calls made by Lewis and Clark County residents over the past three years are directly related to a behavioral health situation – mental health, suicide or substance use. And additional 20% of calls relate to relationship issues, which includes domestic violence and often includes a behavioral health condition.

RESPONSE

The data used in this report to understand crisis response includes Lewis and Clark County dispatch calls, Montana Board of Crime Control offenses, EMS incidents (responded to by any EMS service), St. Peter's Health Mobile Crisis Response Team incidents, and individuals served by the Instar Community Services peer support crisis response program[3]. The data are summarized in Table 9, which includes analysis by gender. A few characteristics of the data in Table 9 are of interest. First, welfare checks, a category that could include suicidal persons and others in crisis, are the most common dispatch call within the set of call codes that could be considered related to behavioral health. This may suggest a role for mobile crisis response or mental health professionals embedded within law enforcement to address. The total of completed suicides is in comparison substantially smaller, and the age-adjusted suicide rate in Lewis and Clark County from 2009-2018 is 21.3 per 100,000, a rate that is lower than the state-wide rate of 27 per 100,000[4].

Table 9. Statistics about crisis response in the crisis services continuum

	Total #	% female	% male	% of all
Dispatch calls (2020)				
Welfare check	3531	--	--	--
Driving under the influence	459	--	--	--
Controlled substances	413	--	--	--
Assault	386	--	--	--
Crime offenses (2019)				% of all offenses
Simple assault	431	--	--	8.0%
Driving under the influence	315	--	--	5.9%
Drug/narcotic violations	255	--	--	4.8%
Drug equipment violations	232	--	--	4.3%
Aggravated assault	166	--	--	3.1%
EMS incidents (2020)				% with a SU/MH primary impression
Substance-related (excluding alcohol)	54	44%	56%	5%
Alcohol-related	167	22%	75%	16%
Suicide-related	232	46%	52%	23%
Anxiety	202	52%	46%	20%
Self-harm-related	42	64%	33%	4%
Mobile Crisis Response Team responses (November 2020-April 2021)	126	57%	43%	--
Instar Community Services individuals served (January 2019-June 2019)	211	--	--	--

Notes: EMS incident data include ICD-10-CM codes related to intentional self-harm, which "do not distinguish between events that were intended to be fatal (i.e., suicide attempt) and events in which the self-harm was intentional but there was no intent to die." Link to definitions. Gender totals may not equal 100% due to non-responses for gender from clients served by a given agency or individuals identifying as neither male nor female.

Males are much more likely to experience an EMS incident that is related to alcohol or substance use – they accounted for 75% of alcohol-related EMS incidents and 56% of substance-related incidents (excluding alcohol) of individuals who were engaged by EMS in 2020. Women are more likely than men to experience an EMS incident related to anxiety or self-harm. Crime offenses that are directly related to substance misuse accounted for 15% of all offenses that occurred in Lewis and Clark County in 2019.

[3]https://instarhelena.com/peer-support.html
[4]https://dphhs.mt.gov/Portals/85/suicideprevention/SuicideinMontana.pdf

911 Dispatch

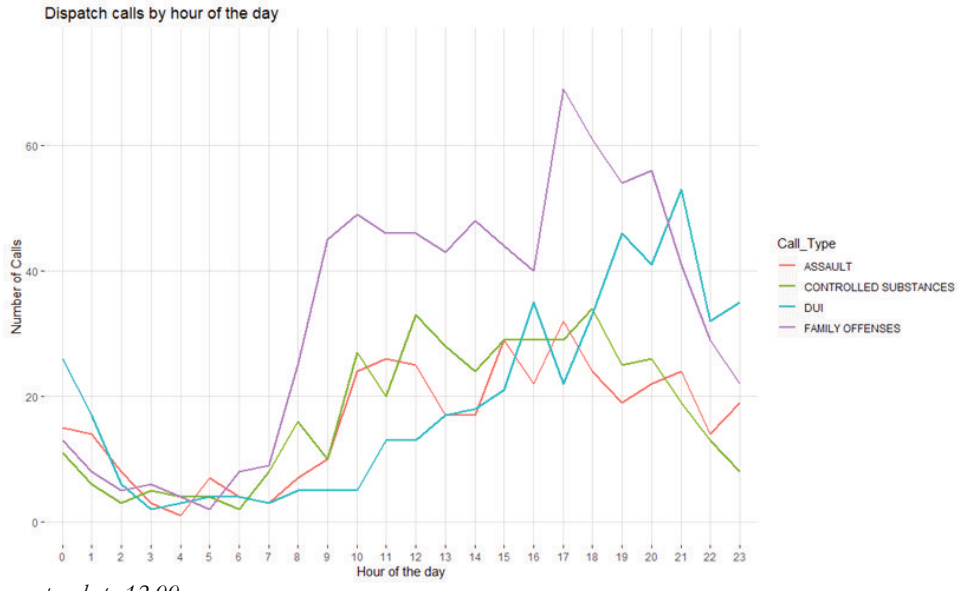
Data provided by the Lewis and Clark County 911 Center included all calls in categories that could potentially be related to a behavioral health crisis. Table 10 shows the prevalence of different call types 2018-2020, as well as the proportion of calls to which law enforcement was dispatched.

Table 10. Dispatch calls by call type, 2018-2020

Call type	2018		2019		2020		
	N	Daily avg	N	Daily avg	N	Daily avg	% with law enforcement dispatched
Suspicious circumstance/ person/vehicle	5034	13.8	4094	11.2	4632	12.7	95%
Welfare check	3437	9.4	3366	9.2	3531	9.6	93%
Disturbance	1058	2.9	1085	3.0	1268	3.5	96%
Disorderly conduct	1155	3.2	1045	2.9	1019	2.8	95%
Family offense	828	2.3	757	2.1	773	2.1	97%
Domestic disturbance	714	2.0	693	1.9	768	2.1	94%
Driving under the influence (attempt to locate)	666	1.8	555	1.5	459	1.3	95%
Controlled substances	485	1.3	436	1.2	413	1.1	97%
Assault	519	1.4	436	1.2	386	1.1	93%
Weapons offenses	201	0.6	199	0.5	211	0.6	92%
Stalking	27	0.07	29	0.08	30	0.08	93%

The burden of responding to calls to 911 and dispatch is on law enforcement. Across the top 11 call types in 2020, almost all (over 90% of the time) receive a response from local law enforcement. Table 10 highlights how often law enforcement is dispatched to situations that might prove to be behavioral health crises, which could potentially be handled by a crisis response team or other trained professionals. Data provided for this assessment do not provide information about the nature of the law enforcement response. However, data provided from the MCRT team (see below) show that about half of MCRT calls come directly from 911 dispatch (see Table 25).

Figure 3. Dispatch calls by hour across call type



Note: Hour 0 corresponds to 12:00 am

Figure 3 demonstrated the time of day of behavioral health crisis calls, with a clear pattern of increasing calls for DUI across a day, and a spike in family offenses in the evening. DUI calls begin to spike at 5 pm, and family offenses at 4 pm. Assault calls and controlled substance calls are most common throughout the working day and into the early evening. Time of day for demand on dispatch for these types of crisis situations is important to consider when developing staffing plans for mobile crisis response programs as well as co-responder efforts.

Crime Data

Crime data for this report comes from the State of Montana Board of Crime Control. The tables in this section provide a targeted overview of criminal activity as it relates to behavioral health conditions and behavioral health crises. Additional tables with complete breakdowns of all criminal activity in Lewis and Clark County can be found in the Appendix.

Table 11. Incidents with at least one substance related offense (DUI, drug/narcotic violation, drug equipment violation), 2016-2019 (combined)

Offense	Incidents	% of all incidents
No drug offense	14,556	85.21
Drug offense	2,526	14.79

Notes: The table includes incidents from 2016 through 2019. One incident can have more than one offense. Each incident is counted only once, even if it has more than one offense within it.

At the highest level, it is important to identify what proportion of criminal incidents to which law enforcement responds are related to behavioral health conditions. When law enforcement responds to potential criminal incidents in Lewis and Clark County, 15% of their responses are related to a substance use offense ('drug offense'), as demonstrated in Table 11.

Table 12. Incidents with arrests by offense type for alcohol-related, drug-related and assault offenses, 2016-2019 (combined)

Offense	Incidents with arrests	% of total incidents
Driving under the influence	1,101	89%
Simple assault	1,165	59%
Liquor law violations	552	56%
Drug/narcotic violations	547	54%
Aggravated assault	344	48%
Drug equipment violations	256	28%

Notes: The table includes incidents from 2016 through 2019. The last column is the percentage of incidents with a given offense that involve at least one arrest. One incident can involve multiple offenses and multiple arrests. An arrestee only has one offense code associated with an arrest within an incident

An incident does not always lead to an arrest. Table 12 provides details about the frequency with which a given incident leads to an arrest, with driving under the influence incidents almost always leading to an arrest as compared to other types of offenses. Simple assault, liquor law violations and drug/narcotic violations incidents also lead to arrests more than 50% of the time.

Table 13. Assault incidents by suspected of using alcohol or drugs, 2016-2019 (combined)

Offense	Total	% using alcohol or drugs	% using alcohol	% using drugs
Aggravated Assault	720	26.81	22.78	4.72
Simple Assault	1,972	28.75	24.95	4.31

Notes: An incident can contain both of these assault offenses and an offender can be suspected of using both alcohol and drugs/narcotics. The data are from 2016 through 2019. Aggravated assault is intentionally harming someone, whereas simple assault is when someone suffers a bodily injury due to the intentional or reckless conduct of another. The indicator for suspected of using drugs or alcohol is not always used, so this is likely an underestimate.

Substance use also contributes to criminal activity indirectly, as either a mood-altering factor that increases the likelihood of criminal behavior, or as a motivation for criminal behavior. Table 13 provides insights into the role that alcohol and/or drugs contributes to incidents with assault offenses in Lewis and Clark County, as identified by law enforcement who are on the scene. Over one-quarter of aggravated and simple assaults (27% and 29% respectively) in the county had indicators of alcohol and/or drug use.

Table 14. Ten most common offense types in 2019

Offense	N	% of all offenses
All Other Larceny	703	13.10
Destruction/Damage/Vandalism of Property	536	9.99
Simple Assault	431	8.03
All Other Offenses	427	7.95
Trespass of Real Property	400	7.45
Shoplifting	386	7.19
Driving Under the Influence	315	5.87
Theft From Motor Vehicle	299	5.57
Drug/Narcotic Violations	255	4.75
Drug Equipment Violations	232	4.32

Notes: Total offenses in 2019 were 5366. A single incident can have more than one offense listed.

Table 14 shows that these represented three of the top ten offense types in Lewis and Clark County in 2019, and simple assault is included in the top ten as well. Larceny, theft from a motor vehicle, and shoplifting may all be motivated, in part, by a desire to acquire money to be able to in turn purchase drugs or alcohol. It may be valuable to estimate the proportion of these offenses where alcohol or drugs were suspected, in order to more accurately characterize the role substance use disorders play in criminal activity in Lewis and Clark County and the associated burden placed on law enforcement directly or indirectly by substance use disorders.

Table 15. Drug/narcotic violations by drug type, 2016-2019 (combined)

Drug	Offenses	% of drug violations
Marijuana	486	49.09
Meth/ Amphetamines	279	28.18
Other Narcotics	54	5.45
Other Drugs	50	5.05
Heroin	46	4.65
Other Stimulants	43	4.34
Unknown	41	4.14
Hashish	17	1.72
Other Hallucinogens	10	1.01
Other Depressants	7	0.71
Cocaine	7	0.71
Opium	6	0.61
Morphine	5	0.51
LSD	3	0.30
Barbiturates	1	0.10
Crack Cocaine	1	0.10

Notes: One offense can have multiple drug types. Data are from 2016 - 2019.

Of the drug and narcotic violations, marijuana and methamphetamines are the most common offenses in Lewis and Clark County. The prevalence of methamphetamines in criminal violations is much higher than estimates of utilization within the population, as demonstrated in Table 3, which suggests that law enforcement prioritize identification of methamphetamine violations.

Table 16. Aggravated assault offenses by victim's relationship to the offender (10 most common), 2016-2019 (combined)

Relationship	Total victims	% male	% female
Victim Was Acquaintance	216	67%	32%
Relationship Unknown	161	63%	35%
Victim Was Boyfriend/Girlfriend	127	22%	78%
Victim Was Child	113	69%	39%
Victim was Otherwise Known	98	72%	28%
Victim Was Stranger	82	70%	30%
Victim Was Spouse	34	32%	68%
Victim Was Friend	30	60%	40%
Victim Was Child of Boyfriend/Girlfriend	28	61%	39%
Victim Was Sibling	24	54%	46%

Notes: Data include offenses from 2016-2019. Aggravated assault is intentionally harming someone. A victim can be included in more than one relationship category, particularly if there were two offenders in the incident. Some victims may be repeat victims, but the data do not have the information to identify repeat victims.

As noted in Table 13, alcohol and drugs contribute to approximately 27% of aggravated assaults in Lewis and Clark County. By analyzing these aggravated assaults by relationship to the offender, a very clear, gendered experience of aggravated assaults emerges, with female victims being much more likely when the offender is a person within whom they are in a relationship, either as a girlfriend or spouse. Male victims are much more likely when the offender is a friend, acquaintance, otherwise known or a stranger. An important note is the high prevalence of aggravated assault in which children are the victims. Adding together the offenders' own children and children of their romantic partners bumps children to the third-most common type of victim of aggravated assault. Further data gathering could clarify how many of these are minor children and help to identify the appropriate services that these children will need in addition to the offenders.

Crime data provides a useful perspective on the types of behavioral health issues, drivers and outcomes that law enforcement is engaging in among Lewis and Clark County offenders. Alcohol, marijuana and methamphetamine are the most commonly engaged substances, and substance use is a significant direct and indirect contributor to criminal offenses and arrests in Lewis and Clark County. Efforts by the treatment court and detention center to respond to these offenses and arrests with a treatment orientation have been longstanding in Lewis and Clark County and can be seen in the Stabilization section of this report. Additional data can provide further insight into the dynamics of these elements of the response system.

EMS incident data

EMS (ambulance) services are provided solely by St. Peter's Health in Lewis and Clark County (volunteer ambulance services are provided in Augusta and Lincoln as well, but no data exists for incidents that do not include a response from the St. Peter's Health ambulance service). EMS incidents provide the most complete picture of the demands being placed on the health care and crisis response system in the county.

Table 17. EMS incidents by incident type, 2018-2020 (combined)

Category	Incidents	% of all	Daily average
Non-SU/MH	20,830	84.48	19.01
SU/MH	3,828	15.52	3.49
SU/MH primary impression	3,081	12.49	2.81

Notes: SU/MH incidents include any incidents where the primary or secondary impressions have a substance or behavioral health diagnosis code. An incident can include up to 21 secondary impressions. The data are incidents from 2018 to 2020 where either the scene location or the destination location is in Lewis and Clark County.

Table 17 shows that of all incidents to which EMS responded from 2018 – 2020, 16% included a primary or secondary impression that received a substance use or mental health code, with most (13% of total) including a primary impression of substance use or mental health issue.

Table 18. SU/MH EMS incidents resulting in transport by destination location, 2018-2020 (combined)

Destination	N	%
Hospital-Emergency Department	2,718	90%
Other	160	5%
Hospital-Non-Emergency Department Bed	38	1%
Not Reported	23	1%
Nursing Home/Assisted Living Facility	43	1%
Mental Health Facility	9	0.15
Medical Office/Clinic	31	1%

Notes: Data include any EMS incident from 2018 through 2020 where the primary impression is substance use or mental health-related and the patient was transported by the EMS agency (N = 3,081).

Table 18 shows that within SU/MH EMS incidents, 90% resulted in transportation to an emergency department. Additional analysis can provide estimates about the proportion of these transports that could have been served at a different care location. In the category of Other, air transport was the most frequented location (69 or 43% of Other destinations).

Table 19. SU/MH EMS incidents by year, 2018-2020

Year	Incidents	Daily avg	Incidents per 1,000 people
2018	1,157	3.17	16.86
2019	1,392	3.81	20.05
2020	1,279	3.49	n.d.

Notes: SU/MH incidents include any incidents where the primary or secondary impressions have a substance or behavioral health diagnosis code. An incident can include up to 21 secondary impressions. The data are incidents from 2018 to 2020 where either the scene location or the destination location is in Lewis and Clark County. Incident rate per 1,000 people is calculated with county-by-year population data from SEER. Population data for 2020 are not available yet, so we do not include a rate for 2020.

SU/MH EMS incidents have remained fairly consistent over the past three years as demonstrated in Table 19, with the daily average number of incidents between 3 and 4 each year.

Table 20. EMS incidents with SU/MH primary impression

Dx code	Description	Incidents	% of SU/MH incidents
F41.9	Behavioral - Anxiety	596	19.34
F10.92	Substance- Alcohol use/intoxication	485	15.74
R45.85	Behavioral - Suicidal/Homicidal Ideation	387	12.56
F99	Behavioral - Mental illness, Not Otherwise Listed	307	9.96
T14.91	Behavioral - Suicide Attempt	255	8.28
R46.2	Behavioral - Strange Behavior	204	6.62
F32.9	Behavioral - Depression	187	6.07
R41.0	Behavioral - Disorientation	145	4.71
R45.851	Behavioral - Suicidal ideations	136	4.41
R45.89	Behavioral - Other emotional symptoms	67	2.17

Notes: The data include EMS incidents with a SU/MH primary impression from 2018 to 2020 where either the scene location or the destination location is in Lewis and Clark County. The total number of EMS incidents with a SU/MH impression is 3081.

The most common primary impression for individuals who have a primary SU/MH impression is anxiety (19% of total) followed by alcohol use/intoxication (16%) and suicidal or homicidal ideation (13%) as shown in Table 20. Other than alcohol use/intoxication, all of the top 10 SU/MH primary impressions are related to mental health conditions. Taken together, EMS incidents with the top nine mental health primary impressions account for 74% of EMS SU/MH incidents.

Table 21. EMS incidents with substance-related primary impression

Dx code	Diagnosis description	N	% of SU incident
F10.92	Alcohol use/intoxication	485	86.30
F10.23	Alcohol withdrawal	23	4.09
T40.601A	Opioid overdose (unintentional)	15	2.67
T50.901	Other drug overdose- unintentional	15	2.67
F15.92	Methamphetamine or other stimulant use/intoxication	8	1.42
F13.92	Sedative, hypnotic, anti-anxiety (depressant) use/intoxication	4	0.71
F19.92	Other psychoactive substance use/intoxication	3	0.53
F11.92	Opioid use/intoxication	3	0.53
F14.92	Cocaine use/intoxication	1	0.18
T40.1	Heroin overdose (unknown intent)	1	0.18
T65.2	Effect of tobacco and nicotine	1	0.18
F12.92	Cannabis use/intoxication	1	0.18
T43.601A	Methamphetamine or other stimulant overdose (unintentional)	1	0.18
F11.23	Opioid withdrawal	1	0.18

Notes: The data included are only EMS incidents where the primary impression is substance related.

Drug use is not a significant primary driver of EMS incidents. Table 21 provides a breakdown of all incidents with a substance-related primary impression, and alcohol accounts for 90% of all primary impressions. Overdoses from heroin, opioids, or other drugs accounted for 5.5% of all EMS primary impressions for a total of 31 incidents.

Table 22. SU/MH EMS incidents resulting in transportation to the emergency department by year

Year	Incidents	Daily avg
2018	864	2.37
2019	1,021	2.80
2020	961	2.63

Notes: SU/MH incidents include any incidents where the primary or secondary impressions have a substance or behavioral health diagnosis code. An incident can include up to 21 secondary impressions. The data are incidents from 2018 to 2020 where either the scene location or the destination location is in Lewis and Clark County.

As noted in Table 19, SU/MH EMS incidents remained fairly steady in Lewis and Clark County in the 2018 to 2020 period. This pattern that also holds for incidents that result in transportation to the emergency department, which Table 22 has remained fairly steady at a daily average of 2 to 3 incidents.

Table 23. EMS SU/MH individuals by the number of EMS incidents with an SU/MH code within the time period 2018-2020

Incidents in the time period	Individuals	% of patients
1	3,289	93.89
2-3	153	4.37
4-5	42	1.20
6+	19	0.54

Notes: Data include any patient with a SU/MH primary or secondary impression in an EMS incident between 2018 and 2020. The total number of patients with a patient ID and at least one SU/MH primary or secondary impression is 3,503.

Heavy utilizers of the emergency department for SU/MH conditions may be an important population to engage to limit overuse of the ED for conditions that could be better treated in other care settings. In Table 23, there is a very small number of individuals (19) who engaged with EMS more than 4 times over the study period, and approximately 6% of patients (214 individuals) had more than 2 incidents during the time period.

Table 24. Most common primary impressions for individuals with more than one EMS incident with a SU/MH primary impression: 2018 – 2020

Dx code	Impression	N	%
F10.92	Substance- Alcohol use/intoxication	97	24.56
F41.9	Behavioral - Anxiety	79	20.00
R45.85	Behavioral - Suicidal/Homicidal Ideation	40	10.13
T14.91	Behavioral - Suicide Attempt	31	7.85
F99	Behavioral - Mental illness, Not Otherwise Listed	31	7.85
R46.2	Behavioral - Strange Behavior	26	6.58
R45.851	Behavioral - Suicidal ideations	18	4.56
F32.9	Behavioral - Depression	16	4.05
R41.0	Behavioral - Disorientation	14	3.54
R45.5	Behavioral - Hostile	9	2.28

Notes: The data include any incident where the patient has had more than one EMS incident with a SUMH primary impression from 2018 to 2020. A patient with multiple incidents does not necessarily have the same primary impression for each incident.

The most common impressions among the group of individuals with more than one incident with a substance use or mental health impression ('heavy utilizers') are consistent with the most common impressions for all individuals with an SU/MH primary impression (Table 20), although the top impressions differ as shown in Table 24. Alcohol use/intoxication accounts for 25% of impressions among repeat patients of EMS in Lewis and Clark County from 2018-2020, anxiety accounts for 20% of impressions among repeat clients, and suicidal/homicidal ideations and suicide attempts collectively accounts for 22% of repeat clients.

Mobile Crisis Response Team Data

The mobile crisis response team (MCRT) is housed at St. Peter's Health and has been operational since November 2020. The MCRT is grant funded and is offered in partnership with Lewis and Clark County. The MCRT responds to both Helena Police Department and Lewis and Clark County Sheriff's dispatch calls. Data included in this assessment has been collected between November 1, 2020 and April 30, 2021.

Table 25. Mobile crisis response team referral source

Referral source	Number of calls	% of total calls
911 Dispatch	65	52%
Law enforcement	48	38%
Mental health professionals	5	4%
Patient call	2	2%
Hospital	1	1%

Note: The MCRT responded to a total 126 calls in the time period, with 121 of those having information about the referral source.

Table 25 shows that it is primarily 911 dispatch and law enforcement calling on the MCRT to provide services. Having the MCRT as an alternative to law enforcement and allowing dispatch to make the decision about sending the MCRT to a given call can potentially create time and cost efficiencies in addition to improving outcomes. In just over half of MCRT calls (52%), the team was called directly by 911 dispatch. However, as shown in Table 27 below, 75% of all MCRT calls still had law enforcement present, so the MCRT is an additional and even primary responder but in the majority of cases is not the sole responder.

Table 26. Mobile crisis response team location of service

Location of service	Number of calls	% of total calls
Private residence	63	50%
Detention Center	26	21%
Public location/Community	20	16%
Emergency department	5	4%
Crisis stabilization facility	2	2%
Emergency department parking lot	2	2%
Medical care facility	2	2%

Note: The MCRT responded to a total 126 calls in the time period, with 120 of those having information about the location of service. It is unclear what is meant by 'crisis stabilization facility' as there is no official facility currently active in Lewis and Clark County.

Table 26 shows that MCRT services are generally focused on community settings, either private residences or public spaces. Sending the MCRT to community settings, before an individual has been engaged by the medical or criminal systems, has the potential to increase diversion from the emergency department or the detention center.

Table 27. Characteristics of mobile crisis response team incidents

Incident characteristic	Number of calls	% of total calls
Law enforcement present	94	75%
Arrest made	2	2%
Resolution in community	72	71%
Used emergency department	25	20%
Average time spent at bedside	61 minutes	

Note: The denominator for proportion of calls that were resolved in the community does not include calls for individuals who were already in jail at the time of service.

Table 27 shows the impact of the MCRT in terms of avoided engagement with the criminal justice or medical systems when not necessary. Of calls made for individuals not currently in jail, 71% were resolved in the community. Only 20% of total calls results in use of the emergency department, and only 2% of calls led to an arrest. Although law enforcement was still present at 75% of calls responded to the MCRT, the time spent 'at bedside' (on average one hour) was undertaken by the MCRT, not law enforcement, freeing their time to be focused elsewhere.

Instar Community Services data

Instar Community Services uses certified peer support specialists for their crisis response program, although they cannot bill for these services to Medicaid.

Table 28: Total individuals served by Instar Community Services peer support crisis response program, 2018-2020

Time period	Individuals served
January 2018-June 2019	311
June 2019-December 2020	101

Response Conclusion

Dispatch, crime and EMS data all demonstrate, very clearly, that alcohol use is the main substance of concern in behavioral health crises in Lewis and Clark County. DUI totals suggest that this issue is not going unaddressed by law enforcement in the county, and that overall dispatch calls for DUIs have decreased over the past three years, with decreases from 2019 to 2020 possibly attributable in part to Covid-19 restrictions as well. However, there are other demands placed on law enforcement and the EMS response system by individuals with potential substance use disorders. 15% of EMS incidents include impressions of behavioral health needs. Alcohol is suspected in over 20% of assault incidents in the county. Alcohol is the primary impression in 90% of SU responses for EMS in Lewis and Clark County, and is the top primary impression for individuals with more than one EMS incident between 2018-2020. The widespread use of alcohol by the population may be the main factor for these totals.

Mental illness impacts on the crisis system are concentrated in a few, interrelated, conditions – anxiety, depression, and suicidal behavior. Suicide completion rates in Lewis and Clark County, which are below the state rate, suggest that individuals with these conditions are being stabilized and are accessing services in a manner that may be having a preventative impact for suicide. Suicide ideation can potentially be addressed by a mobile crisis response team, a response intervention that could decrease the burden on law enforcement, who are reported to be involved in over 90% of calls to 911.

STABILIZATION

The stabilization stage of the continuum includes any service that assists an individual in de-escalation and stabilization of the crisis. Table 29 displays stabilization resources that serve Lewis and Clark County residents and the demand currently places on those resources by Lewis and Clark County residents.

Table 29. Statistics about crisis stabilization in the crisis continuum

	Total #	% female	% male	% of all patients/ clients served
St. Peter's Health emergency department patients (2020)				
Mental health diagnosis	2420	--	--	9%
Substance use disorder diagnosis	4315	--	--	16%
St. Peter's Health inpatient patients with (2020)				
Mental health diagnosis	1316	--	--	27%
Substance use disorder diagnosis	2032	--	--	42%
St. Peter's Health behavioral health unit (BHU) emergency department crisis bed patients (2020)	146	--	--	100%
St. Peter's Health behavioral health unit (BHU) inpatient patients (2020)	302	--	--	100%
Montana State Hospital (2020)				
Stabilization Unit (A&B)	34	--	--	
Continuing recovery unit (D)	2	--	--	
Forensic mental health facility unit (F)	6	--	--	
Mental health group homes	3	--	--	
Shodair Children's Hospital inpatient services (2020)	135	60%	40%	
Acute crisis care	131	60%	40%	
Residential treatment	4	50%	50%	
Group homes	0	--	--	
Lewis and Clark County Detention Center (February 2021)				% of all individuals booked
Self-identified with diagnosed mental illness	48	--	--	36%
Self-identified as current or past suicidality	15	--	--	11%
Lewis and Clark County Attorney's Office (2020)			--	% of filings
Involuntary commitments	32	--		55%
Journey Home (July 2018-September 2019)				
Voluntary admissions	378	--	--	--
Involuntary admissions	34	--	--	--

Notes: Data for St. Peter's Health are for residents of any county. Montana State Hospital and Shodair Children's Hospital are number of Lewis and Clark County residents served. Journey Home, a crisis facility run by Western Montana Mental Health Center, closed in fall 2019.

St. Peter's Health Emergency Department Visits

St. Peter's Hospital has an emergency department that receives any individual in need of emergency care, and within the emergency department, the behavioral health unit (BHU) maintains 18 beds designated for individuals in behavioral health crisis. Table 30 shows the demand placed on the emergency department and the BHU ED crisis beds annually.

Table 30. St. Peter's behavioral health crisis emergency department visits by year

Emergency department (ED) and behavioral health unit (BHU) services	2018		2019		2020	
	N	% of total	N	% of total	N	% of total
Total ED patients with a substance use disorder diagnosis	1901	8%	4663	15%	4315	16%
Total ED visits with a substance use disorder diagnosis	2538	6%	7673	14%	6969	15%
Average weekly ED visits with a substance use disorder diagnosis	48.8		147.6		134.0	
Total ED patients with a mental health diagnosis	2099	9%	2501	8%	2420	9%
Total ED visits with a mental health diagnosis	3197	7%	4025	7%	3780	8%
Average weekly ED visits with mental health diagnosis	61.5		77.4		72.7	
Total BHU ED crisis bed patients with behavioral health diagnosis	130	100%	153	100%	146	100%
Total BHU ED crisis bed visits with behavioral health diagnosis	160	100%	180	100%	180	100%
Average weekly BHU ED crisis bed visits	3.07		3.45		3.44	

Note: Data is for 2018-2020. Data for the general ED is for mental health diagnoses only. Data for BHU visits is for use of the crisis beds. All data is for residents of all counties who visit St. Peter's Health, not only residents of Lewis and Clark County.

Table 30 shows that emergency department visits for substance use disorder doubled from 2018 to 2019 and have remained stable in 2020. This could be due to a change in medical coding practices. Mental health diagnoses in the ED have remained stable over the past three years, as have total visits to the BHU crisis beds. In addition, each year the proportion of total unique individual patients and proportion of total visits attributed to individuals with substance use disorders and mental health needs are the same respectively. This suggests that there are not substantially more repeat individuals ('heavy utilizers') with mental health needs as compared all visit types.

The St. Peter's Health BHU ED crisis beds specifically focus on stabilizing individuals experiencing a crisis associated with SMI or other serious mental health needs. These beds are for mental health and co-occurring crises, and individuals with substance use disorder without a mental health need cannot use them. St. Peter's Health serves as a regional hub for behavioral health crisis stabilization, and as Table 31 shows, BHU ED crisis beds serve those with SMI and suicidal ideation.

Table 31. Top ten diagnoses for St. Peter's BHU ED crisis bed visits

Dx code	Diagnosis	Visits	% of visits
F39	Unspecified mood [affective] disorder	267	51.35
R45.851	Suicidal ideations	135	25.96
F29	Unspecified psychosis not due to a substance or known physiological condition	122	23.46
F32.9	Major depressive disorder, single episode, unspecified	87	16.73
F41.9	Anxiety disorder, unspecified	83	15.96
F22	Delusional disorders	79	15.19
F31.9	Bipolar disorder, unspecified	58	11.15
F43.10	Post-traumatic stress disorder, unspecified	43	8.27
F15.10	Other stimulant abuse, uncomplicated	42	8.08
F23	Brief psychotic disorder	33	6.35

Notes: The data include emergency department visits with a behavioral health-related diagnosis from 2018 to 2020.

Table 31 shows the ten most common diagnoses listed as primary, secondary or tertiary for clients served. The results in both tables are similar, with just over half of clients having a diagnosis of unspecified mood disorder. One-quarter of clients (26%) are diagnosed with suicidal ideations.

Table 32. St. Peter's Health patients by the number of BHU ED crisis bed visits between 2018 and 2020

Visits	Patients	% of patients
1	324	82.03
2	41	10.38
3+	30	7.59

Notes: The data include emergency department visits with a behavioral health-related diagnosis from 2018 to 2020.

As with EMS response, heavy utilizers are a concern for emergency departments and especially for specialized services like the BHU ED crisis beds. Table 32 shows that 18% of patients utilizing the St. Peter's Health BHU ED crisis beds had more than one visit in the 2018-2020 time period. True heavy utilizers, those who had three or more visits, make up almost 8% of all patients served by the behavioral health ED.

Table 33. St. Peter's BHU ED crisis bed visits total visit charges

Charges	Visits	% of visits
$0-$999	123	23.65
$1,000-$1,999	194	37.31
$2,000-$2,999	31	5.96
$3,000-$3,999	26	5.00
$4,000-$4,999	10	1.92
$5,000+	113	21.73
Missing	23	4.42

Notes: The data include emergency department visits with a behavioral health-related diagnosis from 2018 to 2020.

Table 33 shows that the majority of visits (61%) to the St. Peter's Health BHU ED crisis beds cost less than $2,000. However, 22% cost over $5,000.

Table 34. St. Peter's BHU ED crisis bed visits by insurance type

Primary insurance	Visits	% of visits
Medicaid	280	53.85
Other	143	27.50
Medicare	97	18.65

Notes: The data include emergency department visits with a behavioral health-related diagnosis from 2018 to 2020. The 'Other' category is primarily private insurance, as well as VA and Indian Health Service coverage.

Table 34 shows that the majority of patients served in the behavioral health ED are covered by Medicaid, and a substantial minority are covered by Medicare (this is likely because St. Peter's has a focus on geriatric behavioral health crises in addition to providing general adult behavioral health crisis care). Very few individuals (1% of visits) are uninsured.

St. Peter's Health Inpatient Behavioral Health Services

Individuals in Lewis and Clark County are also provided inpatient hospital care at St. Peter's Health, which can include general admissions with mental health diagnoses as well as admissions to the BHU inpatient beds for SMI and related behavioral health needs.

Table 35. St. Peter's behavioral health inpatient admissions by year, 2018-2020

Inpatient behavioral health services	2018		2019		2020	
	N	% of total	N	% of total	N	% of total
Total inpatient patients with a substance use disorder diagnosis	1920	38%	2158	40%	2032	42%
Total inpatient visits with a substance use disorder diagnosis	2577	38%	2922	41%	2752	44%
Average weekly inpatient admissions with a substance use disorder diagnosis	49.6		56.2		52.9	
Total inpatient patients with a mental health diagnosis	1198	24%	1382	26%	1316	27%
Total inpatient admissions with a mental health diagnosis	1628	24%	1911	27%	1774	28%
Average weekly inpatient admissions with mental health diagnosis	31.3		36.8		34.2	
Total BHU inpatient patients	228	100%	323	100%	302	100%
Total BHU inpatient admissions	282	100%	391	100%	410	100%
Average weekly BHU inpatient admissions	5.4		6.1		7.9	

Note: Data is for 2018-2020. Data for the general ED is for mental health diagnoses only. Data for BHU visits is for use of the crisis beds. All data is for residents of all counties who visit St. Peter's Health, not only residents of Lewis and Clark County

Table 35 shows that there has been a slight increase in need for inpatient care for individuals with substance use disorder diagnoses and mental health diagnoses, and specifically for individuals utilizing the BHU inpatient beds. It is notable that in 2020, despite Covid-19 precautions, the average number of weekly BHU admissions increased by almost 30% compared to 2019.

Figure 4. St. Peter's BHU inpatient admissions by month, 2018-2020

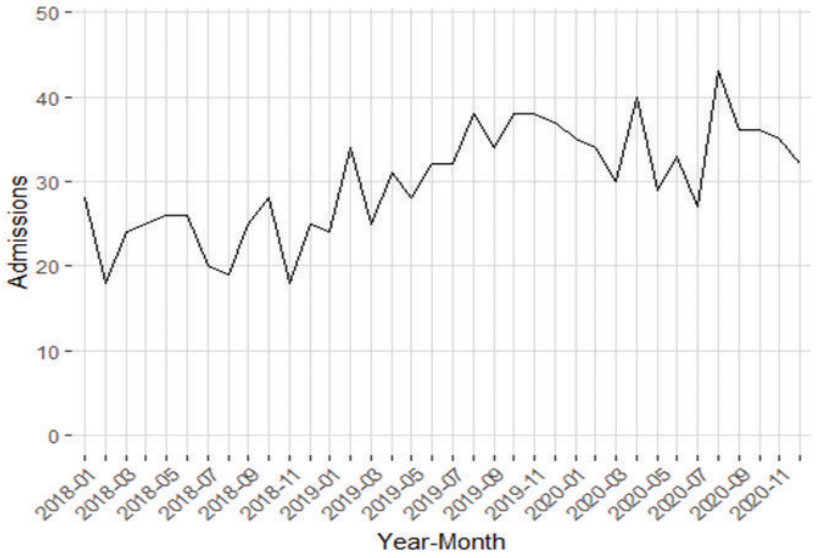


Table 36. St. Peter's Health BHU inpatient admissions 10 most common primary diagnoses, 2018-2020 (combined)

Dx code	Diagnosis	Admissions	% of admissions
F33.9	Major depressive disorder, recurrent, unspecified	180	16.62
F31.9	Bipolar disorder, unspecified	159	14.68
F32.9	Major depressive disorder, single episode, unspecified	106	9.79
F25.9	Schizoaffective disorder, unspecified	78	7.20
F33.1	Major depressive disorder, recurrent, moderate	75	6.93
F39	Unspecified mood [affective] disorder	74	6.83
F33.2	Major depressive disorder, recurrent severe without psychotic features	47	4.34
F29	Unspecified psychosis not due to a substance or known physiological condition	36	3.32
F31.81	Bipolar II disorder	32	2.95
F20.0	Paranoid schizophrenia	31	2.86

Notes: Only primary diagnosis is included here. The data include inpatient admissions to the behavioral health unit from 2018 to 2020.

Table 36 shows that the majority of inpatient admissions to the BHU have a primary diagnosis of a specific serious mental illness. Patients are admitted to these beds from across the region served by St. Peter's Health, and generally have already been assessed by a crisis response team, other mental health or medical professionals, or are being considered for involuntary commitment (see Table 43 below).

Table 37. St. Peter's Health BHU inpatient admissions 10 most common behavioral health diagnoses, 2018-2020 (combined)

Dx code	Diagnosis	Admissions	% of admissions
R45.851	Suicidal ideations	488	45.06
F41.9	Anxiety disorder, unspecified	245	22.62
F33.9	Major depressive disorder, recurrent, unspecified	198	18.28
F31.9	Bipolar disorder, unspecified	187	17.27
F32.9	Major depressive disorder, single episode, unspecified	177	16.34
F43.10	Post-traumatic stress disorder, unspecified	174	16.07
F41.1	Generalized anxiety disorder	107	9.88
F60.3	Borderline personality disorder	94	8.68
F25.9	Schizoaffective disorder, unspecified	82	7.57
F33.1	Major depressive disorder, recurrent, moderate	80	7.39

Notes: The data include inpatient admissions to the behavioral health unit from 2018 to 2020.

The top 10 primary diagnoses mostly specific serious mental illness diagnoses. Summarizing primary, secondary and tertiary diagnoses in Table 37, however, shows that almost half of inpatient admissions to the BHU include a diagnosis of suicide ideation, highlighting the need to address this specific behavioral health challenge in both prevention and response efforts.

Table 38. St. Peter's Health behavioral health unit inpatient admission charges per year

Charges	Admissions	% of admissions
$0-$4,999	204	18.84
$5,000-$9,999	326	30.10
$10,000-$14,999	232	21.42
$15,000-$19,999	94	8.68
$20,000-$29,999	122	11.27
$30,000+	105	9.70

Notes: The data include admissions to the behavioral health inpatient unit from 2018 to 2020.

The total cost of inpatient admissions to the BHU has increased each year analyzed here, from $4.8 million in 2018 to $6.0 million in 2020. Table 38 shows that many admissions are relatively low cost, but about 20% cost over $20,000. Note that these costs are per admission, and some heavy utilizers could have multiple high-cost admissions. Of the high-cost (over $20,000) admissions, 40% have one of three primary diagnoses: major depressive disorder, bipolar disorder, and schizoaffective disorder.

Table 39. St. Peter's Health BHU inpatient admissions by payor, 2018-2020 (combined)

Insurance	Admissions	% of admissions
Medicaid	558	51.52
Other	356	32.87
Medicare	169	15.60

Notes: The data include admissions to the behavioral health inpatient unit from 2018 to 2020. The other category is primarily private insurance, with small numbers of individuals having insurance through the VA and a very small number being uninsured.

Inpatient admissions are paid for primarily by Medicaid, for just over half of admissions, and Medicare. The numbers in Table 39 align closely with those in Table 34, despite the fact that inpatient admissions draw from a much wider geographic radius than ED visits.

Shodair Children's Hospital Inpatient Services

Shodair Children's Hospital is based in Helena and serves children and youth across the state in need of psychiatric care. Table 40 shows the number of Lewis and Clark County residents that are served by Shodair's inpatient services. By far the most commonly used service is acute crisis care for youth age 12-18. This is likely due in part to the fact that adolescence is a time when acute mental health needs often emerge. In addition, crisis care is generally provided close to an individual's place of residence, and Shodair's crisis care services are likely used mostly by children and youth in the region. In contrast, residential treatment provided by Shodair is utilized by children and youth statewide.

Table 40. Lewis and Clark County residents served by Shodair Children's Hospital inpatient services, 2019-2020

Service	2019	2020
Acute crisis care, age 3-11 (High Desert unit)	30	29
Acute crisis care, age 12-18 (Grasslands unit)	109	102
Residential treatment, age 12-14 (Yellowstone unit)	0	1
Residential treatment, age 14-18 (Glacier unit)	2	3
Therapeutic group homes, age 6-10	1	0

Montana State Hospital

The Montana State Hospital (MSH) includes several units focused on different types of services and care. Table 41 shows the number of Lewis and Clark County residents served by MSH by year.

Table 41. Lewis and Clark County residents served by Montana State Hospital by unit, 2018-2020

Unit	2018	2019	2020
Stabilization (A&B)	44	29	34
Continuing recovery (D)	5	4	2
Forensic mental health (F)	7	9	6
Mental health group homes	3	2	3

Proportionally, about 5% of all individuals served by MSH in 2019 come from Lewis and Clark County (a total of 847 individuals were served in 2019). Lewis and Clark County is home to about 6.6% of the adult population of Montana, and thus sends individuals to MSH at a slightly lower rate than would be expected given the county population.

Lewis and Clark County Department of Criminal Justice Services

The Lewis and Clark County Department of Criminal Justice Services (CJS) provides support and alternatives for individuals engaged with the criminal justice system with the goal of improving both public safety and defendant success. CJS can support stabilization after a behavioral health crisis that has led to interception by law enforcement in two ways. First, individuals booked into the Lewis and Clark County Detention Center self-identify with behavioral health needs and are seen by a member of the CJS behavioral health team. In 2020, 256 unique individuals were seen by the team for a total of 990 contacts (on average 4 contacts per individual). Data submitted as reporting for the County-Tribal Matching Grant show that individuals served by behavioral health specialists in the Detention Center are extremely unlikely to utilize the Montana State Hospital or the behavioral health unit at St. Peter's Hospital (less than 1% of individuals served utilize either location). Instead, most behavioral health needs are met by the team within the Detention Center.

Second, Lewis and Clark County offers an innovative Pretrial Services program, which helps ensure defendants make all of their court dates and are not arrested on a new charge while awaiting trial. For defendants with behavioral health needs, Pretrial Services assists in linkages to behavioral health treatment (among other services).

Table 42 shows that about one-third (36%) of individuals booked at the Detention Center in February 2021 self-identified as having a diagnosed mental illness, and 11% self-identified as having current or past suicidality. These numbers highlight the need for continued engagement by the CJS behavioral health services team. Given the prevalence of behavioral health needs among individuals engaged with the criminal justice system, maintaining and expanding both the behavioral health team and the capacity of Pretrial Services could increase the number of individuals who receive stabilizing services while engaged in the Lewis and Clark County criminal justice system.

Table 42. Individuals booked into Lewis and Clark County Detention Center, February 2021

Need or service for booked individuals	N	% of all individuals booked
Self-identified as having a diagnosed mental illness	48	36%
Self-identified as current or past suicidality	15	11%

Note: Data is for February 2021 only. Total bookings were 137

Lewis and Clark County Attorney's Office

The Lewis and Clark County Attorney's Office can file an involuntary commitment request in the immediate aftermath of a behavioral health crisis. While awaiting a determination from a judge, individuals must be held somewhere. Table 43 shows that in 2019 and 2020, the behavioral health unit (BHU) at St. Peter's Hospital was the most common location for a pre-commitment hold.

Table 43. Location of hold during pre-commitment period and average number of days held, 2019-2021

Pre-commitment hold location	2019		2020		2021	
	N	% of total	N	% of total	N	% of total
Behavioral health unit, St. Peter's Health	18	32%	29	48%	4	22%
Montana State Hospital	12	21%	16	27%	12	67%
Journey Home	11	19%	n.a.		n.a.	
Lewis and Clark County Detention Center	7	13%	5	8%	2	11%
VA	5	9%	3	5%		
St. Peter's Health (not BHU)	2	4%	7	12%		
Other facilities	2	4%	n.a.		n.a.	
Average length of stay	5 days		5 days		5 days	

Note: Data was provided from January 1, 2019-May 5, 2021. Journey Home, which was run by Western Montana Mental Health Center, closed at the end of 2019. The other facilities utilized in 2019 were Hannaford House (voluntary residential step-down from Montana State Hospital) and the Hays-Morris House (run by WMMHC in Butte).

Table 43 suggests that the closing of Journey Home in January 2020 added demand mostly to the BHU, as the proportion of individuals held during the pre-commitment period at the BHU jumped from 32% in 2019 to 48% in 2020. In the January-May 2021 period, the majority of individuals (67%) in the pre-commitment period were held at the Montana State Hospital. Changing Covid-19 protocols and demands could have played a role in this shift. The average length of stay for an individual during the pre-commitment period is 5 days.

Table 44. Outcome of involuntary commitment filings, 2019-2021

Outcome	2019		2020		2021	
	N	% of total	N	% of total	N	% of total
Committed	25	47%	32	55%	8	50%
Diverted or dismissed	28	53%	26	45%	8	50%

Note: Data was provided from January 1, 2019-May 5, 2021.

Table 44 shows that individuals for whom an involuntary commitment is filed are committed about 50% of the time in Lewis and Clark County. If committed, they are always taken to the Montana State Hospital.

Journey Home Crisis Stabilization Facility (WMMHC)

Journey Home was an adult crisis stabilization facility managed by Western Montana Mental Health Center (WMMHC) in Lewis and Clark County. Journey Home closed at the end of 2019. While operating, Table 45 shows that the average occupancy rate for voluntary admission beds was 48%, suggesting that there was adequate capacity to meet demand even with a relatively small facility. The involuntary admission bed occupancy rate was 40%, again suggesting that the capacity provided by Journey Home was adequate to meet the needs of the community.

Table 45. Journey Home crisis stabilization facility admissions and occupancy rates, July 2018-September 2019

Admission type	Total admissions	Average admissions per month	Average monthly occupancy rate	Average length of stay (days)
Voluntary (6 beds)	378	25.2	48%	4
Involuntary (2 beds)	34	2.4	40%	n.a.

Stabilization Conclusion

Data from the St. Peter's Health ED show that both alcohol and mental health diagnoses are present in a consistent minority of visits (somewhere between 15 and 25%). For both ED and inpatient visits, SUD diagnoses are more common than are mental health diagnoses. Patterns of care being provided by the St. Peter's Health behavioral health unit focus much more on mental illness than on substance use, despite the dominance of alcohol in crisis situations and crisis-related incidents (crime, EMS, etc.). A substantial proportion of visits to the St. Peter's behavioral health unit are for unspecified mental health disorders, as well as for suicide. Heavy utilization and high visit costs are of concern in the stabilization portion of the crisis continuum, especially since St. Peter's Health behavioral health unit ED costs are highest for those without a specific diagnosis.

Opportunities for stabilization outside of the criminal justice or medical systems in Lewis and Clark County are consistently being utilized. Data from St. Peter's Health BHU show that there is generally adequate capacity of crisis and inpatient beds. The data also suggest that an adult crisis stabilization facility has a consistent role to play in the Lewis and Clark County behavioral health crisis care system. Journey Home had a consistent occupancy rate of 50% in the voluntary beds in the July 2018-September 2019 period, and received about 20% of individuals in the pre-commitment phase of an involuntary commitment process in Lewis and Clark County in 2019.

PREVENTION

The prevention stage of the crisis services continuum includes services that aim to support those who are at higher risk of experiencing a crisis and to link them with supports to minimize the likelihood of a crisis. Treatment services for behavioral health conditions have been included in the prevention portion of the crisis continuum. This decision was made to preserve the primary focus of this report as being about behavioral health crisis. Behavioral health treatment capacity, and a full assessment of this capacity, was outside of the scope of this project.

Within the context of a crisis system, behavioral healthcare that is intended to provide short or long-term services for mental health or substance use conditions are an essential part of preventing a crisis for those at risk of crisis, hence inclusion in the prevention portion of the crisis continuum. Another key element to prevention is the utilization of screening tools in primary care settings as a method for identification of untreated mental health conditions or substance use disorders.

For this assessment, data about engagement with behavioral health in primary care settings is displayed through data provided by PureView Health Center (a federally qualified health center). Data about engagement with outpatient behavioral health treatment is provided by St. Peter's Health Outpatient Behavioral Health Services, the Center for Mental Health, Boyd Andrew Community Services, Instar Community Services, Shodair Children's Hospital Outpatient Services and Youth Dynamics. Data about residential behavioral health treatment is provided by Florence Crittenton. These data are intended to provide some understanding of where individuals are receiving ongoing care, across multiple modalities and settings, that may prevent utilization of crisis services.

Table 46. Statistics about prevention services and diagnoses in the crisis services continuum

	Total #	% female	% male
PureView Health Center (2020)	6856	55%	45%
Mental health services	695	--	--
Substance use disorder services	164	--	--
Helena Indian Alliance outpatient clients served (2020)	493	46%	54%
St. Peter's Health outpatient clinical psychiatry visits (2020)	42	75%	25%
Center for Mental Health (FY19-20)			
Recovery services (outpatient)	487	--	--
Residential (group homes)	106	--	--
Intensive (PACT)	92	--	--
Boyd Andrew Chemical Dependency Services (2020)			
Total clients served	277	--	--
Chemical dependency assessments	154	--	--
Recovery residence clients served	13	--	100%
Instar Community Services (2020)			
Outpatient	384	48%	52%
Recovery residences	37	--	--
Florence Crittenton (2020)			
Recovery home	6	100%	--
Transitional living program	19	100%	--
Outpatient	10	100%	--
Good Samaritan/Our Place Drop-in Center (2020)			
Total client visits	8607		
Targeted peer support management client visits	224		
SUD client visits	113		
Shodair Children's Hospital Outpatient Services (2020)	424	55%	45%
Youth Dynamics (2020)			
Outpatient services	169	52%	48%
Group home (Helena)	22	64%	36%

Notes: Gender totals may not equal 100% due to either non-response from clients or individuals identifying as neither male nor female. Center for Mental Health data is for the southern region, which includes Lewis and Clark, Broadwater, Jefferson and Meagher counties. Data for Youth Dynamics outpatient services is for Lewis and Clark County residents and for group homes is for the home located in Helena.

PureView Health Center

PureView Health Center is a federally qualified health center (FQHC) that serves primarily Lewis and Clark County residents (86% of clients are residents of Lewis and Clark County). PureView provides primary care and integrated behavioral health services, including medication-assisted treatment (MAT) for opioid use disorder.

Table 47. Behavioral health services provided by PureView Health Center 2020

Service	Number of visits		Number of clients	% of total clients
	Clinic	Virtual		
Mental health services	734	821	695	10%
Healthcare for the Homeless			40	
Substance use disorder services	271	50	164	2%
Healthcare for the Homeless			15	

Notes: Visit totals come from service line figures and client totals come from service details.

Table 48 highlights the dominance of mental health diagnoses for clients served by PureView. Anxiety (including PTSD) and depression are each present for 15% of clients, and while there are likely some people with multiple diagnoses, it is still likely that at least 10% of PureView clients experience at least one of these diagnoses. Substance use disorders are less commonly noted as diagnoses.

Table 48. Diagnostic categories for behavioral health conditions served by PureView Health Center, 2020

Diagnosis	Number
Anxiety disorders, including PTSD	1049
Depression and other mood disorders	1029
Other mental disorders (excluding drugs and alcohol dependence)	349
Tobacco use disorder	251
Alcohol-related disorders	182

Helena Indian Alliance

Helena Indian Alliance (HIA) is an FQHC look-alike, meaning that they provide the services and meet the requirements of an FQHC but have a different reimbursement and grant-funding structure. HIA provides a range of behavioral health prevention services, including counseling, education classes, and medication-assisted treatment, as well as primary health care services in the Leo Pocha Memorial Clinic. Table 49 shows the number of clients receiving behavioral health services at HIA.

Table 49. Clients receiving outpatient behavioral health services from Helena Indian Alliance, 2018-2020

Year	Total clients	Average visits per client	Male		Female	
			N	%	N	%
2018	548	9.5	305	59%	215	41%
2019	511	9.3	292	57%	219	43%
2020	493	5.7	265	54%	228	46%

The average number of visits per client receiving behavioral health services dropped substantially from 2019 to 2020, likely due to Covid-19 restrictions on in-person treatment. Table 49 also shows that there is a fairly proportional gender breakdown of clients receiving behavioral health services from HIA, with women making up almost half (46%) of the clientele in 2020.

Table 50. Top ten primary diagnoses of clients receiving behavioral health care services at HIA in 2020

Dx code	Diagnosis	Diagnoses	% of total diagnoses
F10.20	Alcohol dependence, uncomplicated	134	18%
F11.20	Opioid dependence, uncomplicated	82	11%
F15.20	Other stimulant dependence, uncomplicated	71	9%
F32.9	Major depressive disorder, single episode	41	5%
F41.9	Anxiety disorder, unspecified	36	5%
F19.10	Other psychoactive substance abuse, unsp.	34	4%
F10.10	Alcohol abuse, uncomplicated	32	4%
F17.200	Nicotine dependence, uncomplicated	28	4%
F41.1	Generalized anxiety disorder	27	4%
F31.9	Bipolar disorder, unspecified	24	3%

*Notes: Data presented here are unique client*unique primary diagnosis. This means that the same client could have visits over the course of the year with different primary diagnoses, and each would be included as a separate primary diagnosis. However, repeat visits for the same client with the same diagnosis are only counted once.*

Table 50 that the 10 most common primary diagnoses of clients receiving behavioral health services from HIA. Substance use disorders are by far the most common, with alcohol, opioids and other stimulants (primarily methamphetamines) accounting for over one-third (37%) of all diagnoses for behavioral health visits. Alcohol as the single most common primary diagnosis, which reflects the data elsewhere in this report, especially in the Response and Stabilization sections, that shows alcohol as by far the most common substance used. A substantial proportion of diagnoses are for opioid dependence, a SUD treated at HIA using medication-assisted treatment (MAT). Finally, a small proportion of diagnoses are for SMI, including major depressive disorder and bipolar disorder.

St. Peter's Health Outpatient Behavioral Health Services

St. Peter's Health provides outpatient behavioral health services to individuals determined to need behavioral health care, either through self-identification, referral from outside of the primary care setting, or through screenings conducted in primary care settings. In addition, outpatient behavioral health services are also provided as a follow-up to receiving care in the behavioral health unit ED or inpatient beds. provides outpatient services to a small number of individuals.

Table 51. St. Peter's Health outpatient behavioral health care services, 2018-2020

Outpatient behavioral health services	2018		2019		2020	
	N	% of total	N	% of total	N	% of total
Clients served by OP psychiatric services	1456	100%	1872	100%	2059	100%
Clients who had BHU visit before OP psych visit	65	4%	58	3%	42	2%
Clients who are screened into OP psych visit	728	50%	1187	63%	996	48%
Patients screened for depression (PHQ)	17450	100%	19135	100%	17629	100%
Clients who screen high-risk	3417	20%	4258	22%	3921	22%
High-risk clients who see BHP in same year	249	7%	418	10%	549	14%
High-risk clients who see OP psych in same year	728	21%	1187	28%	996	25%
High-risk clients who see BHP or OP psych in same year	835	24%	1363	32%	1281	33%

Note: Data is for 2018-2020. There were only two outpatient psychiatrists in 2018, and three in 2019 and 2020.

Table 51 shows that each year, about half of individuals who received outpatient psychiatric services in are screened into those services through universal screening using the PHQ tools. In general, about 20% of individual clients who were screened for depression screened as being high risk. The proportion of those high-risk clients who go on to have at least behavioral health visit (with either a behavioral health provider or a psychiatrist) has increased from one-quarter to one-third from 2018 to 2020.

Shodair Children's Hospital Outpatient Services

Shodair Children's Hospital Outpatient Services are provided primarily to residents of Lewis and Clark County. Table 52 shows the total number of individual patients and the gender breakdown for county residents served by Shodair outpatient services.

Table 52. Lewis and Clark County residents served in outpatient treatment by Shodair Children's Hospital

Year		Male		Female	
	Total	N	%	N	%
2019	283	137	48%	146	52%
2020	424	191	45%	233	55%

Center for Mental Health

The Center for Mental Health provides the following services in Lewis and Clark County or for Lewis and Clark County residents: medication management, crisis support and consultation, recovery residences and a Program for Assertive Community Treatment (PACT) team. The Center for Mental Health focuses on mental health and has the expertise to engage and treat individuals with SMI.

Table 53. Primary diagnosis for Center for Mental Health clients in Lewis and Clark County, FY19-20

Substance	% of primary diagnoses
Psychotic disorders	24%
Depressive disorders	23%
Bipolar disorders	22%
Trauma-related disorders	15%
Anxiety disorders	6%
Substance use disorders	3%
Personality disorders	1%
Youth Behavioral disorders	1%
Other/unspecified	5%

Table 53 shows that over two-thirds of primary diagnoses for Center for Mental Health patients in Lewis and Clark County are depressive disorders, bipolar disorder or psychotic disorders (combine these represent 69% of primary diagnoses).

Table 54. Total clients served by Center for Mental Health service line, FY19-20

Service line	Unique clients served	Number of services provided	Average number of services per client
Medical (medication management)	375	2,208	5.9
Recovery (outpatient treatment)	487	6,086	12.5
Residential (group homes)	106	10,568	99.7
Intensive (PACT)	92	20,929	227.5

Although there is a range of severity for the diagnoses listed in Table 53, both bipolar and psychotic disorders often must be managed at a high level of intensity to avoid crisis, and the PACT team at the Center for Mental Health provides both stabilization and prevention services for individuals with these and other SDMI diagnoses. Service provision data from the Center for Mental Health in Table 54 represents the entire southern service area, consisting of Lewis and Clark, Broadwater, Jefferson and Meagher counties. Lewis and Clark County is by far the most populated of the four, and thus these regional service area numbers are likely to be a fairly accurate reflection of need and capacity in Lewis and Clark County.

The services provided by the Center for Mental Health vary in intensity, in terms of the average number of services provided per client per year. It is important to note that the services provided by the PACT team, which consists of 15 staff members, are both the most intensive and have the potential to avoid even more intensive and expensive service provision by working to avoid crisis situations.

Boyd Andrew Community Services

Boyd Andrew Community Services provides outpatient chemical dependency services in Lewis and Clark County, including chemical dependency assessments, outpatient and intensive outpatient treatment services and an ASAM 3.1 recovery residence. Data presented here are for 2018 to 2020.

Table 55. Total clients served by Boyd Andrew Chemical Dependency Services by age and county of residence, 2018-2020

Clients served	2018		2019		2020	
	N	% of total	N	% of total	N	% of total
Total	455	--	394	--	277	--
Age						
20-29	81	18%	85	22%	53	19%
30-39	160	35%	140	36%	102	37%
40-49	112	25%	88	22%	74	27%
50-59	61	13%	56	14%	35	13%
60+	34	7%	20	5%	9	3%
County of residence						
Lewis and Clark	413	91%	324	82%	247	89%
Jefferson	12	3%	17	4%	8	3%
Broadwater	4	1%	11	3%	11	4%

Note: For age breakdown, each year there are a few clients for whom age in unknown, so percentages will not quite add up to 100. For county of residence, Boyd Andrew serves clients from several other counties as well but at much lower rates (generally 1-2 clients per year).

Table 55 shows the total number of clients served by Boyd Andrew Chemical Dependency Services each year, as well as a breakdown by age and county of residences. The majority of Boyd Andrew clients are under 40 and the vast majority live in Lewis and Clark County.

Table 56. Diagnosis of clients served by Boyd Andrew Chemical Dependency Services, 2018-2020

Clients served	2018		2019	2020
	N	% of total	N	N
Total	455	--	394	277
Alcohol				
Use disorder (untreated)	305	67%	20	56
Use disorder (in remission)	93	20%	19	14
Amphetamines				
Use disorder (untreated)	196	43%	35	60
Use disorder (in remission)	99	22%	--	28
Cannabis				
Use disorder (untreated)	39	9%	19	25
Use disorder (in remission)	37	8%	--	13
Opioids				
Use disorder (untreated)	36	8%	--	7
Use disorder (in remission)	--		--	5
Cocaine				
Use disorder (untreated)	--		--	--
Use disorder (in remission)	22	5%	--	--

Note: Diagnoses as percent of total clients served are provided only for 2018 because diagnosis data are incomplete for 2019 and 2020. Untreated diagnoses are those not noted to be in remission.

Table 56 shows that alcohol is by far the common substance used by clients receiving services, which is likely due in part to the fact that Boyd Andrew provides Assessment, Course & Treatment (ACT) services for individuals who have been convicted of DUI or misdemeanor dangerous drug charges (for small amounts of cannabis). In addition, almost half of Boyd Andrew clients have an untreated amphetamine use disorder. The figures presented in Table 56 for 2018 highlight the prevalence of polysubstance use, as over three-quarters (87%) of clients have an alcohol use disorder diagnosis (untreated or in remission) and almost two-thirds (65%) have an amphetamine use disorder diagnosis (untreated or in remission). Untreated cannabis and opioid use disorders comprise a small proportion of total diagnoses.

Table 57. Disposition of clients assessed by Boyd Andrew for substance use disorder, 2018-2020

Disposition type	2018		2019		2020	
	N	% of total	N	% of total	N	% of total
Total clients assessed and referred	162	--	218	--	154	--
Inpatient ASAM 3.7	4	2%	8	4%	1	1%
Inpatient ASAM 3.5	55	34%	99	61%	61	40%
Inpatient ASAM 3.1	22	14%	22	10%	13	8%
Intensive outpatient ASAM 2	30	19%	43	20%	26	17%
Outpatient ASAM 1 traditional (individual and group)	38	23%	31	14%	45	29%
Outpatient ASAM 1 individual	12	7%	15	7%	7	5%
Outpatient ASAM 1 relapse prevention	1	1%	0	0	1	1%

Boyd Andrew provides chemical dependency assessment services for voluntary clients as well as for clients ordered by courts, probation officers or employers to be receive an assessment. Table 57 shows the outcome of those assessments by disposition/referral type. The figures show that a majority of clients assessed are found to be in need of some level of inpatient treatment (ASAM 3.1 or higher), with most requiring ASAM 3.5 care. For those referred to outpatient care, most require intensive outpatient (ASAM 2.1) or traditional outpatient (ASAM 1 with individual and group treatment). The severity of SUD for clients assessed by Boyd Andrew is likely due in part to the fact that assessments are generally ordered only in extreme situations and voluntary assessments similarly are likely not sought out until situations are extremely challenging. However, the number of individuals referred just by Boyd Andrew to ASAM 3.5 treatment highlights the demand for this level of treatment intensity and a potential lack of capacity in the state (there are currently 12 ASAM 3.5 facilities in Montana).

Table 58. Total individuals served in Boyd Andrew recovery residence (men only) by primary diagnosis, 2018-2020

Diagnosis	2018	2019	2020
Total clients served	23	23	14
Alcohol use disorder	9	15	7
Amphetamine use disorder	12	6	7
Opioid use disorder	1	1	--
Cannabis use disorder	--	1	--
Anxiety disorder	1	--	--

Boyd Andrew runs a seven-bed recovery residence for men licensed as an ASAM 3.1 treatment facility. Table 58 shows the total clients served by year at the recovery residence as well as their primary diagnosis. Alcohol and amphetamines are the most common substances for individuals served at the recovery residence, which aligns with the most common substances for all clients served by Boyd Andrew Chemical Dependency Services (Table 56).

Youth Dynamics

Youth Dynamics provides a range of outpatient services for behavioral health needs of children, youth and families as well as four therapeutic group homes across the state, including one in Helena.

Table 59. Clients served by Youth Dynamics outpatient services and group homes, 2016-2020

Service	2018			2019			2020		
	N	% M	%F	N	% M	% F	N	% M	% F
Outpatient services	132	52%	48%	165	48%	52%	169	48%	52%
Therapeutic group home	16	50%	50%	25	48%	52%	22	36%	64%

Notes: Data on outpatient services is for Lewis and Clark County Residents, and data on the therapeutic group home is on the home in Helena.

Table 59 shows the total number of Lewis and Clark County residents served by Youth Dynamics' outpatients services over the past three years. The gender breakdown of clients has switched, from being predominantly male in 2018 to predominantly female in 2019 and onward. Youth Dynamics has served an increasing number of clients each year with outpatient services.

Florence Crittenton

Florence Crittenton has an inpatient (ASAM level 3.1) recovery residence and a transitional living program, as well as provides outpatient treatment and recovery services for pregnant and parenting women. Children age 5 and under can reside with their mothers in the residential facilities. Florence Crittenton provides early childhood education and care to these children in addition to parenting support to their parents.

Table 60. Treatment and recovery services provided by Florence Crittenton, 2018-2020

Client characteristics	2018		2019		2020	
	N	% of total	N	% of total	N	% of total
Residential services: Total clients	10		33		25	
Clients in transitional living program	10	100%	23	70%	19	76%
Clients in recovery residence	0	0	10	30%	6	24%
Clients age 0-5	4	40%	17	52%	12	48%
Clients age 12+	6	60%	16	48%	13	52%
Pregnant clients	3	50%	3	19%	5	38%
Pregnant or parenting clients	6	100%	16	100%	13	100%
Clients from Lewis and Clark County	2	20%	6	18%	4	16%
Outpatient program: Total clients	n.a.		9		10	

Notes: Clients age 0-5 are served only with a parent in treatment. Proportions for pregnant and pregnant or parenting clients use clients age 12+ as the denominator. Florence Crittenton has only had an outpatient program since 2019.

Table 60 shows the number of clients served by program and by client characteristics. It is important to note that only about 20% of Florence Crittenton's clients are residents of Lewis and Clark County (prior to entering treatment).

Instar Community Services

Instar Community Services provides certified peer support specialists and licensed addiction counselors for individuals with substance use, gambling and mental health needs.

Table 61. Total individuals served by Instar Community Services, 2018-2020

Time period	Individuals served in outpatient treatment			Individuals served in recovery residences
	Male	Female	Total	
2018	88	178	266	
2019	165	138	303	12 (opened November)
2020	201	183	384	37

Table 61 shows the number of individuals served in outpatient treatment and recovery residences (which opened in November 2019).

Good Samaritan Ministries: Our Place Drop-in Center and Street Outreach Team

Good Samaritan Ministries took over the Our Place drop-in center in December 2019. Our Place is a peer-run support program that provides a range of behavioral health services as well as help finding jobs, housing, food, and other things for people recovering from addiction and behavioral challenges. Although in some specific situations, Our Place peer-support specialists might provide early intervention/crisis mitigation support, in general the approach taken by Our Place is focused on preventing behavioral health crises by addressing both behavioral health and social needs. Table 62 and Table 63 provide figures about the services provided.

Table 62. Client visits to Our Place for behavioral health needs, 2020

Visit type	Total visits/clients	Average hours per client
Total client visits	8607	
Targeted peer support management clients	224	1.45
Substance use disorder support clients	113	1.52

Note: Data on total client visits are January-December 2020. Data on TPSM and SUD are July-December 2020.

Table 63. Services provided to address social needs of clients at Our Place, 2020

Service	Total provided
Job service participation	7
Housing intakes	256
Housing units found	54
Birth certificate copies secured	24
SSI application completed	39
SNAP applications completed	55
Food packs given	368
Meals served	4598
Rides given	434
Miles driven	5234

Note: Data cover the period of July-December 2020.

In addition to providing services at Our Place, Good Samaritan Ministries has several other programs designed to address some social determinants of behavioral health with the goal of keeping people out of crisis. The Street Outreach team focuses on individuals experiencing homelessness, the vast majority of whom have behavioral health needs that are often going unmet. The Street Outreach team works to connect individuals to housing services (including shelter beds, hotel beds or permanent housing as appropriate), medical and behavioral health services, and social services. If an individual is experiencing a behavioral health crisis the Street Outreach team will provide transportation to the emergency department or to treatment facilities and recovery residences. The Housing Navigation team is a city/county funded program that works with both landlords and tenants. It is designed to engage individuals and families who are facing housing insecurity or instability and to provide support to connect them to open units (for example, by covering housing application fees). The program has served 456 people in total and has housed 312 individuals. The Assistance Ministry spends an average of $230,000 per year for individuals and families who are facing eviction, power shut-off, or need help paying for bills such as daycare, internet, doctor visits medical-eye-dental, phone, insurance, hotel, transportation (bus or gas), among many other forms of help (including the Christmas adopt-a-family program).

Prevention Conclusion

A large number of individuals are provided prevention services through primary care clinics (PureView and Helena Indian Alliance) that include integrated behavioral health and hospital outpatient behavioral health services, as well as through state-approved treatment providers. In primary care settings, the focus seems to be primarily on mental health issues, possible because these could lead most immediately or acutely to crisis if not actively addressed. Primary mental health diagnoses are most commonly anxiety and depression, a finding which mirrors those in the Stabilization section of this report. In addition, SUD treatment needs are primarily alcohol, with substantial minorities of clients using opioids or amphetamines.

State-approved treatment providers focus on both SUD treatment and care for serious mental illness, and together these providers offer more treatment capacity than the primary care clinical settings. There is also substantial capacity to provide care to children and youth, including through Shodair Children's Hospital and Youth Dynamics. There is also strong capacity to provide peer support treatment and prevention services.

KEY TAKEAWAYS & RECOMMENDATIONS

GENERAL OBSERVATIONS AND RECOMMENDATIONS

- Overall much of the behavioral health crisis continuum in Lewis and Clark County is meeting the needs of the community, including in providing adequate capacity to meet demand and in utilizing innovative best practices to improve outcomes.
- The process of gathering data on all of the actors and organizations engaged in providing care within the crisis continuum highlighted many challenges associated with aging data management systems, and incomplete record keeping specifically as it relates to both crisis services provided and referrals made.
- Prevalence estimates suggest a continued focus on alcohol use disorder prevention and treatment, as a substantial proportion of all incidents, responses and visits across the crisis continuum are related to alcohol as a primary driver of crisis.
- Cannabis and stimulants are consistently the most common illicit substances present in incidents related to behavioral health crisis.
- Suicide and self-harm are consistently one of the top diagnoses in incidents, visits and admissions with mental health needs. Medicaid data suggests that youth (age 10-17) are overrepresented in terms of individuals with a suicide or self-harm threat or attempt.

General recommendations

- Build upon this assessment and look specifically at the **financing** of crisis services, **workforce capacity**, behavioral health **treatment capacity**, and **referral practices** and client flows within the crisis system.
- **Improve data integration** and coordination across crisis service organizations. In light of HIPAA and CFR 42C compliance concerns, this may best be done through a team that includes analysts from each key organization providing aggregated totals.
- Maintain and expand **suicide prevention campaigns** in the context of universal and selected prevention programming, with a focus on **universal screening** and **campaigns targeting youth**.

EARLY INTERVENTION

Key takeaways

- Lewis and Clark County residents are utilizing hotlines as a way to manage and avert behavioral health crises. Of specific note is the prevalence of immediate suicide crisis (attempt or threat) as the main reason for calling, with almost 15% of all calls made by county residents being focused on suicide crisis.

Recommendations

- Ensure adequate **community awareness of suicide hotline** resources to continue to encourage their use.

RESPONSE

Key Takeaways

- Behavioral health needs are present in a small but consistent proportion (roughly 15%) of incidents responded to by 911, law enforcement (especially assault incidents) and EMS services in Lewis and Clark County.
- Alcohol misuse is the most common substance misuse impression or reason for incidences or offenses responded to by law enforcement and EMS.
- Anxiety and suicide are the most common mental health impressions for EMS
- Law enforcement is engaged for virtually all (over 90%) dispatch calls with a possible behavioral health diagnosis. Incidents to which the mobile crisis response team (MCRT) is called have a lower law enforcement presence (they are present about 75% of the time), highlight the cost savings and de-escalation that the MCRT can provide.
- EMS transports 90% of individuals with behavioral health needs to the emergency department, compared to 20% of individuals engaged by the MCRT.

Recommendations

- Continue to **invest in and expand the MCRT** to divert individuals when appropriate from engagement with law enforcement and the emergency department. This saves money by saving time of law enforcement and medical professionals, and the national evidence shows improved outcomes for individuals experiencing behavioral health crisis.
- Invest in t**raining for all types of first responders** in addressing crises related to suicide threats or attempts.
- Consider **linking behavioral health prevention and treatment efforts with crime reduction efforts**, given the presence of substance misuse in many criminal incidents.

STABILIZATION

Key Takeaways

- St. Peter's Health BHU serves as a regional hub for inpatient mental health crisis stabilization and thus serves a much large population than that of Lewis and Clark County. Capacity appears to be adequate to address current demand.
- The adult crisis stabilization facility that closed in January 2020 played a clear role in the crisis continuum, especially for individuals awaiting a decision about involuntary commitment.
- Capacity to serve children is strong and expanding. Shodair has launched a building/capital improvement campaign that has broken ground as of June 2021. When complete, it will have an additional "nearly 131,000 square feet with classroom space, recreational space, family meeting space, a new pool, and individual rooms and attached restrooms for all inpatient residential and acute care programs."6

[6]https://shodair.org/hope-takes-flight/

Recommendations

- Consider **reinvesting in an adult crisis stabilization facility**, in order to ensure that the St. Peter's Health BHU capacity is not stretched and that clients can receive the lowest appropriate intensity care. This would also ensure that Lewis and Clark County continues to not place an undue burden on the Montana State Hospital.
- Consider **linking an adult crisis stabilization facility to MCRT** services in order to add an additional low-intensity clinical stabilization option for MCRT staff to utilize.
- **Maintain the capacity of the Criminal Justice Services program**, including linkages to behavioral health treatment both in and out of custody.

PREVENTION

Key Takeaways

- There is robust capacity within Lewis and Clark County for both primary and specialized preventative behavioral health care. This includes universal screenings in primary care settings, programs and services for specific groups recovering from substance use disorder or mental health crises, and specialized care for pregnant and postpartum women.
- Prevention activities in primary care settings focus on both substance use and mental health needs, though different providers engage more or less with one or the other type of behavioral health need.
- Alcohol and stimulants are the most common substances identified through prevention activities as being misused.
- Children and families are served by a variety of providers but load seems to be increasing every year.
- Several prevention providers focus on providing peer support and addressing the social determinants of behavioral health.

Recommendations

- Ensure that **all primary care providers are screening for both substance use and mental health needs**, and that there are clear referral pathways for clients who screen of concern and need to be seen outside of a providers' practice.
- Engage prevention providers with a **specific focus on children and families** to meet what appears to be an increasing need in Lewis and Clark County.
- Expand prevention providers focused on **peer support and social determinants of health**, with a specific focus on housing, fidelity to treatment plans (i.e. behavioral health treatment visits), and long-term recovery support.

Lewis and Clark County is well-positioned to have a comprehensive behavioral health care system, including a well-functioning crisis system. The community has a high degree of engagement from and coordination among service providers and contains an array of existing, engaged medical and community-based organizations that are currently providing crisis and behavioral health services, including an inpatient behavioral health unit that provides regional services. The analysis done to support the Lewis and Clark County Behavioral Health System Improvement Leadership Team has identified the heavy burden that alcohol misuse and methamphetamines, and anxiety and depression are placing on the crisis response system. Addressing these issues may be the highest priority for ongoing improvements to the behavioral health crisis system. The prevalence of alcohol-related incidents responded to by law enforcement and served in the emergency department limits the ability of each of these providers to respond to other forms of behavioral health crisis.

Improving coordination within the crisis system organizations is a perpetual goal. The shifting nature of funding, staffing, and organizational priorities requires vigilance to retain strong collaborations and distributed responsibilities. One direct way that coordination could be enhanced is through creative strategies for sharing data, which can improve understanding about capacity and about heavy utilizers who flow across organizations within the crisis system. The Helena Regional Housing and Healthcare Initiative (FUSE Project), led by the Helena Housing Authority, and the Criminal Justice Information Sharing Initiative, led by the Criminal Justice Services Department in Lewis and Clark County, both include a focus on data sharing and tracking across services and over time, to address the burden of heavy utilizers and to ensure that individuals are receiving comprehensive social and clinical services. In addition, ongoing data sharing and integrated data analysis can help identify and track key metrics for improving efficiency, value and outcomes in the behavioral health crisis system. Enabling this type of data sharing will require both financial and technical support for behavioral health services providers to ensure that staffing levels and capacity can effectively manage reporting and interpretation of data.

In behavioral health care nationally, there is a perpetual tension among medical models of care and those that are based on a social concept of addiction regarding how to best support individuals in crisis. Integration of these models of care also play out in the crisis response system, and in our view the Lewis and Clark County behavioral health crisis system is striving to balance these two elements of the care system.For example, the creation of the mobile crisis response team through a collaboration between Lewis and Clark County and St. Peter's Health, has shown a high level of success at diverting people from the emergency department to other, more appropriate sites of care, not all of which are clinical. In addition, officers with the Lewis and Clark County Sheriff's Office have received Crisis Intervention Training (CIT) in order to address behavioral health crisis situations with the most appropriate skill set. It is valuable for the Behavioral Health System Improvement Leadership Team to continue to reflect on how best to balance these approaches to ensure clear, accessible care in a timely manner for those in the community who experience a behavioral health crisis.

APPENDIX

APPENDIX A: RESPONSE TABLES

Crime

Table 64: Number of offenses by year and offense type

Offense	2016	2017	2018	2019
All Other Larceny	635	746	911	703
Destruction/Damage/Vandalism of Property	520	577	622	536
Simple Assault	523	521	497	431
All Other Offenses	393	431	496	427
Trespass of Real Property	388	361	518	400
Shoplifting	278	285	341	386
Driving Under the Influence	282	273	369	315
Theft From Motor Vehicle	299	257	407	299
Drug/Narcotic Violations	234	232	285	255
Drug Equipment Violations	200	206	274	232
Burglary/Breaking & Entering	256	298	304	212
Aggravated Assault	191	193	170	166
Motor Vehicle Theft	140	156	191	157
Theft From Building	124	124	88	90
Liquor Law Violations	115	120	125	88
Counterfeiting/Forgery	107	120	161	83
Fondling	84	99	84	82
Theft of Motor Vehicle Parts or Accessories	31	45	83	72
Disorderly Conduct	172	144	111	71
Rape	68	78	62	62
Identity Theft	74	51	45	59
False Pretenses/Swindle/Confidence Game	70	65	82	55
Credit Card/Automated Teller Machine Fraud	78	55	72	44
Intimidation	45	33	24	25
Kidnapping/Abduction	25	20	20	21
Family Offenses, Nonviolent	25	26	17	17
Weapon Law Violations	23	11	11	15
Robbery	23	28	13	11
Arson	19	19	11	9
Sodomy	9	6	5	9
Animal Cruelty	0	5	15	9
Embezzlement	9	10	13	5
Bad Checks	11	12	9	4
Pornography/Obscene Material	2	0	4	3
Incest	7	4	5	3
Statutory Rape	5	8	6	2
Purse-snatching	2	1	0	2

Theft From Coin-Operated Machine or Device	1	3	2	2
Murder and Nonnegligent Manslaughter	2	2	3	1
Stolen Property Offenses	4	5	7	1
Welfare Fraud	0	0	2	1
Prostitution	1	1	0	1
Operating/Promoting/Assisting Gambling	1	0	1	1
Peeping Tom	0	0	0	1
Gambling Equipment Violation	1	0	0	0
Sexual Assault With An Object	5	1	1	0
Curfew/Loitering/Vagrancy Violations	1	2	0	0
Pocket-picking	0	1	1	0
Hacking/Computer Invasion	0	1	0	0
Wire Fraud	0	1	1	0

Table 65: Number of incidents with arrests by offense category

Offense	Incidents with arrest	% of incidents with arrest
Simple Assault	1,165	59.08
Driving Under the Influence	1,101	88.86
All Other Offenses	1,017	58.21
Shoplifting	642	49.77
Drug/Narcotic Violations	547	54.37
All Other Larceny	434	14.49
Disorderly Conduct	367	73.69
Aggravated Assault	344	47.78
Trespass of Real Property	288	17.28
Drug Equipment Violations	256	28.07
Liquor Law Violations	252	56.25
Destruction/Damage/Vandalism of Property	197	8.74
Burglary/Breaking & Entering	101	9.44
Motor Vehicle Theft	81	12.58
Theft From Building	53	12.44
Theft From Motor Vehicle	51	4.04
Family Offenses, Nonviolent	43	50.59
Counterfeiting/Forgery	39	8.28
Fondling	33	9.46
Intimidation	33	25.98
Robbery	32	42.67
Rape	30	11.11
False Pretenses/Swindle/Confidence Game	29	10.66
Weapon Law Violations	25	41.67
Bad Checks	25	69.44
Arson	12	20.69
Embezzlement	11	29.73
Theft of Motor Vehicle Parts or Accessories	9	3.90

Kidnapping/Abduction	5	5.81
Stolen Property Offenses	5	29.41
Animal Cruelty	4	13.79
Murder and Nonnegligent Manslaughter	3	37.50
Incest	3	15.79
Statutory Rape	3	14.29
Sodomy	2	6.90
Credit Card/Automated Teller Machine Fraud	2	0.80
Identity Theft	2	0.87
Pornography/Obscene Material	2	22.22
Sexual Assault With An Object	1	14.29
Pocket-picking	1	50.00
Purse-snatching	1	20.00
Theft From Coin-Operated Machine or Device	1	12.50
Operating/Promoting/Assisting Gambling	1	33.33
Peeping Tom	1	100.00

Notes: Data include all incidents from 2016 through 2019. The last column is the percentage of incidents with a given offense that involve at least one arrest. One incident can involve multiple offenses and multiple arrests. An arrestee only has one offense code associated with an arrest within an incident.

Table 66: Criminal activity for offenses involving drug/narcotic violations and drug equipment violations

Criminal activity type	Drug/narcotic violations	%	Drug equipment violations	%
Possessing/Concealing	758	75.35	799	87.61
Using/Consuming	106	10.54	91	9.98
Buying/Receiving	23	2.29	13	1.43
Operating/Promoting/Assisting	4	0.40	1	0.11

Notes: The table only includes drug/narcotic violations and drug equipment violations because these are the only drug-related crimes that require the criminal activity type to be reported. One offense can include more than one criminal activity type.

Table 67: Number of offenders by drug-related offense type

Offense	Offenders	Daily avg
Driving Under the Influence	1,322	0.90
Drug Equipment Violations	1,129	0.77
Drug/Narcotic Violations	1,296	0.89

Notes: An individual can have more than one of these offenses within an incident. Some offenders may be repeat offenders, but the data do not have the information to identify repeat offenders. The data are from 2016 - 2019.

Table 68: Offenders with at least one drug-related crime by gender

Gender	Offenders	% of drug-related offenders
Male	2,031	69.75
Female	881	30.25

Notes: The data include any offender with a DUI, drug/narcotic violation, or a drug equipment violation offense. An individual can have more than one of these offenses within an incident, but the individual is only counted once per incident. Some offenders may be repeat offenders, but the data do not have the information to identify repeat offenders. Gender columns may not add to 100% due to unknown gender.

Table 69: Offenders with at least one drug-related crime by age group

Age group	Offenders	% of drug-related offenders
10 to 17	257	8.83
18 to 19	182	6.25
20 to 29	957	32.86
30 to 39	754	25.89
40 to 49	395	13.56
50 to 59	268	9.20
60 to 69	87	2.99
70+	12	0.41

Notes: The data include any offender with a DUI, drug/narcotic violation, or a drug equipment violation offense. An individual can have more than one of these offenses within an incident, but the individual is only counted once per incident. Some offenders may be repeat offenders, but the data do not have the information to identify repeat offenders.

Table 70: Offenders with at least one drug-related crime by age group and gender

Age group	Offenders	% male	% female
10 to 17	257	66.93	33.07
18 to 19	182	73.63	26.37
20 to 29	957	69.07	30.93
30 to 39	754	70.29	29.71
40 to 49	395	67.34	32.66
50 to 59	268	73.51	26.49
60 to 69	87	71.26	28.74
70+	12	75.00	25.00

Notes: The data include any offender with a DUI, drug/narcotic violation, or a drug equipment violation offense. An individual can have more than one of these offenses within an incident, but the individual is only counted once per incident. Some offenders may be repeat offenders, but the data do not have the information to identify repeat offenders. Gender columns may not add to 100% due to unknown gender.

Table 71: Offenders with at least one drug-related crime by race

Race	Offenders	% of drug-related offenders
White	2,563	88.02
American Indian or Alaska Native	208	7.14
Black or African American	77	2.64
Unknown	34	1.17
Native Hawaiian or Other Pacific Islander	21	0.72
Asian	9	0.31

Notes: The data include any offender with a DUI, drug/narcotic violation, or a drug equipment violation offense. An individual can have more than one of these offenses within an incident, but the individual is only counted once per incident. Some offenders may be repeat offenders, but the data do not have the information to identify repeat offenders.

Table 72: Offenders with a DUI offense by gender

Gender	Offenders	% of DUI offenders
Male	931	70.42
Female	391	29.58

Notes: The data include any offender a drug/narcotic violation. Some offenders may be repeat offenders, but the data do not have the information to identify repeat offenders. Gender columns may not add to 100% due to unknown gender.

Table 73: Offenders with a DUI offense by age group

Age group	Offenders	% of DUI offenders
10 to 17	33	2.50
18 to 19	71	5.37
20 to 29	466	35.25
30 to 39	325	24.58
40 to 49	190	14.37
50 to 59	167	12.63
60 to 69	59	4.46
70+	11	0.83

Notes: The data include any offender with a DUI offense. Some offenders may be repeat offenders, but the data do not have the information to identify repeat offenders.

Table 74: Assault offenders by gender

Gender	Ag. assault offenders	%	Simple assault offenders	%
Female	206	25.28	619	27.68
Male	609	74.72	1,617	72.32

Table 75: Assault offenders by age group

Age group	Ag. assault offenders	%	Simple assault offenders	%
10 to 17	89	10.92	357	15.97
18 to 19	38	4.66	132	5.90
20 to 29	235	28.83	598	26.74
30 to 39	224	27.48	531	23.75
40 to 49	110	13.50	302	13.51
50 to 59	78	9.57	235	10.51
60 to 69	34	4.17	67	3.00
70+	7	0.86	14	0.63

Table 76: Assault offenders by race

Race	Ag. assault offenders	%	Simple assault offenders	%
White	691	84.79	1,901	85.02
American Indian or Alaska Native	74	9.08	208	9.30
Black or African American	23	2.82	71	3.18
Unknown	14	1.72	30	1.34
Native Hawaiian or Other Pacific Islander	8	0.98	20	0.89
Asian	5	0.61	6	0.27

Table 77: Victims of aggravated and simple assault by gender

Gender	Agg. assault victims	%	Simple assault victims	%
Female	400.00	41.67	1,333.00	57.23
Male	555.00	57.81	992.00	42.59
Unknown	5.00	0.52	4.00	0.17

Notes: An individual can be a victim of both aggravated and simple assault within the same incident. Some victims may be repeat victims, but the data do not have the information to identify repeat victims.

Table 78: Victims of aggravated and simple assault by age group

Age group	Agg. assault victims	%	Simple assault victims	%
0 to 9	159.00	16.56	50.00	2.15
10 to 17	128.00	13.33	243.00	10.43
18 to 19	36.00	3.75	106.00	4.55
20 to 29	207.00	21.56	644.00	27.65
30 to 39	193.00	20.10	566.00	24.30
40 to 49	123.00	12.81	355.00	15.24
50 to 59	74.00	7.71	242.00	10.39
60 to 69	35.00	3.65	94.00	4.04
70+	5.00	0.52	29.00	1.25

Notes: An individual can be a victim of both aggravated and simple assault within the same incident. Some victims may be repeat victims, but the data do not have the information to identify repeat victims.

Table 79: Aggravated and simple assault victims by gender of victim and gender of offender

Relation	Aggravated assault victims	% of aggravated assault victims	Simple assault victims	% of simple assault victims
Male victim with Male offender	404.00	42.08	667.00	28.64
Female victim with Male offender	304.00	31.67	988.00	42.42
Male victim with Female offender	151.00	15.73	334.00	14.34
Female victim with Female offender	108.00	11.25	354.00	15.20

Notes: A victim is counted once in each relation category, even if they had two or more offenders of the same gender. A victim is included in more than one category if they have multiple offenders of different genders. The percent columns are the percent of total victims of a given assault type.

Table 80: Simple assault offenses by victim's relationship to the offender

Relationship	Total victims	% male	% female
Victim Was Acquaintance	532	52.07	47.56
Victim Was Boyfriend/Girlfriend	525	21.52	78.48
Relationship Unknown	265	56.98	42.26
Victim was Otherwise Known	211	59.72	40.28
Victim Was Spouse	187	21.39	78.61
Victim Was Stranger	171	70.18	29.82
Victim Was Parent	142	23.94	76.06
Victim Was Sibling	91	49.45	50.55
Victim Was Child	58	39.66	60.34
Victim Was Offender	49	61.22	38.78
Victim Was Friend	43	46.51	53.49
Victim Was Other Family Member	39	48.72	51.28
Victim was Ex-Spouse	35	25.71	74.29
Victim Was Common-Law Spouse	31	16.13	83.87
Victim Was Child of Boyfriend or Girlfriend	20	45.00	55.00
Victim Was Stepchild	17	29.41	70.59
Victim Was Neighbor	13	30.77	69.23
Victim was Employee	12	41.67	58.33
Victim Was In-law	10	50.00	50.00
Victim Was Stepparent	9	44.44	55.56
Victim Was Grandparent	8	0.00	100.00
Homosexual Relationship	7	42.86	57.14
Victim Was Stepsibling	4	50.00	50.00
Victim Was Grandchild	1	100.00	0.00
Victim was Employer	1	0.00	100.00
Victim Was Babysittee	1	100.00	0.00

Notes: Data include offenses from 2016-2019. Simple assault is when someone suffers a bodily injury due to the intentional or reckless conduct of another. A victim can be included in more than one relationship category, particularly if there were two offenders in the incident. Some victims may be repeat victims, but the data do not have the information to identify repeat victims.

Table 81: 10 most common youth crime offenses (ages 10-17)

Offense type	Total	% male	% female
All Other Offenses	436	66.97	33.03
Simple Assault	357	63.87	36.13
Destruction/Damage/Vandalism of Property	263	74.90	25.10
Liquor Law Violations	255	58.82	41.18
Disorderly Conduct	201	79.10	20.90
Drug/Narcotic Violations	175	68.57	31.43
Shoplifting	167	46.71	53.29
Drug Equipment Violations	161	69.57	30.43
Fondling	141	86.52	13.48
All Other Larceny	127	61.42	37.80

Notes: Data are from offenders ages 10 to 17 in years 2016 through 2019. One offender can have multiple offenses within an incident. Percentages of male and female may not add to 100% due to sex sometimes being unknown.

EMS

Table 82: SU/MH EMS incidents by age group

Age group	Incidents	% of SU/MH incidents
0 to 9	75	2.00
10 to 17	674	17.60
18 to 19	98	2.60
20 to 29	432	11.30
30 to 39	432	11.30
40 to 49	394	10.30
50 to 59	517	13.50
60 to 69	518	13.50
70+	688	18.00

Notes: The data include any incident with a SUMH primary or secondary impression. The data are at the incident level, so the same individual may be included multiple times if they were involved in multiple incidents.

Table 83: SU/MH EMS incidents by age group with rates

Age group	Incidents	Incidents per 1,000 people
0 to 9	28	3.42
10 to 17	262	39.49
18 to 19	30	18.28
20 to 29	160	20.25
30 to 39	139	15.16
40 to 49	139	17.64
50 to 59	209	22.38
60 to 69	188	18.55
70+	237	27.71

Notes: The data include any EMS incident in 2019 with a SUMH primary or secondary impression. The data are at the incident level, so the same individual may be included multiple times if they were involved in multiple incidents. The incident rates are calculated with 2019 county population data by age group from SEER data. Column 3 equals column 2 multiplied by 1,000 divided by the population of that age group in the county.

Table 84: SU/MH EMS incidents by gender

Gender	Incidents	% of SU/MH incidents
Female	1,696	44.31
Male	1,958	51.15
Not Reported	174	4.55

Notes: The data include any incident with a SUMH primary or secondary impression. The data are at the incident level, so the same individual may be included multiple times if they were involved in multiple incidents.

Table 85: SU/MH EMS incidents in 2019 by gender with rates

Gender	Incidents	Incidents per 1,000 people
Female	627	17.88
Male	688	20.02
Not Reported	77	

Notes: The data include any EMS incident in 2019 with a SUMH primary or secondary impression. The data are at the incident level, so the same individual may be included multiple times if they were involved in multiple incidents. The incident rates are calculated with 2019 county population data by gender from SEER data. Column 3 equals column 2 multiplied by 1,000 divided by the population of that gender in the county.

Table 86: Number of pts with a SUMH incident by gender

Gender	Total patients	Patients with > 1 SU/MH incident	% of col. 2 with > 1
Male	1,765	118.00	6.69
Not Reported	168	1.00	0.60
Female	1,570	95.00	6.05

Notes: Data include any patient with a patient ID and a SUMH primary or secondary impression in an EMS incident between 2018 and 2020 where the scene or destination location is in Lewis and Clark County.

Table 87: Patients with a SU/MH incident by age group

Age group	Total patients	Patients with >1 SUMH incident	% of col. 2 with >1
0 to 9	72	2.00	2.78
10 to 17	658	16.00	2.43
18 to 19	95	2.00	2.11
20 to 29	398	25.00	6.28
30 to 39	397	27.00	6.80
40 to 49	361	23.00	6.37
50 to 59	427	41.00	9.60
60 to 69	463	41.00	8.86
70+	632	37.00	5.85

Notes: Data include any patient with a patient ID and a SUMH primary or secondary impression in an EMS incident between 2018 and 2020. Some individuals with more than one incident cross an age group threshold over the time period, but here each individual is only counted once. To do this, age is averaged across incidents within a patient ID that has multiple incidents. After rounding that average to the nearest whole number, that individual is included in the corresponding age group.

Table 88: EMS incidents with a substance-related primary impression by gender

Gender	N	%
Male	379	67.44
Female	156	27.76
Not Reported	27	4.80

Notes: The data are at the incident level, so the same individual may be included multiple times if they were involved in multiple incidents.

Table 89: EMS incidents with a substance-related primary impression by age group

Age group	N	%
0 to 9	6	1.07
10 to 17	16	2.85
18 to 19	15	2.67
20 to 29	77	13.70
30 to 39	85	15.12
40 to 49	84	14.95
50 to 59	144	25.62
60 to 69	80	14.23
70+	55	9.79

Notes: The data are at the incident level, so the same individual may be included multiple times if they were involved in multiple incidents.

Table 90: EMS incidents with alcohol/drug use indicators

Alcohol/drug use indicators	Incidents	% of incidents
No indicator	23,086	93.62
At least one indicator	1,572	6.38

Notes: An incident is included in "No indicator" if the variable was blank or indicated "Not Recorded" or "Not Applicable". The data include all EMS incidents from 2018-2020.

Table 91: EMS incidents with alcohol/drug use indicators that have SU/MH impressions

	Total incidents	With alcohol/drug use indicators	% of total
SUMH primary impression	3,081.00	590.00	19.15
Any SUMH impression	3,828.00	776.00	20.27

Notes: An incident is included if it has an alcohol or drug use indicator. Column 4 is the percent of SUMH incidents in the given category (primary or any) that have an alcohol/drug use indicator, which is Column 3 dividied by Column 2.

Table 92: EMS incidents with alcohol/drug use indicators

Alcohol/drug use indicators	Incidents	% of incidents with any alcohol/drug use indicator
Patient Admits to Alcohol Use	1,067	67.88
Smell of Alcohol on Breath	493	31.36
Patient Admits to Drug Use	332	21.12
Alcohol Containers/Paraphernalia at Scene	277	17.62
Drug Paraphernalia at Scene	83	5.28
Positive Level known from Law Enforcement or Hospital Record	66	4.20
Patient Admits to	1	0.06
Patient Admits to Al	1	0.06

Notes: An incident is included if it has an alcohol or drug use indicator. Some incidents have more than one alcohol or drug use indicator, which is why the last column sums to more than 100%.

Table 93: EMS incidents with anxiety-related primary impression (F41) by gender

Gender	Incidents	%
Female	341	57.21
Male	227	38.09
Not Reported	28	4.70

Notes:The data are at the incident level, so the same individual may be included multiple times if they were involved in multiple incidents. The data include any incident with an F41 primary impression.

Table 94: EMS incidents with anxiety-related primary impression (F41) by age group

Age group	Incidents	%
0 to 9	6	1.01
10 to 17	62	10.40
18 to 19	26	4.36
20 to 29	104	17.45
30 to 39	76	12.75
40 to 49	68	11.41
50 to 59	72	12.08
60 to 69	98	16.44
70+	84	14.09

Notes: The data are at the incident level, so the same individual may be included multiple times if they were involved in multiple incidents. The data include any incident with an F41 primary impression.

Table 95. SU/MH EMS incidents by disposition

Disposition	SU/MH incidents	%
Patient Treated, Transported by this EMS Unit	3,312	86.52
Patient Refused Evaluation/Care (Without Transport)	122	3.19
Patient Evaluated, No Treatment/Transport Required	96	2.51
Patient Treated, Released (per protocol)	81	2.12
Patient Treated, Transferred Care to Another EMS Unit	72	1.88
Patient Treated, Released (AMA)	60	1.57
Patient Treated, Transported by Law Enforcement	42	1.10
Assist, Agency	19	0.50
Patient Treated, Transported by Private Vehicle	11	0.29
Patient Dead at Scene-No Resuscitation Attempted (Without Transport)	7	0.18
Assist, Public	3	0.08
Patient Dead at Scene-No Resuscitation Attempted (With Transport)	2	0.05
Patient Dead at Scene-Resuscitation Attempted (Without Transport)	1	0.03

Notes: The data include any EMS incident from 2018 to 2020 with a SU/MH primary or secondary impression where the scene location or destination location is in Lewis and Clark County.

Table 96. Percent of SU/MH EMS incidents within a county that have a given disposition

Disposition	Missoula (%)	Ravalli (%)	Silver Bow (%)	Lewis and Clark (%)	Flathead (%)
Patient Treated, Transported by this EMS Unit	95.87	77.42	98.44	86.52	92.27
Patient Refused Evaluation/Care (Without Transport)	1.12	4.53	0.97	3.19	1.93
Patient Treated, Released (per protocol)	0.93	3.20	0.00	2.12	1.23
Patient Treated, Transferred Care to Another EMS Unit	0.58	3.36	0.00	1.88	0.47
Patient Evaluated, No Treatment/Transport Required	0.44	2.66	0.10	2.51	1.89
Patient Treated, Transported by Law Enforcement	0.44	0.70	0.10	1.10	0.37
Patient Treated, Released (AMA)	0.39	7.34	0.10	1.57	0.93
Patient Treated, Transported by Private Vehicle	0.08	0.23	0.00	0.29	0.40
Assist, Agency	0.03	0.08	0.00	0.50	0.07
Assist, Public	0.03	0.08	0.00	0.08	0.26
Canceled on Scene (No Patient Contact)	0.03	0.00	0.00	0.00	0.02
Patient Dead at Scene-No Resuscitation Attempted (Without Transport)	0.03	0.39	0.19	0.18	0.12
Canceled (Prior to Arrival At Scene)	0.02	0.00	0.00	0.00	0.00
Standby-Public Safety, Fire, or EMS Operational Support Provided	0.02	0.00	0.00	0.00	0.00
Patient Dead at Scene-No Resuscitation Attempted (With Transport)	0.00	0.00	0.00	0.05	0.00
Patient Dead at Scene-Resuscitation Attempted (Without Transport)	0.00	0.00	0.10	0.03	0.05

Notes: The data include any EMS incident from 2018 to 2020 with a SU/MH primary or secondary impression where the scene location or destination location is in the given county. One incident may be included in multiple counties if the scene is in one of the counties listed and the destination is in one of the other counties.

Table 97: SU/MH EMS incidents by complaint reported to dispatch (10 most common)

Complaint	Incidents	% of SU/MH incidents
Transfer/Interfacility/Palliative Care	1,039	27.14
Overdose/Poisoning/Ingestion	477	12.46
Psychiatric Problem/Abnormal Behavior/Suicide Attempt	466	12.17
No Other Appropriate Choice	321	8.39
Breathing Problem	238	6.22
Sick Person	204	5.33
Chest Pain (Non-Traumatic)	177	4.62
Falls	148	3.87
Convulsions/Seizure	131	3.42
Not Reported	104	2.72

Notes: The data include any incident with a SUMH primary or secondary impression. An incident can include up to 21 secondary impressions.

APPENDIX B: STABILIZATION TABLES

St. Peter's Behavioral Health Unit emergency department services

Table 98: St. Peter's behavioral health emergency department visits by gender

Gender	Visits	% of visits
Female	283	54.42
Male	237	45.58

Notes: The data include emergency department visits with a behavioral health-related diagnosis from 2018 to 2020.

Table 99: St. Peter's behavioral health emergency department visits by age group

Age group	Visits	% of visits	% female	% male
17 and under	79	15.19	58.23	41.77
18-19	27	5.19	55.56	44.44
20-29	98	18.85	44.90	55.10
30-39	100	19.23	49.00	51.00
40-49	75	14.42	53.33	46.67
50-59	75	14.42	68.00	32.00
60 and over	66	12.69	57.58	42.42

Notes: The data include emergency department visits with a behavioral health-related diagnosis from 2018 to 2020.

Table 100: St. Peter's behavioral health emergency department visits by race

Race	Visits	% of visits
Caucasian	462	88.85
Native American	36	6.92
Other	14	2.69
Black	4	0.77
Asian	3	0.58
Unknown	1	0.19

Notes: The data include emergency department visits with a behavioral health-related diagnosis from 2018 to 2020.

Table 101: St. Peter's behavioral health emergency department visits by primary diagnosis (five most common)

Dx code	Diagnosis	Visits	% of behavioral health visits
F39	Unspecified mood [affective] disorder	196	37.69
F29	Unspecified psychosis not due to a substance or known physiological condition	91	17.50
R45.851	Suicidal ideations	45	8.65
F22	Delusional disorders	43	8.27
F23	Brief psychotic disorder	23	4.42

Notes: The data include emergency department visits with a behavioral health-related primary diagnosis from 2018 to 2020.

Table 102: St. Peter's behavioral health emergency department visits by mode of arrival

Mode of arrival	Visits	% of behavioral health visits
Ambulatory	379	72.88
Law Enforcement	83	15.96
EMS/Stretcher	28	5.38
EMS/Ambulatory	13	2.50
Wheelchair	7	1.35
Unknown	6	1.15
ED Stretcher	2	0.38
Carried	1	0.19
EMS/Wheelchair	1	0.19

Notes: The data include emergency department visits with a behavioral health-related diagnosis from 2018 to 2020.

Table 103 St. Peter's behavioral health emergency department visits by disposition

Disposition	Visits	% of visits
Home	249	47.88
St. Peter's Behavioral Health Inpatient	106	20.38
Journey Home	60	11.54
St Peters Health	44	8.46
Mt State Hospital Warm Springs	20	3.85
Against Medical Advice	15	2.88
Court/Law	9	1.73
Psychiatric Facilities Not Listed	6	1.15
Shodair Hospital	6	1.15
St. Peter's Health Outpatient Services Per Plan	1	0.19
Other Facility	1	0.19
Benefis Psychiatric Care	1	0.19
VA Hospital	1	0.19
Eloped	1	0.19

Notes: The data include emergency department visits with a behavioral health-related diagnosis from 2018 to 2020.

St. Peter's Behavioral Health Unit inpatient services

Table 104: St. Peter's behavioral health inpatient admissions by gender

Gender	Admissions	% of admissions
Female	579	53.46
Male	504	46.54

Notes: The data include admissions to the behavioral health inpatient unit from 2018 to 2020.

Table 105: St. Peter's behavioral health inpatient admissions by age group

Age group	Admissions	% of admissions	% female	% male
<20	19	3.65	68.42	31.58
20-29	201	38.65	48.76	51.24
30-39	208	40.00	53.85	46.15
40-49	176	33.85	50.00	50.00
50-59	196	37.69	65.31	34.69
60+	283	54.42	49.47	50.53

Notes: The data include admissions to the behavioral health inpatient unit from 2018 to 2020.

Table 106: St. Peter's behavioral health inpatient admissions by race

Race	Admissions	% of admissions
Caucasian	1,011	93.35
Native American/Alaska Native	32	2.95
Unknown	13	1.20
Other	12	1.11
African American	8	0.74
Asian	7	0.65

Notes: The data include admissions to the behavioral health inpatient unit from 2018 to 2020.

Table 107: St. Peter's behavioral health inpatient annual charges, 2018-2020

Year	Dollars
2018	4,752,860.38
2019	5,046,997.23
2020	5,957,192.93

Notes: The data include admissions to the behavioral health inpatient unit from 2018 to 2020.

Table 108: St. Peter's behavioral health inpatient admissions by admission/referral source

Referral source	Admissions	% of admissions
Physician Referral	840	77.56
Court/Law Enforcement	107	9.88
Transfer Ip To Bhu Or Bhu-Ip	72	6.65
Transfer From Acute Care Hosp	43	3.97
Transfer From Nursing Home	20	1.85
Transfer From Another Hc Fac	1	0.09

Notes: The data include admissions to the behavioral health inpatient unit from 2018 to 2020.

Table 109: St. Peter's behavioral health inpatient admissions by disposition

Disposition	Admissions	% of admissions
Home	821	75.81
Against Medical Advice	97	8.96
Mt State Hospital Warm Sprs	32	2.95
Assisted Living Facility	30	2.77
Snf Other Facility	20	1.85
Court/Law	14	1.29
St Peters Health	13	1.20
Chem Other	10	0.92
Snf Big Sky Care Center	6	0.55
Snf Elkhorn Care Center	6	0.55
Snf Cooney Nursing Home	6	0.55
Home Health Svc Other	4	0.37
Mt Chem Dependency Center	4	0.37
Snf Rocky Mtn Care Center	3	0.28
Psy Facilities Not Listed	2	0.18
Hospital Not Listed Here	2	0.18
Icf Trans Elkhorn Care Cent	2	0.18
Chemical Other	1	0.09
Corrections	1	0.09
Journey Home	1	0.09
Hospice Home	1	0.09
Sph Outpt Svcs Per Dc Plan	1	0.09
Hospice Medical Facility	1	0.09
Rehab Lewis and Clark Community	1	0.09
Va Hospital	1	0.09
Snf Broadwater Nursing Home	1	0.09
Null	1	0.09
Rehab Units Other Facility	1	0.09

Notes: The data include admissions to the behavioral health inpatient unit from 2018 to 2020.

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