****ATTENTION****

The City Council meeting will be held in a hybrid format that may include both in-person AND virtual attendance via Zoom. Unless they have cause to appear virtually, Councilmembers will attend the meeting in person in Council Chambers, second floor of City Hall, 220 N. 27th Street. In order to honor the Right of Participation and the Right to Know in Article II, Sections 8 and 9, of the Montana Constitution, the City of Billings and City Council are making every effort to meet the requirements of the open meeting laws.

Citizens are invited to:

- Review the Agenda Packet on the City's website at: www.billingsmt.gov and click on "Your Government," "City Council," and "Agendas & Minutes".
- View the meeting:
  - On Community 7 TV - Channel 7 or Channel 507 -- Spectrum Cable. *(On evenings when there is a conflict with School District No. 2 Board meetings, the City Council meeting will be broadcast on Channel 8 - Spectrum Cable.)*
  - Online at www.comm7tv.com and click on the "Watch Live" icon. Community 7 also has links to their Facebook page and YouTube channel.
  - On the City's website at www.billingsmt.gov and click on "Watch Meetings Online" on the homepage.
  - In-Person.
  - Virtually via Zoom (see the link below).

Citizens may submit public comment via the following methods:

- Mail: City Clerk, P.O. Box 1178, Billings, MT 59103
- Email: Council@billingsmt.gov.
  - Emails received after 3:00 PM on the day of the meeting, may be posted on the Council's webpage the following day for public viewing.
- Attend the meeting in person.
- Attend the meeting virtually through Zoom by entering the Webinar ID and Passcode indicated below. Click on *Zoom Meeting Instructions* and *Zoom Hybrid Meeting Details* below for more information. The link will allow you to attend, view and participate in the meeting on your computer, laptop or smart phone. (You must have the Zoom App on your device Click Here to Download Zoom App) To provide public comment at the appropriate time, click on the "raise hand" icon located at the bottom of the screen and the moderator will unmute your device.
  - **Don't have a smart phone, computer or laptop?** That's okay -- you can attend a Zoom meeting using your **landline phone.** Call the Zoom phone number, **1.253.215.8782** to join the meeting and follow the operator's instructions. Want to give public comment? Simply *"raise your hand"* by pressing *9 and the moderator will give you permission to speak when it is your turn. **Note this is a long distance toll number and charges may apply depending on your plan.*
- Click Here for Zoom Meeting IDs and Passcodes
- Click Here for Zoom Meeting Instructions for Attendees (as guests)

Please contact Denise Bohlman, City Clerk, at bohlmand@billingsmt.gov, or at 406.657.8210, with any questions.

CITY OF Billings

VISION STATEMENT:
"The Magic City: A diverse, welcoming community where people prosper and business succeeds."

WORK SESSION AGENDA

COUNCIL CHAMBERS | SEPTEMBER 6, 2022 | 5:30 P.M.

CALL TO ORDER: Mayor Cole

PUBLIC COMMENT. This is the time to comment on any matter falling within the scope of the Billings City Council. There will also be time in conjunction with each agenda item for public comment relating to that item. You may only speak once for each item.

Please note, the City Council cannot take action on any item which does not appear on the agenda. Comments are limited to three (3) minutes or as set by the Mayor. **Speaker sign-in required.** Please sign the roster at the cart located at the back of the Council chambers or at the podium.

1. **Department of Homeland Security.**

   (Presented by: Jason Lyon, Battalion Chief)
   -Public Comment

2. **Community Health Needs Assessment Update.**

   (Presented by: Chris Kukulski, City Administrator and Eden Sowards, Riverstone Health, Community Health Improvement Manager)
   -Public Comment

3. **Allocation of 2 Mills and Local Option Marijuana Revenues.**

   - Crisis Response RFP update
   - Low Barrier Shelter options
   - Crime Prevention -- Nurse Family Partnership introduction and recommendation

   (Presented by: Chris Kukulski, City Administrator and Eric Owen, Riverstone Health, Vice President of Public Health Services)
   -Public Comment

4. **Highlight Upcoming Agenda Items of Council Interest.**

   (Presented by: Chris Kukulski, City Administrator)
   -Public Comment

COUNCIL DISCUSSION:

PUBLIC COMMENT on "NON-AGENDA ITEMS". Speaker Sign-in required. (*Restricted to ONLY items not on this printed agenda. Comments are limited to 3 minutes or as set by the Mayor. Please sign the roster at the cart located at the back of the Council chambers or at the podium.)*

ADJOURN:

Note:

- This meeting is an "informal" meeting of the City Council. The content of the Agenda is subject to change at the meeting.
- In the event there is a Closed Executive Session at the end of a Work Session, the sole purpose is to discuss litigation strategy. The other parties to the case(s) discussed are not public bodies or associations as described in Section 2-3-203(1) and (2), MCA. The meeting is closed, as allowed by Section 2-3-203(4)(a), MCA, "to discuss a strategy to be followed with respect to litigation when an open meeting would have a detrimental effect on the litigating position" of the City of Billings.

City Council Work Session

Date:	09/06/2022
Title:	FIRE: U.S. DOD / Israeli Ministry of Defense Joint Hazmat Training - BC Jason Lyon
Presented by:	Pepper Valdez, Fire Chief
Department:	Fire
Presentation:	No
Legal Review	No

RECOMMENDATION

Staff recommendation is to approve the travel request by Jason Lyon, Battalion Chief/Hazmat Coordinator to attend the U.S. Department of Defense/Israeli Ministry of Defense test and training in Israel September 29 - October 6, 2022. Council must approve any travel outside the continental United States.

BACKGROUND (Consistency with Adopted Plans and Policies, if applicable)

Battalion Chief Jason Lyon, the Billings Fire Department's Hazmat Team Leader, has been solicited by the U.S. Department of Defense's Irregular Warfare Technical Support Directorate to be one of six first responders in the United States to travel to Israel.

This test will involve the actual detonation of a live radiological dispersion device (dirty bomb). This test aims to validate FEMA guidance to first responders on how to best respond to an incident involving radiological materials. All six Montana Regional Hazmat Team members, led by Chief Lyon, recently received instruction in these tactics. Chief Lyon was then asked to support the validation mission. Additionally, Battalion Chief Lyon will evaluate how this guidance may improve response to chemical releases similar to the recent ammonia leak here in Billings.

This once-in-a-lifetime opportunity allows the Billings Fire Department to impact national planning scenarios, a field mostly dominated by large metropolitan fire departments, by representing the interests of medium-sized urban centers. It also gives the Billings Fire Department a subject matter expert in the field who continues to train other first responders in our state successfully.

Finally, being invited to participate in this elite training is a testament to the professionalism of the Billings Fire Department and its Regional Hazmat Team.

STAKEHOLDERS

Chief Lyon has secured over 1.3 Million dollars in grant money for the Montana Regional Hazmat Teams. These funds have led to implementing a statewide hazmat-medic program, three trainings and exercises at federal training facilities, and new, state-of-the-art hazmat and rescue equipment.

Jason is also the Secretary of the Montana State Hazmat Advisory Group, which advises the State Emergency Response Committee and the Governor on hazmat/WMD incidents. Additionally, in 2018, Chief Lyon organized a whole-of-community, FEMA-led training on active shooter/high threat incidents. This program reinforced the Billings Police Department/Fire Department Rescue Task Force program.

ALTERNATIVES

City Council may: Approve; or, Not Approve this travel.

FISCAL EFFECTS

All participants in this program are expected to fund their travel. The estimated cost is $5,500, including airfare, lodging, rental car, and per diem. Grant Funds previously awarded through the State of Montana in the Regional Hazmat Team budget will be used for these expenses.

This travel will not affect the current Fire Department budget. Costs associate with this will be provided by HazMat Team training funds.

Attachments

Chief Lyon letter of support

FIRE DEPARTMENT CITY OF NEW YORK
Hazardous Materials Operations
FDNY Training Academy
Building No. 8
Randall's Island, New York 10035

To: Whom It May Concern

From: Timothy Rice Battalion Chief WMD Coordinator

Date: August 8, 2022

Subject: **Green Day Testing 2022**

I am writing on behalf of Battalion Chief Jason Lyon. Chief Lyon and I have been colleagues and peers for several years. He, along with five other hazmat response leaders from the first responder community have been invited to participate in the Green Day testing this fall. This series is funded in part by the Counterterrorism Technical Support Office (CTTSO), the Department of Energy as well international partners from Israel and Canada.

Having been involved in a number of unique projects opportunities during my tenure, none has been more impactful and realistic than the radiological dispersal device test series. The radiological competency for hazmat personnel in my opinion is the most challenging to maintain and improve. Decades of research, tests, and procedures for response to radiological incidents were taken to task in 2018 and again in 2019. In 2018, my role was to provide a responder perspective to what was until that time theoretical emergency response procedures. The following year in 2019, I participated again with the condition I expand this knowledge and opportunity to a larger cross-section of the emergency response community. To meet that objective, we invited five other hazmat experts and responders from around the country. This is the next iteration of that test series. Chief Lyon is an ideal candidate given his role in Billings, the region, and the state of Montana. He demonstrates the strategic perspective required for incidents of this nature.

Experiments and training of this type are typically inaccessible to personnel who would be first on scene. All emergencies start locally, and just as importantly, end locally. No amount of classroom or simulated training can provide the level of practical experience that this test series provides. While large urban areas and agencies may have the resources at their disposal to pursue planning guidance for a large-scale radiological accident, emergency, or intentional act, it is virtually impossible to demonstrate real competency or proliferate the concepts nationally across the First Responder community. This unique opportunity and partnership has exponentially increased the ability to disseminate best practices by some of the nation's HazMat community leadership. I strongly encourage you to consider Chief Lyon for participation.

Respectfully,
BC Timothy Rice, FDNY
WMD Coordinator
Timothy.rice@fdny.nyc.gov
347-203-7125

City Council Work Session

Date:	09/06/2022
Title:	Community Health Needs Assessment Update
Presented by:	Chris Kukulski, City Administrator
Department:	City Hall Administration
Presentation:	Yes
Legal Review	Not Applicable

RECOMMENDATION

RiverStone Health representatives will be presenting an update to Council on the Community Health Needs Assessment. No action is needed.

BACKGROUND (Consistency with Adopted Plans and Policies, if applicable)

See the attached presentation on the Community Health Needs Assessment

STAKEHOLDERS

NA

ALTERNATIVES

City Council may:

- Approve; or,
- Not Approve

FISCAL EFFECTS

NA

SUMMARY

NA

Attachments

Community Health Needs Assessment

2022 - 2023
Community Health Needs Assessment (CHNA)

September 6, 2022

healthy by design

We acknowledge that this discussion is taking place on the land of tribal nations whose time in the area ranged from over tens of thousands years to hundreds of years. These tribes included the Assiniboine (Nakoda), Blackfeet (Amskapi Pikuni), Northern Cheyenne (Tsetsêhesêstâhase/So'taahe), Crow (Apsaalooke), Gros Ventre (A'aninin), and Sioux (Dakota/Lakota).

We recognize their connection to this region and give thanks for the opportunity to provide public health services on their traditional homeland.

Very Brief Community Health Needs Assessment Overview

History of Collaboration

- **Community Health Needs Assessments (CHNA)**
- Healthy By Design Coalition
- Shared Community Health Improvement Plan (CHIP)
- Chronic Pain Task Force
- Community Crisis Center
- Community Flu Shot Challenge
- Cover the Uninsured Week
- Health Communications Team
- Health Insurance Marketplace Outreach & Enrollment
- Legislative Advocacy
- Medication Assistance Programs
- Unified Health Command
- Montana Family Medicine Residency (MFMR)

Billings Clinic

RiverStone Health

SCL Health ST. VINCENT
Now Intermountain Healthcare

Billings Clinic

RiverStone Health

SCL Health
ST. VINCENT
Now Intermountain Healthcare

Billings
PLANNING
& COMMUNITY
SERVICES

The Rehabilitation
Hospital of Montana
In Partnership with
Billings Clinic & St. Vincent Healthcare

Shared County Community Health Needs Assessment (CHNA)

↓

Shared County Community Health Improvement Plan (CHIP)

↓

healthy by design

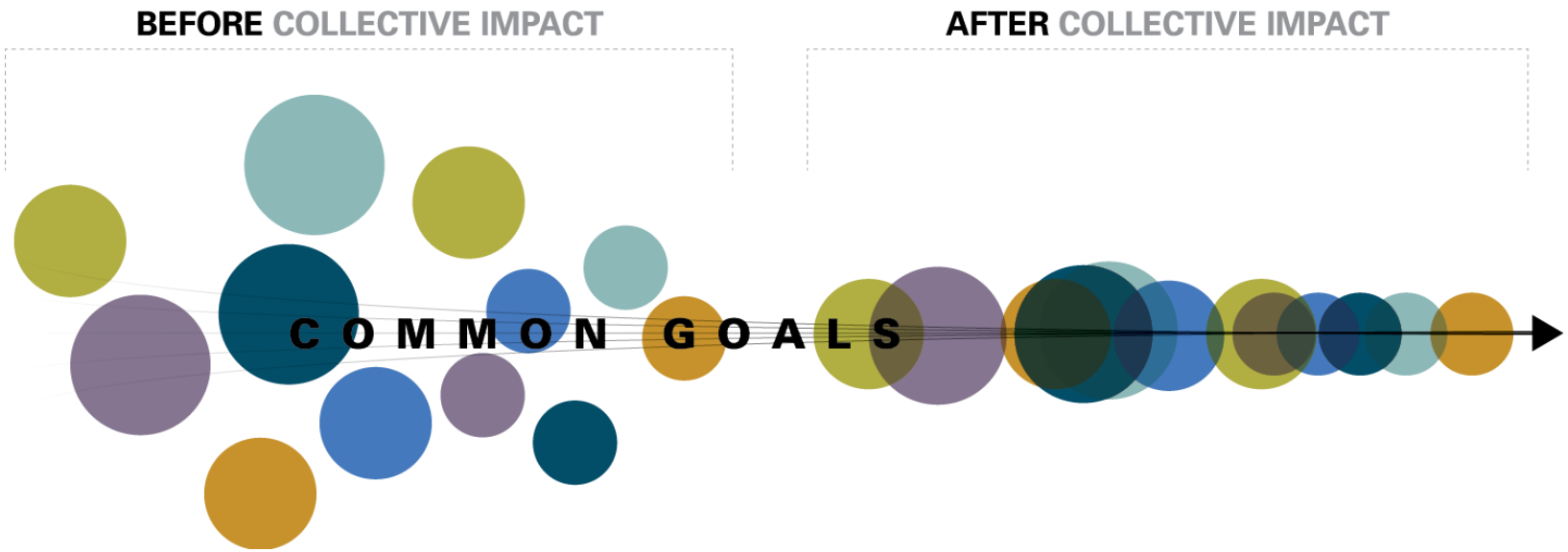
Focus: Innovative *policy, systems, and built environment* opportunities

Why complete an assessment?

- Provides **comprehensive** information about the community's **current** health status, needs, and issues
- Opportunity to **engage broader community** in assessing and addressing community health
- Justifies how and where **resources** should be allocated to best meet community needs
- Supports the development of a **coordinated** community health improvement plan

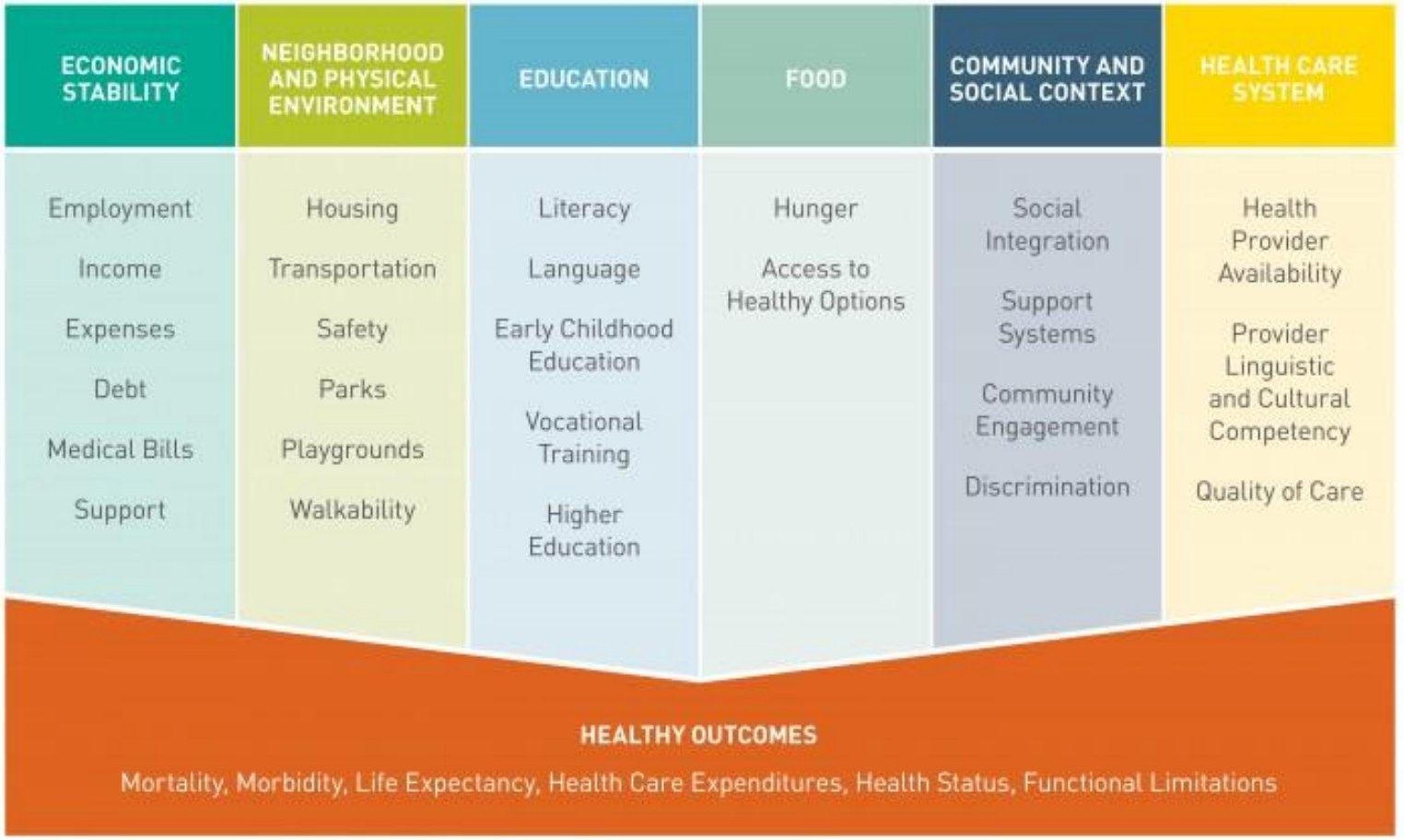
healthy by design

Leveraging our Collective Impact



healthy by design

What contributes to overall health?



Source: Kaiser Permanente, 2018.

healthy by design

healthy by design

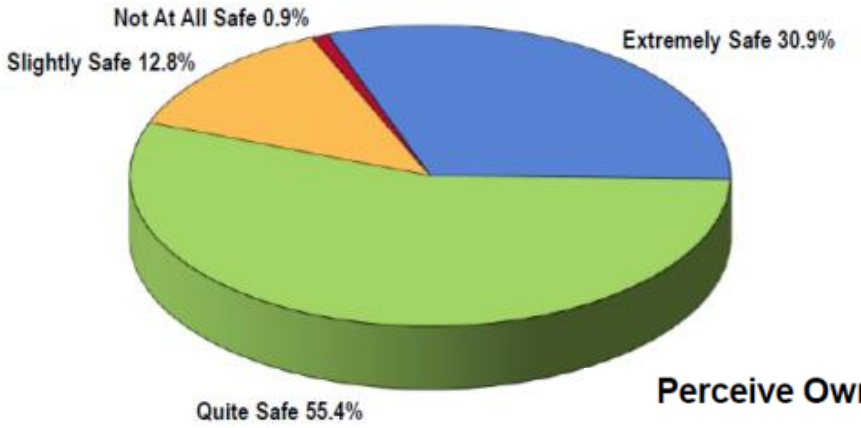
Community Informed

- CHNA Work Team
- CHNA Advisory Committee
- Population Survey Respondents
- Key Informant Survey Respondents
- Forum Attendees
- Resilient Yellowstone project partners

healthy by design

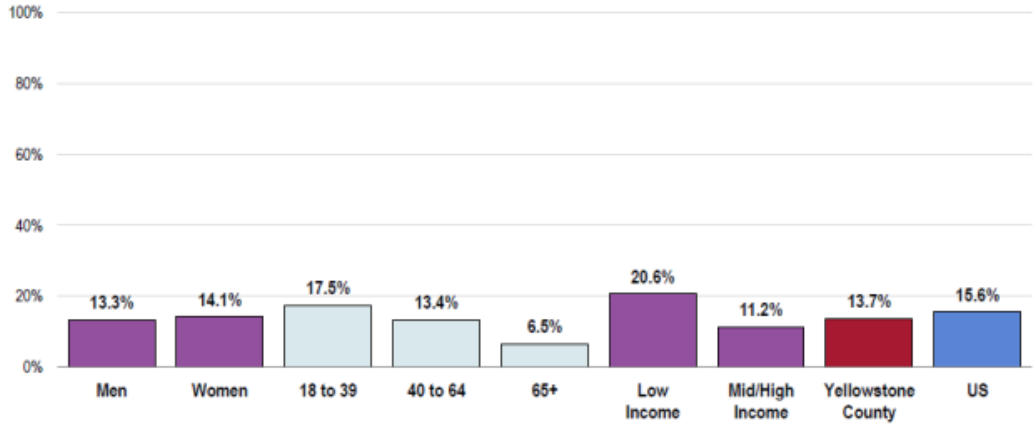
Areas of focus- Stay tuned for 2022/2023 data

Perceived Safety of Own Neighborhood
(Yellowstone County, 2020)



Sources: • 2020 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: • Asked of all respondents.

Perceive Own Neighborhood as "Slightly" or "Not At All" Safe
(Yellowstone County, 2020)



Sources: • 2020 PRC Community Health Survey, PRC, Inc. [Item 303]
• 2017 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Areas of focus- Stay tunes for 2022/2023 data

New Questions added this cycle:

- Since the beginning of the pandemic, would you say your mental or physical health has..
- Has there been a time since the start of the pandemic when you needed medical care or had a medical appointment scheduled, but you chose to avoid receiving care due to concerns about coronavirus?
- I am confident in my ability to manage stress and work through life's difficulties.
- I feel that my community is a welcoming place for people of all races and ethnicities.
- Other questions related to perceived discrimination

Coming Up- Community Forum!

- Join us!
  - When: Friday, November 18th (Lunch, exact time TBD)
  - Where: Billings Hotel and Convention Center
  - What: PRC data presentation, lunch, discussion, prioritization from attendees

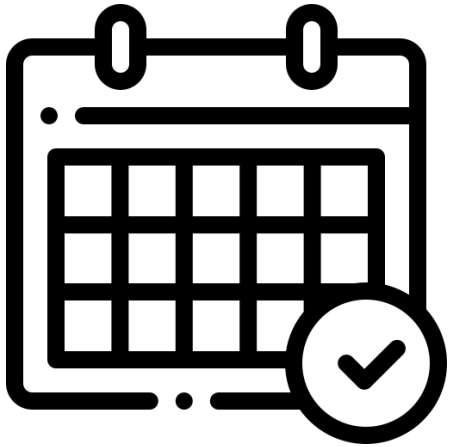


Image by Freepik at flaticon.com

Thank you!

Website: www.hbdyc.org

Facebook: @HBDYellowstone

Contact:

Eden Sowards, CHES

eden@hbdyc.org 247.3223

Community Health Improvement Manager

City Council Work Session

Date:	09/06/2022
Title:	Discussion of Allocation of 2 mills and local option marijuana revenues
Presented by:	Chris Kukulski, City Administrator
Department:	City Hall Administration
Presentation:	Yes
Legal Review	Not Applicable

RECOMMENDATION

Listen to and engage in a dialogue with staff, presenters and agencies making public comment to provide direction to the city administrator on next steps. I will provide a brief update and introduction and will be followed by a presentation on Nurse-Family Partnership (NFP) by RiverStone Health. Additionally, representatives from School District 2 (SD2), Continuum of Care (CoC), Montana Rescue Mission (MRM) and Substance Abuse Connect (SAC) will be present to make public comment and answer questions.

BACKGROUND (Consistency with Adopted Plans and Policies, if applicable)

Improving the safety of Billings remains the city's #1 priority. Our September 6 work session conversations will focus on crime prevention. When discussing the 2021 PSML (public safety mill levy) we included two additional mills to invest in mental health and substance abuse. The conversations where broad, consistently including, what causes crime and crime prevention. Many in the community insisted we invest some PSML dollars into crime prevention since it is well understood that millions are spent annually dealing with the consequences of crime.

The following strategies to reduce crime were presented throughout 2020 and 2021:

1. Collaboration with Federal, State and County officials.
2. Improve safety of neighborhoods and crime prevention, building stronger community relationships, efficient code enforcement and proactive law enforcement.
3. Invest in mental health and substance abuse through our partnership with Substance Abuse Connect.
4. Hold criminals accountable and help break the cycle of crime and abuse.
5. Help victims recover from the trauma of crime.
6. Efficiently respond to emergency calls for aid from our Fire Department.

Stated more broadly, nearly every PSML presentation included a commitment to reduce violent crime, improve downtown safety, improve traffic safety, and support mental health, substance abuse and prevention partners.

Improving the safety of a city of 120,000 is extremely complex. The city's crime rates have steadily increased over the past decade. In 2019, 2020 and 2021, Billings experienced 2,123 aggravated assaults (116 FMA strangulations 2021 alone), 36 homicides, 319 sexual assaults and 388 robberies. Each crime impacts a victim, their family, and friends. These individuals, the occurrences of domestic violence and prevalence of drugs are subjecting many of our children to an epidemic of trauma. Trauma ignored, results in way too many children witnessing and then repeating cycles of violence later in life.

Data throughout the country provides strong evidence that most of today's criminals are coming from homes where the parents had trauma. Arguably the greatest injustice is that their children are too often destined to enter the criminal justice system if we don't make significant investments into preventing and addressing childhood trauma. Therefore, I have been focusing my attention on learning about strategies and programs that break this cycle. The Deepest Well by Nadine Burke Harris, MD and Hope Rising by Casey Gwinn, JD & Chan Hellman, PHD are resources I used and recommend gaining important knowledge on the impacts of childhood trauma. By no means is this exhaustive, but they are research based and extremely informative for those of us who don't regularly work in this area.

It was excited to learn that one of the most respected, heavily analyzed, and effective programs, strongly supported by the US Justice Department, is operating out of Riverstone Health. However, the programs capacity is nowhere close to meeting the growing need for such a service. This evidence-based program is Nurse Family Partnership (NFP).

RiverStone will be presenting their NFP program to the Council and sharing its findings. Over the last 10 years, NFP has served more than 400 Yellowstone County families. This voluntary program with home visits from RiverStone Health nurses has improved the lives of pregnant women, new moms and dads, and their babies. Among participants, smoking decreased 25%, alcohol use dropped 56%, reports of domestic violence dropped 63% and the number of mothers who were back in the workforce 12 weeks after delivery increased 31%. (see attachments)

Additionally, community data indicates that we have ~360 births annually, to moms who had inadequate prenatal care. This data along with the skyrocketing levels of foster care indicate childhood trauma is becoming all too common. NFP's critically important standards, require nurses' caseloads remain under 30. Therefore, the current program needs to grow from serving 62 families with 2.5 nurses to between 12 -- 15 nurses building trusting life changing relationships with several hundred Billings families annually. The great news is we are helping 62 families break this cycle. Unfortunately, to lower crime across our city we need to significantly increase the number of families who have access to this effective program.

I recommend the city set aside a minimum of $200,000 year one and $300,000 for years two and three. For the program to meet our community's need we will need to partner with other agencies. School District 2 (SD2) is also considering providing financial support. The goal is to allow every expecting mother in Billings to participate in NFP. Why, the hard data in this programs history over the past 40 years throughout the US and for its shorter history in Montana show an $8 to $1 return of investment (ROI). This ROI is primarily connected to the high numbers of NFP families who stay out of the criminal justice system, achieve educational goals, and remain in the workforce (several reports have been provided to the council on the impacts of NFP over the past few months).

I recommend the Council consider committing all revenue generated from the marijuana local option tax to crime prevention. In addition to NFP, I will be looking to our community stakeholder to help make recommendations on other evidence-based prevention programs.

In addition to prevention, we will also discuss the fiscal year 2023 budget adoption amendment that passed:

1) As recommended by staff, the FY23 budget should reflect the assessment of the 2 mills from the Public Safety Mill Levy. The revenue generated from those mills, plus $400k of the anticipated cannabis tax revenues should be placed in an accounting fund explicitly designated for improving public safety and reducing crime in our community through programs addressing substance abuse, mental and behavioral health, housing essential to public safety, and related support services.

Per the adopted budget, $864,952 dollars are anticipated (2 mills = $432,452 + 3% marijuana local option tax $432,500) and will be placed in a fund to improve public safety and reduce crime in our community through programs addressing substance abuse, mental and behavioral health, housing essential to public safety, and related support services. Additionally, the city collected $83,000 from last fiscal year's local option marijuana tax.

2) The City Administrator should designate a staff member, or contract with an external resource using the funds allocated in item #1, whose role it will be to engage with service agencies working on the issues of mental and behavioral health, housing security and homelessness, and related public safety issues in our community and to advance solutions through public-private partnerships.

I have not signed a contract or designated a staff member to guide our decisioning yet. I have been working in this area to learn enough to make more informed decisions and recommendations. I also believe the scope of work for these responsibilities will be significantly impacted by decisions Substance Abuse Connect (SAB) is making over the next several months. The Executive Committee of SAB, of which I am a member, is in the process of determining the structure of SAB moving forward. Additionally, the board will also hire a new executive director since Kristin Lundgren has accepted another position. Rimrock, has also asked to step away from providing "backbone" services to SAB since their staff support is being incorrectly perceived as controlling SAB. Both United Way and Riverstone are being considered as a better fit to provide administrative and financial services. I am also learning from our criminal justice professionals of the impacts of a Family Justice Center. Once these decisions are made, I will decide how the city should move forward in this area. Please understand that I see and agree with the sense of urgency to solve these problems, but I also want to make sure we don't lock into long term contracts or hire additional staff before we have fully committed to our path forward.

3) The City Administrator should solicit input or proposals from agencies or firms that desire to provide behavioral health co-responder services for the Crisis Response Units beginning in FY23. Input should include, but not be limited to, costs, implementation plan, and success metrics. Responders should operate under the assumption that City funding will include at least the EMT/paramedic resources required as part of a best-practice solution.

The RFP is now complete. Proposals will be due in mid-October. We anticipate needing to invest between $250,000 and $350,000 to implement and operate a CRU (crisis response unit) in the first year. However, if we find the right partner and if the state and federal government support crisis response through eligible reimbursable expenses, the net cost to the city should go down. Mobile crisis response, is quickly being recognized as a best practice for effectively and more efficiently meeting the needs of citizens in crisis while lowering costs and risks to first responders. Once the proposals are reviewed, a staff recommendation will be made for Council's consideration.

4) The City Administrator should solicit input or proposals from agencies or firms that desire to provide seasonal low-

barrier shelter and/or sobering center services for all or part of the period from October 1, 2022 through March 31, 2023. Input should include, but not be limited to, location, costs, implementation plan, and success metrics. Case management services would ideally be included as a factor of success for the program.

The city has not issued an RFP. We have received written proposals from CoC (Continuum of Care) and MRM (Montana Rescue Mission). I have also spoken to OtS (Off the Streets). OtS supports the CoC 6-month shelter option for this winter, while they work towards a long-term low barrier shelter. (see attachments from CoC and MRM)

The final CoC project budget was included in a Progress Update that Kari Boiter sent to the Mayor, City Council, and city on July 30th. The total for both program components is $410,000. This includes seasonal sheltering and case management services. The year-round Care Coordination component (aka case management) would be designed to augment the CoC's Coordinated Entry System (CES), which is presently utilized by 17 service providers in our community.

MRM's proposal is also attached. The following is abbreviated:

Proposed Budget: Addressing Public Safety Community Needs Through Emergency Sheltering Services

Category	**Annual Cost**
Staffing:	$373,300
Sheltering:	$ 60,000
Data/Adm in/Overhead:	$ 76,700
Total Annual Budget/ Request	$510,000

Terms and Conditions:

- 24 Month Contract.
- Payable in quarterly installments, net 30 days from invoice.
- We will operate our emergency shelter 365 days per year.
- We will accept those who are not a danger to themselves or others.
- We will accept qualifying referrals from Law Enforcement, Mobile Crisis Team, and Crisis Center, as well as walk ins.
- We will file quarterly reports with numbers served, numbers moved to our regular shelter, number of law enforcement, crisis center or mobile crisis unit referrals/hand offs as well as walk ins.
- We will meet with the City Administrator to deliver this data and provide quarterly updates.

5) The City Administrator should provide regular progress updates and the results of #2 and #3 above to Council with all due haste, especially prioritizing #2 as seasonal low-barrier shelter services will be required in just over 3 months.

Candidly, this timeline has been difficult to adhere to while assessing how best to invest this new fund designated for improving public safety and reducing crime in our community through programs addressing substance abuse, mental and behavioral health, housing essential to public safety, and related support services. When you consider the CRU and the proposals from CoC and MRM, nearly all of the funds will be allocated. This leaves no meaningful investment into prevention.

As I gain knowledge in this area, I'm becoming more convinced that to make a meaningful and lasting impact on our community, most, if not all new dollars should be invested into proven, evidence-based prevention programs. Particularly, programs that are not or cannot be provided by our for profit, non-profit and or faith-based partners. We expect to be held fully accountable for how all public dollars are spent and I am not willing to recommend spending $410k or $521k annually for sheltering and related services without better understanding our most impactful and probable options. I realize this is frustrating for our partners, particularly at the CoC but this is new territory for the city, and we have yet to collect $1 dollar from the 2021 PSML. Somewhere, somebody once said "patience is the key to success and the companion of wisdom."

I expect to have a productive and educational dialogue between all of us. I know that several partners of SAC and CoC will be in attendance. They will be making public comments, and all are willing to share there perspective and expertise to address this extremely complex issue as a community.

STAKEHOLDERS

These challenges can only be overcome by working collaboratively with our community. No-one within our community is immune from the effects of crime, addiction and trauma. Implementing plans and strategies developed by our

stakeholders in SAC and CoC along with all those who work in the criminal justice system, crime and addiction prevention, intervention and treatment all contribute to long term solutions.

ALTERNATIVES

N/A

FISCAL EFFECTS

Per the adopted budget, $864,952 dollars are anticipated (2 mills = $432,452 + 3% marijuana local option tax $432,500) and will be placed in a fund to improve public safety and reduce crime in our community through programs addressing substance abuse, mental and behavioral health, housing essential to public safety, and related support services. Additionally, the city collected $83,000 from last fiscal year's local option marijuana tax.

Difficult decisions will need to be made sense there is not enough revenue to meet this growing need and problem. This is one of the reasons that partnerships are so critical. It is also important that we remain engaged with our state and federal partners to ensure appropriate reimbursements are available to the City and our partners who are providing medical services.

As a reminder - The Council appropriated $200,000 in last years budget to help the YWCA build their new facility for victims of domestic violence. Reducing domestic violence and breaking the cycle of DV must be one of our critical strategies. When you research DV, (Hope Rising Chapter 13) you will learn that men who strangle women have a strong propensity to commit homicide of their partners and police officers.

SUMMARY

Background information is being shared with the council and public to provide informed guidance on future appropriations of funds for the purpose of improving public safety and reducing crime in our community through programs addressing substance abuse, mental and behavioral health, housing essential to public safety, and related support services.

Attachments

Nurse-Family Partnership
CoC LBS Progress Update
CoC LBS Memorandum of Agreement
LBS Questionnaire - CoC
LBS Questionnaire - OTS
MRM Shelter Proposal
MRM Emergency Shelter Questionnaire
LBS Questionnaire - MRM

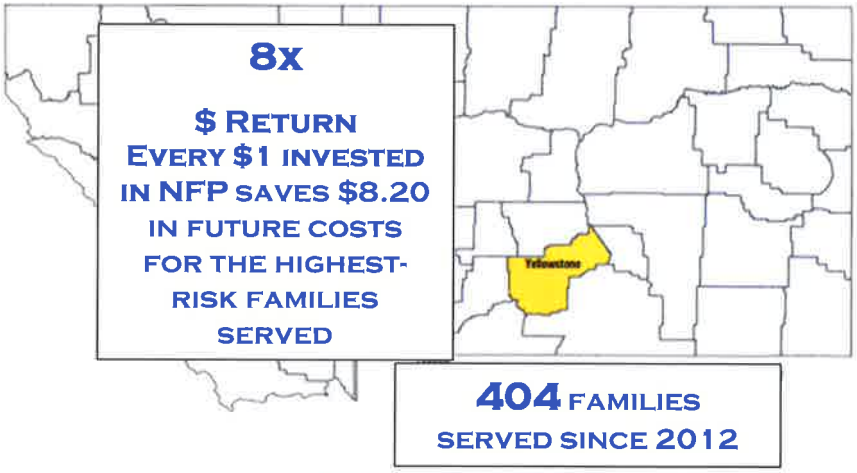
Nurse-Family Partnership

Helping First-Time Parents Succeed

NURSE-FAMILY PARTNERSHIP IN YELLOWSTONE COUNTY

Why Nurse-Family Partnership® (NFP)?

NFP is an evidence-based, community health support that helps transform the lives of pregnant, vulnerable mothers. Each mother served by NFP is partnered with a registered nurse in pregnancy and receives ongoing nurse home visits that continue through her child's second birthday. Independent research proves that communities benefit from this relationship. Nurses are the most trusted professionals in America, rated highest for honesty and ethics, positioning nurses to provide an intensive level of support to the highest families in need. Nurses support family health through building strong relationships with parents.



8x

$ RETURN
EVERY $1 INVESTED IN NFP SAVES $8.20 IN FUTURE COSTS FOR THE HIGHEST-RISK FAMILIES SERVED

404 FAMILIES SERVED SINCE 2012

NFP GOALS:

- Improve pregnancy outcomes.
- Improve child health and development
- Improve the economic self-sufficiency of the family

POSITIVE OUTCOMES LOCALLY SINCE 2012

- Smoking in pregnancy - **DECREASED** by 25%*
- Alcohol use in pregnancy - **DECREASED** by 56%*
- Reported experience of Intimate Partner Violence - **DECREASED** by 63%**

*Intake to 36 weeks gestation
**Intake to 12 weeks postpartum; self-report

For questions or more information about Nurse-Family Partnership, contact:

RiverStone Health
Nurse-Family Partnership of Montana
123 South 27th Street
Billings, Montana 59101
Phone: 406.247.3360

CLIENT DEMOGRAPHICS

At Intake

22 Years	Median Age
$12,250	Median income
75%	Medicaid Recipients
89%	Single Parent Home

Race

1%	Black or African American
75%	White
7%	Asian
5%	Multi-racial
1%	Native Hawaiian or other Pacific Islander
17%	American Indian or Alaska Native

Ethnicity

16%	Hispanic/Latina
84%	Non-Hispanic/Latina

Data current through August 2022

Nurse Family Partnership - Support for moms, babies, families, community

Year 1-2 Goal: Add 3 nurses to our existing Nurse Family Partnership team, allowing us to serve 75-90 additional families. This is double the number of families we currently serve and significantly expands our community impact.

Year 3-5 Goal: Our vision is to identify cost-effective approaches to provide home visiting services to all families in our community who need/want them. Sustain funding and build on our successes to find ways to support serving additional families.

Each year data will be reported and opportunities for program sustainability discussed.

RiverStone Health's Commitment

- Employ, train, and supervise qualified nurses.
- Provide management, administration, and infrastructure.
- Collect data continue to monitor effectiveness of Nurse Family Partnership
- Outreach and connections with community referral sources

RiverStone Health | Public Health
Connecting you to a better life

City of Billings Request

A 5-year commitment to fund 3 additional nurses at a cost of $100,000 per nurse per year.

Core Activities - Nurse Family Partnership

Support at risk pregnant women and their families

- Identify current needs and concerns
- Support parenting and life skill development, building protective factors
- Follow evidence-based model to fidelity to realize long term benefits
- Deliver screenings to support mom and baby physical, mental, emotional health

Short term health outcomes:

- Safe home environment
- Healthy birth weight
- Decreased risk behaviors
- Increased protective factors

Long term health outcomes:

- Positive mom-baby interactions/competent care
- Improve pregnancy outcomes-preventative health practices
- Improve economic self-sufficiency by helping parents develop vision for their own future

Community connections

- Consult with providers and social service agencies ensuring care coordination for benefit of clients
- Establish and support key referral sources needed to best support client

Additional Local Home Visiting Program Offerings and Opportunities

Current Offerings:

- Parents As Teachers: existing evidence-based model offered at RiverStone Health, delivered by parent coaches https://homvee.acf.hhs.gov/effectiveness/Parents%20as%20Teachers%20%28PAT%29%C2%AE/In%20Brief
- Maternal Child Health Home Visits: short term intervention based, focused on goals of client, typically 2-4 visits in duration.

Future Opportunity:

- Universal Home Visiting: a broader opportunity, with evidence of success through Family Connects (Durham Connect) https://homvee.acf.hhs.gov/effectiveness/Family%20Connects/In%20Brief
- This would include connecting with every person giving birth in Yellowstone County to determine level of need and interaction.

1

RiverStone Health

Nurse Family Partnership

Billings City Council

September 6, 2022

Eric Owen, Vice President of Public Health Services
Shannon Hauck, RN, Nurse Supervisor, Nurse Family Partnership
Greg Upham, School District 2 Superintendent

2

Overview

- Why Prevention?
- Why Nurse Family Partnership?
- Why Invest?

3

Key Concept - Trauma

A painful or distressing experience often resulting in lasting mental and physical effects.

-NCSL Preventing and Mitigating the effects of ACEs report (2018)

4

Key Concept – Adverse Childhood Experiences (ACEs)

1. Physical abuse
2. Sexual abuse
3. Verbal abuse
4. Physical neglect
5. Emotional neglect
6. A family member who is depressed or diagnosed with other mental illness
7. A family member who is addicted to alcohol or another substance
8. A family member who is in prison
9. Witnessing a mother being abused
10. Losing a parent to separation, divorce or death

https://www.resilientchildfund.org/top-10-aces/

5

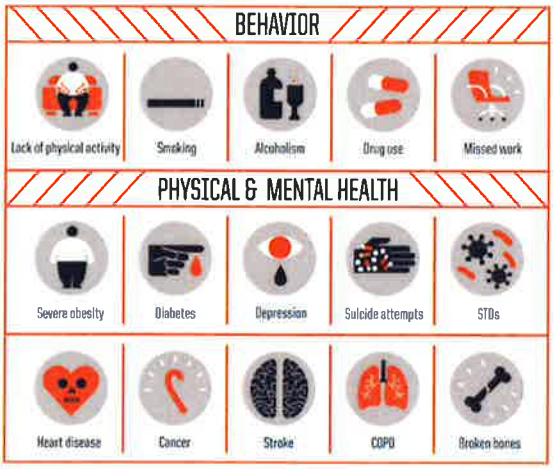
Key Concept – Toxic Stress

Extreme or extended activation of the body 's stress response without the presence of adult support.

-NCSL Preventing and Mitigating the effects of ACEs report (2018)

6

Impact of ACEs/Toxic Stress - Individual



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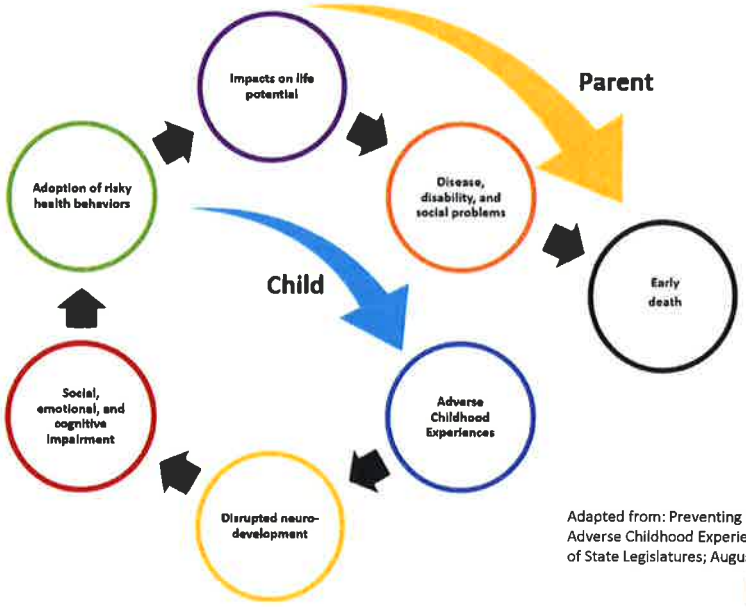
Impact of ACEs – Life Cycle and Family



Adapted from: Preventing and Mitigating the Effects of Adverse Childhood Experiences; National Conference of State Legislatures; August 2018

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Experiences with ACEs

Experience with ACEs: 2011 -2014 – 23 states*	National Foster Care System Rates Ages 0-17**	Montana Foster Care System Rates Ages 0-5**
• 62% of adults reported at least 1 ACE	• National Average: 3-4/1,000	• 26.8/1,000: Montana
• 25% of adults reported 3 or more	• Montana: 15/1,000	• 36/1,000: Yellowstone County

* Preventing and Mitigating the Effects of Adverse Childhood Experiences; August 2018; National Conference of State Legistures
** Kids Count Data Center; 2020; Annie E. Casey Foundation

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Preventing ACEs - Positive Experiences

Positive Childhood Experiences

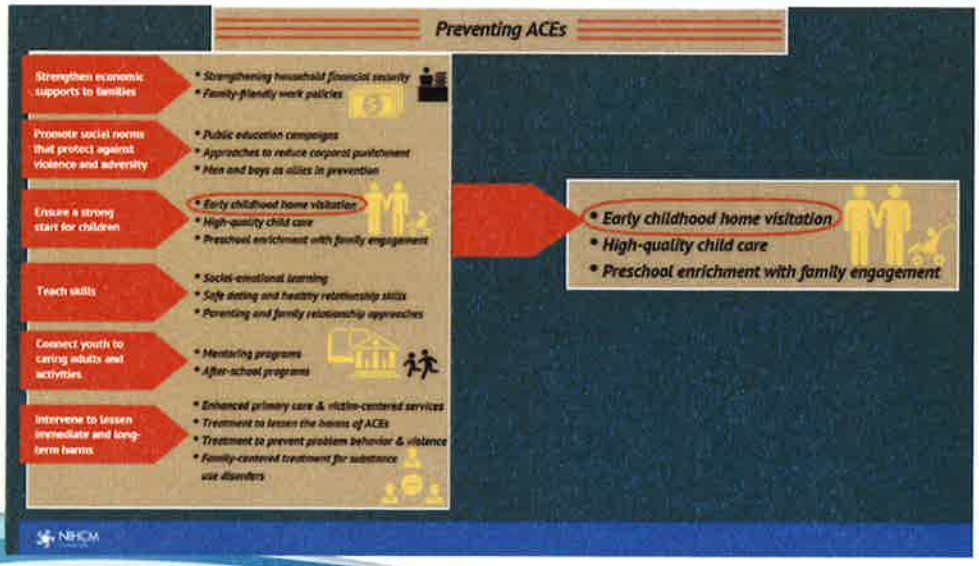
Counter-ACEs

- Liking school
- Teachers who care
- Opportunities to have fun
- A predictable home routine
- Feeling comfortable with yourself
- Having a caregiver whom you feel safe with
- Beliefs that provide comfort
- Having good friends and neighbors

https://earlymilestones.org/counter-effects-of-aces/

10

Preventing ACEs - Systemically



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11

Why Home Visiting Works

Trusted Relationship, Healthy Pregnancy, Positive Birth Outcomes, Healthy Birthweight, Positive Parenting Skills and Supports, safe/stable home environment

= School Readiness

= Reading at 3rd Grade

= School engagement, graduation

= Gainfully employed

= Avoiding criminal justice

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What is Nurse Family Partnership?

Nurse Home Visiting + Relational Skill Building = Healthy Mom, Healthy Baby

- Evidence based nursing intervention
- Pregnancy through 2 years
- 25-30 families per Nurse
- Parenting Skills-Confident and competent care
- Parent self-efficacy: develop a vision for their own future
- Promoting stable, safe, and caring environment during most important time for child's development

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Why Nurse Family Partnership?

1. Not a new program - expanding capacity of **existing** program
2. Data, studies, and experts agree – Nurse Family Partnership is the gold standard
3. Nurses are a trusted resource
4. Relationship, relationship, relationship
5. Consistently effective
6. Individualized
7. Multi-generational
8. Long-lasting impacts

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Why a City of Billings Investment?

Why Public Safety Mill? Why Marijuana Tax Dollars?

- Crime, violence, school performance…all impact decisions of people moving into community and our children staying
- Relational crime-break the cycle-relational problems take relational responses
- Our situation will continue to have negative impact on our quality of life and place to raise a family if we don't get control of crime

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Why Billings School District 2?

- Prepare our children for pre-K and promote school readiness
- Reduced dropouts means reduced juvenile crime
- School environment is mirroring our community environment
- When families are more stable and children are ready we create a guardrail against increased city tax dollars needed to react to more expensive down-stream problems.

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A Case/Cost Comparison

Nurse Family Partnership

Average Cost Per Family Served

$8,500

17

A Case/Cost Comparison

- A parent struggling with substance use disorder, unsafe behaviors, criminal actions, and CPS placement of child
  - ~ $2,000 – Child and Family Services Cost
  - ~ $1,000 – Law Enforcement Intervention
  - ~ $5,000 – Court Costs
  - ~ $15,000 – Foster Care Placement
  - ~ $5,000 – Outpatient Treatment
  - ~ $36,500 – One year of incarceration

18

A Cost Comparison

Preventive Nurse Family Partnership Intervention	Downstream Costs of Dealing with After the Fact Consequences
~$8,500	**~$64,500**

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Why Prevention Works

Nurse Family Partnership Return on Investment

8.2 times for every dollar spent

20

Benefits of Prevention-Based Services

- Prevents harm before it happens
- Supports development of a safe, stable, caring environment for children's first 5 critical years of development
- Breaks the intergenerational cycle of
- Cost effective compared to addressing downstream consequences

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Proposal

Let's build on something that works!
Let's share this commitment… council, school district and public health!

Our goal: Finding a sustainable way to provide home visiting services to all families in our community who need/want the support.

RiverStone Health's investment: data, outreach, infrastructure, training and supervision; alignment with public health and coalition efforts in the community

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NCSL

Preventing and Mitigating the Effects of Adverse Childhood Experiences

Health

NATIONAL CONFERENCE of STATE LEGISLATURES | AUG 2018

Preventing and Mitigating the Effects of Adverse Childhood Experiences

BY AMBER BELLAZAIRE

The National Conference of State Legislatures is the bipartisan organization dedicated to serving the lawmakers and staffs of the nation's 50 states, its commonwealths and territories.

NCSL provides research, technical assistance and opportunities for policymakers to exchange ideas on the most pressing state issues, and is an effective and respected advocate for the interests of the states in the American federal system. Its objectives are:

- Improve the quality and effectiveness of state legislatures
- Promote policy innovation and communication among state legislatures
- Ensure state legislatures a strong, cohesive voice in the federal system

The conference operates from offices in Denver, Colorado and Washington, D.C.

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Executive Summary

The term adverse childhood experiences (ACEs) is defined as potentially traumatic events that occur before the age of 18. Such experiences can interfere with a person's health and opportunities throughout his or her lifetime—and can even affect future generations. Researchers have identified connections between ACEs and a greater likelihood of developing risky behaviors, chronic health conditions and poor workforce performance, among other outcomes.[1] Moreover, ACEs can be cyclical.[2] Research suggests that children who experience physical abuse, for example, may be more likely to commit violence, including abusing or neglecting their own children, as well as to be revictimized in the future.[3,4]

From 2011 to 2014, over half of all U.S. adults (62 percent) from 23 states reported having at least one adverse childhood experience and 25 percent of adults reported three or more.[5] As such, some state policymakers are interested in preventing such experiences, mitigating their effects, and reducing the associated costs to state health care, education, child welfare and correctional systems. This brief presents research on adverse childhood experiences and highlights state strategies to prevent and reduce their occurrence and negative effects. Such policies include strategies to build resilience in children and families, help parents reduce stress, and increase screening and treatment for ACEs.

Introduction

Early life experiences, whether beneficial or harmful, have tremendous effects on one's development, behavior, and long-term health and opportunity. The Adverse Childhood Experience (ACE) Study provided evidence of this connection, noting that ACEs—potentially traumatic events that occur before the age of 18—increase an individual's risk of disease and behavioral challenges, such as obesity, depression and alcoholism.[1] And, the greater the number of ACEs, the greater the risk for negative outcomes.[6] Researchers have even identified a link between ACEs and a higher risk of premature death.[7]

Nearly all people experience stress in their life, such as the stress felt before an important test or job interview. However, chronic stress sustained over time can be damaging to the body and the brain. This is particularly true for children because the earliest years are a critical time for development. In our first three years of life, we create 1 million brain connections every second and develop critical abilities, such as language, memory and socialization.[8] The accumulation of excessive stress in the body (a result of ACEs) interferes with the development of healthy neural, immune and hormonal systems and can alter the expression of our DNA. Furthermore, when a child lacks a supportive adult to turn to in times of adversity, this continuous stress activation becomes particularly toxic.[9]

Toxic stress on our bodies and brains affects behavior in addition to development. The stress of ACEs can inhibit natural, positive methods of coping. In place of healthy behaviors, people with ACEs are more prone to impulsivity and risky behaviors, such as smoking or illicit drug use. These high-risk behaviors account for nearly 50 percent of the increased risk of negative consequences associated with ACEs.[10]

Glossary

TRAUMA: A painful or distressing experience often resulting in lasting mental and physical effects.

ADVERSE CHILDHOOD EXPERIENCE: A potentially traumatic experience, which occurs before 18 years of age. Types of ACEs include:

Abuse

- Emotional abuse
- Physical abuse
- Sexual abuse

Neglect

- Emotional neglect
- Physical neglect

Household Challenges

- Mother treated violently
- Household substance abuse
- Mental illness in household
- Parental separation or divorce
- Incarcerated household member

TOXIC STRESS: Extreme or extended activation of the body's stress response without the presence of adult support.

Sources: *Felitti, 1998; National Institute of Mental Health; Centers for Disease Control and Prevention; Center on the Developing Child at Harvard University*

How ACEs Influence Health

Source: *Centers for Disease Control and Prevention*

The Adverse Childhood Experiences (ACE) Study[1]

Beginning in the '90s, an obesity clinic doctor grew curious about why so many of his patients were prematurely ending their treatment. Through surveys and analysis, the doctor identified that these patients, struggling to overcome obesity and often choosing to end treatment entirely, consistently reported a history of childhood sexual abuse. This observed connection between childhood trauma and poorer health later in life ultimately led to the seminal Adverse Childhood Experiences Study.

Between 1995 and 1997, the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente surveyed more than 17,000 male and female adults residing in Southern California. Participants of the study were predominately middle-income, with at least some college experience, white (75 percent) and over the age of 40 (85 percent).

Participants completed a confidential survey about their childhood and current health status and behaviors. Questions about the individual's childhood measured 10 ACEs: emotional, physical and sexual abuse; emotional and physical neglect; parental separation and divorce; parental incarceration; domestic violence; and substance misuse and mental illness in the household. (Since the original study, research on ACEs has expanded to include additional potentially traumatic experiences such as bullying, teen dating violence, community violence, homelessness, economic hardship and the death of a parent.)[11,12] Participants' ACE scores were derived by summing up each of the 10 ACEs the individual had experienced. ACE scores do not reflect frequency or severity of experiences and do not account for positive experiences early in life that may protect a child from the effects of trauma.

Study findings indicated that adverse childhood experiences were prevalent among participants. Nearly two-thirds reported at least one such experience, and more than 20 percent reported three or more. The most common ACEs reported by study participants were physical and sexual abuse, exposure to substance misuse and mental illness in the household, and parental separation and divorce.

The study also revealed the connection between a high ACE score and an increased risk of disease. Autoimmune disease, chronic lung disease and liver disease were some of the chronic health conditions found to be associated with ACEs. In addition, individuals with multiple ACEs were more likely to perform poorly in school, be unemployed and develop high-risk behaviors, such as smoking and promiscuity.

The Scope of the Challenge

From 2011 to 2014, over half of all U.S. adults (62 percent) from 23 states reported having at least one adverse childhood experience and 25 percent of adults reported three or more.[5] The prevalence of ACEs and their association with various negative outcomes mean costs to states can be high. For example, the Centers for Disease Control and Prevention (CDC) estimates that child abuse and neglect, which account for half of the 10 original ACEs, cost approximately $124 billion per year.[13] These costs affect employers through lost productivity, as well as the health care, education, child welfare and corrections systems. Lost productivity and health care spending contribute the most to overall annual costs.[14, 15]

Behavioral Risk Factor Surveillance System (BRFSS)[16]

The BRFSS, an annual phone survey administered by the Centers for Disease Control and Prevention, collects state data about health-related risk behaviors, chronic health conditions and the use of preventive services. Each year, residents in 50 states, Washington, D.C., and three U.S. territories complete the survey.

Since 2009, 42 states and D.C. have included ACE questions in their BRFSS survey for at least one year, making it a tool for identifying state-specific trends in adverse childhood experiences.

Strategies for Prevention and Mitigation

In the two decades since the original ACE study, an extensive number of publications have added to the body of research on adverse childhood experiences. Many of these publications provide evidence of effective strategies to prevent and manage the consequences of ACEs. For example, many of the recommendations for achieving strong physical health—adequate sleep, good nutrition and regular exercise—are also useful for protecting children from the harms of ACEs. Social support and stress reduction strategies, such as mindfulness and psychotherapy, are also well-supported.[10] Efforts that focus on building healthy families early in the life of a child are cited as among the most influential means of preventing ACEs and reducing their damaging effects.[17,18]

Resilience

STRATEGY	STATE OPTIONS
Build Resilience	• Increase positive parenting skills and safe, stable and nurturing relationships through home visitation. • Explore opportunities to expand access to quality early child care and education.

The Center on the Developing Child at Harvard University offers three principles for policymakers to consider in helping families with young children thrive: enhancing responsive relationships, strengthening core life skills and reducing sources of stress.[19] These principles target characteristics of the individual, family and community that are associated with physical health—sometimes referred to as protective factors.[17,20] Such factors are important because they increase a family's ability to effectively cope and adapt to hardship and change. This ability to grow and recover from adverse experiences is called resilience.[21] In other words, protective factors, such as strong family bonds, cultivate greater resilience

that can help protect children from the detrimental effects of adverse experiences.[22] When children perceive at least one stable, supportive adult in their life, they are less likely to experience toxic stress and develop unhealthy coping strategies, such as bullying or substance misuse. Safe, stable and nurturing relationships help to build resilience, prevent violence, improve mental health and support health across one's lifespan.[4,23,24]

Home Visiting

Developing strong family bonds is a teachable skill, and high-quality home visiting programs are one way to do so.[25] Home visiting programs employ nurses, social workers, early childhood educators and other trained professionals to visit families in their homes during pregnancy and early childhood. These programs teach positive parenting skills (including best practices for coping with stress), provide health education, and connect families to supportive services such as the Women, Infants and Children (WIC) Food and Nutrition Service program.

Home visiting has been linked to positive results. These include improved school readiness, higher-quality parenting, more positive child-parent interactions and improvements in parents' mental health as they develop more responsive connections to their children. Home visiting has also been found to reduce the likelihood of child abuse and neglect. For families facing added challenges, such as substance dependence, maternal depression, or limited social or financial support, home visiting programs may be especially beneficial.

States that recognize the potential return on investment of home visiting programs may support them through a combination of federal, state, local and private funds. The federal Maternal, Infant and Early Childhood Home Visiting Program, for example, provides funding for all 50 states, the District of Columbia and five territories to operate home visiting programs for at-risk pregnant women and parents with infants or young children.[26] For more on home visiting, please visit the NCSL Home Visiting webpage.

State Examples

- In 2015, Oklahoma lawmakers enacted the Family Support Accountability Act, which mandates that home visiting programs work in partnership and sets minimum outcomes programs must achieve.
- In 2016, the Rhode Island General Assembly enacted the Rhode Island Home Visiting Act, which requires the Department of Health to implement a statewide home visiting system using evidence-based models.
- In 2016, New Jersey established a three-year Medicaid home visitation demonstration project to provide ongoing health and parenting information, parent and family support, and links to essential health and social services during pregnancy, infancy and early childhood.

A more complete list of home visitation legislation passed between 2008 and 2017 can be found here.

Did You Know?

Nurse Family Partnership (NFP) is the most extensively evaluated early home visitation program in the U.S. NFP helps new parents keep themselves and their babies healthy, connect to needed services, and continue their education or find work. NFP has been found to reduce child abuse and neglect by 48 percent and emergency room visits for accidents and poisoning by 56 percent.[27]

Additionally, there are many evidence-based programs that offer positive parenting education and parenting support services, such as Healthy Families America®, Incredible Years®, Minding the Baby®, SafeCare® and Triple P®.

Quality Early Child Care and Education

In addition to building secure attachments with caring adults, expanding access to early childhood education is a promising pathway to resilience. Early learning opportunities allow children to think, play and explore, which exercise critical executive functions such as "working memory" (storing and accessing information for a limited time) and self-regulation. Children learn to take turns, manage information and avoid distractions, and the more these abilities are practiced the stronger they become. Early childhood education also supports social and emotional development, which includes building self-confidence and positive relationships. These critical abilities emerge through mastering new tasks and learning to interact with others. They also instill in children the motivation, persistence and other life skills necessary to be inventive, flexible and functional adults, and to be resilient in the face of life's challenges.

Moreover, according to a recent report by Child Trends and the Alliance for Early Success, preschool participation is associated with markedly better academic outcomes, such as improved math, reading and language skills.[28] Additionally, high-quality early childhood education may contribute to long-term benefits such as higher earnings, better health and less criminal activity.[29] Dr. James Heckman, an economics professor at the University of Chicago, demonstrates a 13 percent return on investment for high-quality, birth-to-5 early childhood education for each year of a child's life.[30] Because high-quality child care and education equip children with opportunities to establish healthy connections with others and skills to be productive adults, broadening access may help prevent the accumulation of toxic stress commonly associated with ACEs.

State Examples

- In 2017, Washington state established a state-supported early childhood education and assistance program.
- In 2017, state lawmakers in Louisiana created a special fund to support early childhood education.
- In 2015, New Hampshire lawmakers tasked the state's Wellness and Primary Prevention Council to establish a system of family resource centers to provide parental education and support for children from birth to age 5.

Did You Know?

Between January and May of 2018, at least 68 legislative proposals in 25 states incorporated ACEs. These bills addressed appropriations for prevention, task force creation, and training for educators and others on trauma-informed practices.

For more on what states are proposing to address ACEs, please visit the NCSL Injury Prevention Legislation Database. Visitors to the database can search legislation from all 50 states and the District of Columbia on 10 injury prevention topics, including adverse childhood experiences and child abuse and neglect. Searches can be organized by topic, state and year.

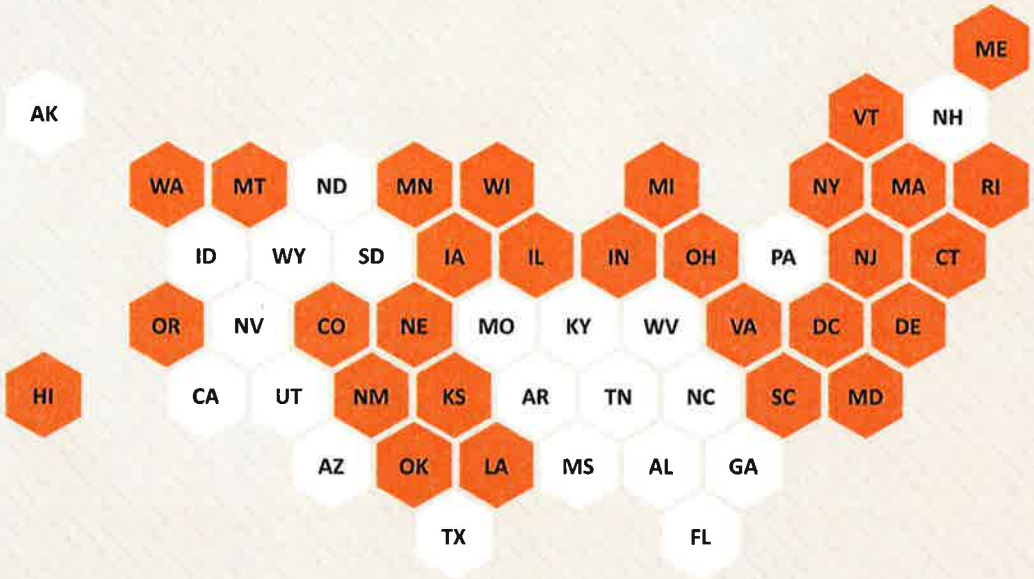
Parental Stress

STRATEGY	STATE OPTIONS
Support Parental Stress Reduction	• Consider economic supports, family-friendly workplace policies and affordable housing developments.

Nearly a quarter of U.S. children live below the federal poverty level, and, in almost every U.S. state, economic hardship is now the most common adverse childhood experience.[12,31] Economic hardship affects children because it can cause high parental stress and increase their likelihood of experiencing abuse or neglect. Efforts to strengthen families' economic security may help reduce parental stress and establish greater household stability—two factors that can help protect children from abuse and neglect.[32] Policies such as minimum wage increases, full pass-through child support payments and earned income tax credits are potential mechanisms for reducing ACEs.[33,34,35]

For example, the earned income tax credit (EITC) is a policy the federal government, 29 states, the District of Columbia, Guam, Puerto Rico and some municipalities have implemented to build workers' economic security, especially those with children.[36] The Center on Budget and Policy Priorities reports that, in 2016, the EITC lifted nearly 6 million people—half of them children—out poverty. Research suggests the policy encourages workforce participation and increased earnings, and people most often use the tax credit refund to pay bills and debts and to build their assests.[37,38] Furthermore, while government policies that provide economic supports to families are not the only option for addressing ACEs—business leaders also play a role—research does support the effectiveness of such policies in improving parents' ability to provide for the physical and emotional needs of their children.[39] The following highlights states that have enacted some of these measures.

States with an Earned Income Tax Credit



State EITC

Source: NCSL, Tax Credits for Working Families

State Examples

- In 2017, Colorado lawmakers extended the income tax credit for child care expenses paid by an individual with a federal adjusted gross income of $25,000 or less.
- In 2016, Virginia lawmakers increased outreach to potential EITC recipients by providing an annual notice to recipients of various state benefits of the availability of the federal and state EITC.

Did You Know?

Rhode Island enacted the first state earned income tax credit (EITC) in 1986.

Hawaii, Montana and South Carolina are the most recent states to create state EITCs.

States with a Minimum Wage Greater than $7.25 Per Hour

State minimum wage greater than federal rate of $7.25 per hour

Source: NCSL, State Minimum Wages

States with Paid Family and/or Sick Leave

Paid Sick Leave
Paid Family Leave
Paid Family and Sick Leave

Source: NCSL, State Family and Medical Leave Laws

Housing

Unstable or unaffordable housing, poor neighborhood quality and eviction can also be profound sources of stress for parents and children. Neighborhood quality often informs the quality of available jobs, schools and health care, as well as a families' social mobility.[40,41,42] And research suggests that the stress associated with housing instability can increase known risk factors for child abuse and neglect, such as harsh parenting practices and maternal depression.[20,22,43] Nearly 80 percent of mothers experiencing homelessness have significant histories of childhood trauma, and many have experienced intimate partner violence as adults.[44,45,46,47] Thus, housing instability can be thought of as both a cause and a consequence of ACEs.

Harvard University's Joint Center for Housing Studies reports that in 2016, nearly a third of U.S. households were cost-burdened, meaning they paid more than 30 percent of their income for housing.[48] In a survey by the University of Southern California and the Los Angeles Business Council, 60 percent of surveyed companies reported that housing costs are a barrier to employee retention.[49] Thus, housing and zoning policies that increase the number of available, affordable units in a community and support neighborhood investments and diversification are likely to benefit employers as well as families.

Examples of such policies include rent control and inclusionary zoning. Rent control refers to the limits on the rent that landlords may charge. Research on the effectiveness of rent control is mixed. For example, some experts suggest that rent-controlled buildings can suffer from deterioration from lack of investment and rent control laws exacerbate housing shortages. Others assert that rent control helps to maintain neighborhood diversity and stability, often increasing property values.

Inclusionary zoning requires a specified percentage of new housing construction to be affordable to people with low to moderate incomes. Current research about the effects of inclusionary zoning policies is limited. Proponents note the policy's ability to increase the production of affordable homes, while opponents argue such policies increase building costs and place the burden of providing affordable units on developers and market-rate purchasers. At least three states–Connecticut, Louisiana and New Hampshire–allow inclusionary zoning where there is rent control pre-emption.

Additional policies communities can consider when seeking to address the issue of housing affordability include reductions in regulatory barriers to development and shared equity homeownership, such as community land trusts.[50,51] Given the role of counties and municipalities in establishing and altering housing policy, lasting solutions to affordability and availability will likely require a comprehensive strategy from multiple levels of government, as well as support from the private sector.

Screening and Treatment

STRATEGY	STATE OPTIONS
Increase Screening and Treatment	• Broaden access to and coverage of comprehensive health services.

Between 14 percent and 20 percent of U.S. children experience a diagnosable mental, emotional and behavioral disorder, such as depression, anxiety and obsessive-compulsive disorder.[52] However, for people with adverse childhood experiences, the likelihood of developing one or more of these disorders is significantly greater. Specifically, those with four or more ACEs are about four times more likely to develop depression and 12 times more likely to attempt suicide.[53] Children with four or more ACEs are also 32 times more likely to have a learning or behavioral issue when compared to children with no adverse childhood experiences.[54] Frequent classroom disruptions, aggression, underperformance, truancy, poor attitude, bullying and social withdrawal are symptoms commonly expressed by children struggling to manage a learning or behavioral issue.

Schools and child care centers are uniquely positioned to detect these issues early and link children to supportive services and formal assessments. Early interventions may mitigate the most dire consequences of childhood trauma and frequently demonstrate positive effects on long-term health.[55,56] Many children report feeling most comfortable receiving health-related services at school and a majority of those accessing mental health services do so through their school.[57,58] Thus, school-based mental health services may prove to be an effective method for addressing the health care needs of children with ACEs. Specifically, efforts by schools and child care settings to consider a child's history of trauma and subsequent coping strategies—an approach commonly called trauma-informed care—are likely to be highly valuable in mitigating some of the consequences of ACEs.[59]

Finally, children who grow up in households with family members with an untreated substance use disorder (SUD) or mental illness often witness significant dysfunction. Preventing these types of ACEs may require innovative policies that support comprehensive health care for children and parents. For example, parental opioid dependence is increasingly damaging the health of infants and children. Recent data suggests that, on average, every 15 minutes a baby is born in the U.S. withdrawing from opioids.[60] In response, states have begun integrating addiction treatment into existing home visiting programs, as well as supporting addiction treatment programs designed specifically for pregnant women and women with young children. Kentucky, Ohio and Vermont are three states with programs designed specifically for mothers combatting an SUD.[61,62,63] Such efforts to provide comprehensive health services may support better SUD treatment, mental health and child welfare outcomes.[64]

State Examples

In 2015, Iowa enacted a law allowing for state block grant allocation to develop a range of children, youth and family services through existing community mental health centers. Services include school-based mental health projects, mobile crisis intervention services and mental health assessment capacity development based in public and nonpublic schools.

In 2013, Connecticut enacted a law allowing school-based health centers to extend their hours and provide services to students who do not reside in the school district where a health center is located. It also allows the centers to provide behavioral health services, expand health care services, conduct community outreach about their services, and receive reimbursement from private insurance.

In 2017, Indiana lawmakers established an opioid addiction recovery pilot program to assist expectant mothers with an opioid addiction. The program provides treatment in a residential care facility and home visitation services following discharge from the facility.

Moreover, 19 states have either created or funded drug treatment programs specifically for pregnant women, and 17 states and the District of Columbia provide pregnant women with priority access to state-funded drug treatment programs.[65]

Conclusion

Adverse childhood experiences affect development and behavior and, if left unaddressed, threaten long-term health and well-being. To improve the lives of families and reduce the societal costs of ACEs, policymakers are exploring a range of strategies to prevent and mitigate childhood trauma. Effective strategies include building resilience in children and families, supporting parents to develop stress management and positive parenting skills, and increasing access to and use of comprehensive health services.

What Now?

- **Identify existing evidence-based prevention efforts in your state.** Learning about initiatives already underway can help avoid duplication of efforts. For example, does your state or district have an operational home visiting program?
- **Connect with potential partners.** The effects of ACEs are evident in many sectors, so it may be useful to identify and collaborate with businesses, community- and faith-based organizations, and government agencies invested in lessening the occurrence and harms of ACEs.
- **Support evaluation and needs assessment.** Data enables state leaders to recognize policy gaps, target limited resources to populations most in need and understand which strategies are most effective in specific contexts. For example, do public agencies, academic institutions or other entities in your state collect a range of social and economic data?

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The Yellowstone County Continuum of Care (CoC) has taken several steps toward establishing a temporary low-barrier shelter for the winter season, beginning October 1, 2022 and ending March 31, 2023. Our intent is to be responsive to feedback from City Council, provided during CoC presentations on May 9, June 6 & June 20, 2022. The CoC has also relied on the text of the Rupsis Amendment, particularly Item 4, which says:

> *"The City Administrator should solicit input or proposals from agencies or firms that desire to provide seasonal low-barrier shelter and/or sobering center services for all or part of the period from October 1, 2022 through March 31, 2023. Input should include, but not be limited to, location, costs, implementation plan, and success metrics. Case management services would ideally be included as a factor of success for the program."*

Broad Coalition Support

During our Low Barrier Shelter Workgroup and General Membership meetings in July, the CoC:

- sought input from numerous coalition partners in a variety of ways;
- developed and circulated a questionnaire for parties interested in providing low barrier shelter this winter (see email attachments);
- conducted an electronic vote of the CoC General Membership to determine which option had the broadest coalition support.

Members voted overwhelmingly in support of the CoC proposal in partnership with the Community Crisis Center (CCC) and Billings First Congregational Church (BFCC), with 14 votes in favor. The questionnaires submitted by Montana Rescue Mission (MRM) and the newly-formed Off The Streets Corporation (OTSC) received two votes each. Moving forward, the CoC coalition will formally support and offer its limited operational capacity to the seasonal shelter proposal in conjunction with BFCC and CCC.

Memorandums of Agreement and Understanding

With the timetable for implementation narrowing in on just 9 weeks, the CoC has moved forward with drafting MOA/MOU's with partner organizations and agencies who are interested in helping meet the critical need for low-barrier shelter this winter.

- The CoC, BFCC, and CCC have tentatively approved an operational MOA (see email attachments) for seasonal shelter, pending legal review.
    - The intent of partners is to operate a *temporary* low-barrier shelter for a 12-hour period overnight, located on the first floor of BFCC, allowing for ADA accessibility.
    - Trained staff from CCC will be on site nightly at BFCC to provide guest screening, assessments, and diversion to the most appropriate service provider.
    - On-site security, janitorial and laundry services will be provided by BFCC through outside contractors, to be procured once funding is secured.
    - Transportation will be provided on a limited basis by CCC when a guest is beyond the scope of basic shelter at BFCC. If a guest is an extreme danger to themselves or others, 9-1-1 will be called.
    - Success metrics and outcomes will be closely monitored through the CoC's Coordinated Entry and Homeless Management Information System (HMIS).

The CoC Board of Directors is in the process of soliciting letters of support and generating partner MOU's to augment the seasonal shelter, such as:

- warm clothing and sober living accommodations through Gratitude in Action;
- outreach and treatment referrals by Downtown Billings Alliance HOT & MAAP programs;
- social services from Salvation Army, such as mobile meals and hygiene items;
- referral arrangements for YWCA, HRDC, CLDI, MRM, Family Promise, HomeFront and other community partners who wish to take part in seasonal shelter efforts this winter.

The CoC is also convening a workgroup of willing community partners to discuss how to best design and implement the care coordination component that is referenced in the final sentence of Item 4 in the Rupsis Amendment. We anticipate seeking support from the City of Billings for 3.0 FTE's to address gaps within the Homeless Crisis Response System by bolstering system engagement, wraparound supports, and assessment/diversion of unhoused clients within the CoC Coordinated Entry and HMIS Systems.

Total Project Budget: $410,000

1. The CoC anticipates the need for a minimum award amount of $200,000 (not to exceed $240,000) to operate an overnight seasonal shelter for our community's non-sober and disabled adult population during the six coldest months of winter. This allowance includes the cost of facilities, staffing, contracted services, transportation, training, project management, coordinated entry, and administrative oversight.
2. The CoC anticipates the Care Coordination component of the program referenced in the Rupsis Amendment, which would operate year-round rather than seasonally, would cost $210,000 to fund. The 3.0 FTE's we are seeking support for would be in the following areas of the ***Crisis Response System from the National Alliance to End Homelessness***
    a. Diversion and Prevention
    b. Coordinated Entry
    c. Permanent Housing Supports

    Visit https://endhomelessness.org/ending-homelessness/solutions/crisis-response/ to learn more about the Homeless Crisis Response System

Conclusion

In addition to the project above, the CoC remains committed to continuing the ongoing work in its five-year Strategic Plan to pursue development of critical infrastructure that includes a *permanent* Low-Barrier Shelter (LBS) in Billings and additional units of Permanent Supportive Housing (PSH). Much of this discussion occurs in the two Task Forces and related workgroups convened by the CoC on LBS and PSH. We welcome participation from Council Members, City Administration, and others who desire to play an active role in helping the CoC tackle housing instability in Billings and the surrounding community.

MEMORANDUM OF AGREEMENT
FOR SEASONAL LOW BARRIER SHELTER
OCTOBER 1, 2022 – MARCH 31, 2023

MOA Overview	
CONTEXT AND PURPOSE	**History:** Below are key highlights that provide history and context for this MOA: • The Yellowstone County Continuum of Care (CoC) responded to community need during the COVID-19 pandemic by creating and managing a *temporary* quarantine/isolation site and low-barrier shelter called Off The Streets. After developing a Consensus Agreement with 12 community partners, Off The Streets opened Oct. 31, 2020 with the intent to operate until Oct. 31, 2021. • As the closing date for Off The Streets approached, the CoC convened a Low Barrier Shelter Task Force with community partners interested in developing a *permanent* low-barrier shelter facility in Billings. Participants identified seasonal shelter as a top priority, directing the CoC to continue its low-barrier sheltering efforts through Mar. 31, 2022. • A catastrophic sewage leak required the closure of Off The Streets on Dec. 30, 2021. The CoC responded by setting up a temporary, emergency shelter in partnership with Billings First Congregational Church (BFCC) and the Community Crisis Center (CCC). The project operated in the basement of BFCC from Dec. 30, 2021 through Apr. 3, 2022, when funding expired. • The CoC made a series of presentations to Billings City Council on May 9, June 6, and June 20, 2022, seeking funding for the purpose of providing low-barrier shelter from Oct. 1, 2022 through Mar. 31, 2023. • On June 27, 2022, the Billings City Council voted 7-4 in favor of setting aside two mills in the Public Safety Mill Levy (approx. $400,000), plus the City's share of anticipated revenue from recreational cannabis taxes (approx. $400,000), into a budget fund "explicitly designated for improving public safety and reducing crime in our community through programs addressing substance abuse, mental and behavioral health, housing essential to public safety, and related support services." In the same motion, City Council directed the City Administrator to solicit input or proposals from groups who desire to provide seasonal low-barrier shelter services from Oct. 1, 2022 through Mar. 31, 2023 with consideration factors to include "location, costs, implementation plan, and success metrics." **Current:** The CoC together with its partners at BFCC and CCC now have plans in place to formally and fully develop a static site for seasonal low-barrier shelter from October 1, 2022 through March 31, 2023. BFCC has expressed a willingness to serve as a host location and manage contracted services as necessary, with CCC committing to provide security screening, medical and behavioral assessment, and where appropriate, diversion to alternative community service providers whenever possible. **MOA Purpose:** This MOA is intended to clarify expectations of all parties.
PARTICIPANTS	Yellowstone County Continuum of Care (CoC), Billings First Congregational Church (BFCC), and Community Crisis Center (CCC).
ACTIVE DATE	October 1, 2022 – March 31, 2023

MEMORANDUM OF AGREEMENT
FOR SEASONAL LOW BARRIER SHELTER
OCTOBER 1, 2022 – MARCH 31, 2023

FORMAL AGREEMENTS: Participants agree to the following:

1. Yellowstone County CoC Agrees To:
Coordinate communication and reporting to Billings City Council as required by the terms of any grant proposal, and if necessary, serve as primary signatory on any MOA developed with the City of Billings.
Create and maintain a project within its Homeless Management Information System for enrolling shelter guests, tracking related data, and pulling project reports as requested by MOA participants.
Provide technical assistance and support to Billings First Congregational Church and the Community Crisis Center as requested and appropriate.

2. Community Crisis Center Agrees To:
Serve as fiscal agent and primary administrator of funds from the City of Billings, ensuring all MOA participants are justly compensated in the manner outlined in final project budget, to be formalized no later than Aug. 31, 2021.
Employ appropriately-trained staff to work on site at Billings First Congregational Church to provide security screening, required assessments, and diversion to alternate partners, as appropriate.
Act as liaison for CoC Coordinated Entry System, conducting nightly tracking of shelter diversion, including but not limited to: 1) referrals to community partners and 2) overnight stays by clients.
Conduct and offer regular trainings on de-escalation and trauma-informed care training to contracted security, staff, and/or volunteers at Billings First Congregational Church.
Deliver transport from Billings First Congregational Church to the Community Crisis Center for guests deemed to be in crisis and/or in need of care beyond what is available at the low-barrier shelter site.
Provide assistance and support to Billings First Congregational Church as requested and appropriate.

3. Billings First Congregational Church Agrees To:
Accept and utilize designated funding from the City of Billings for shelter operations, and comply with all terms and conditions in the grant proposal.
Oversee all shelter operations, starting no later than Oct. 1, 2022 and ending no earlier than Mar. 31, 2023.
Assume responsibility for shelter staffing, laundry and janitorial services, and other operations and incidentals, upon the dates stated above.
Act as project lead for CoC Homeless Management Information System, assuming responsibility for entering all required data, and developing mechanisms for 1) determining number of unique individuals served and 2) nightly tracking of shelter stays.

Shelter services provided by Billings First Congregational Church are owned and managed by the Church, with technical assistance from the Community Crisis Center and the Yellowstone County CoC. MOA participants agree and affirm this project is not affiliated with the former Off The Streets site operated by the CoC, nor the newly-established corporation of the same name.

This MOA is entered into voluntarily. Participants acknowledge this Agreement constitutes a statement of mutual understanding and intentions. Agreement may be modified with written consent of all parties.

MEMORANDUM OF AGREEMENT
FOR SEASONAL LOW BARRIER SHELTER
OCTOBER 1, 2022 – MARCH 31, 2023

AUTHORIZED SIGNATURES:

Signature: _____ Date: _____
Kari Boiter, Board President, Yellowstone County CoC

Signature: _____ Date: _____
MarCee Neary, Director, Community Crisis Center

Signature: _____ Date: _____
Lisa Harmon, Senior Pastor, Billings First Congregational Church

LOW-BARRIER SHELTER QUESTIONNAIRE

1. Can you provide low-barrier shelter from October 1, 2022 – March 31, 2023?
   YES

2. What is your monthly budget for doing so?
   $30,000

3. Where will low-barrier shelter services be located this winter?
   Billings First Congregational Church

4. What is the capacity that can be served nightly?
   40-60

5. Is the location compliant with building and fire codes OR are you willing to make modifications requested by the Fire Marshal and Building Inspector in order to bring the facility into compliance prior to October 1, 2022?
   Similar to the emergency shelter operated earlier this year, Billings First Congregational Church and its community partners will work with the Fire Marshal and Building Inspector to ensure the shelter space is suitable for overnight occupancy.

6. What hours of day/night will low-barrier shelter be open?
   A 12-hour period overnight, TBD based on community need and partner capacity. Initial plans call for hours of operation from 7pm – 7am, with 6:30pm – 6:30am also being considered to equalize the gap between the available hours of programs at St. Vincent de Paul (8:00am – 5:00pm).

7. Do you have operational procedures developed and/or in place?
   YES

8. How will you prevent liability and/or insure a low-barrier shelter?
   Individual partners will carry insurance and/or liability for their facilities, staff and volunteers, with the contracted security obtained by Billings First Congregational Church required to carry an additional general liability policy with coverage of at least $1,000,000.00

9. Do you offer a warm handoff between service providers?
   YES

10. Do you plan to provide transportation to/from other service providers?
    On a limited basis, primarily to/from the Community Crisis Center for screening, assessment, diversion, or crisis care.

11. Do you plan to provide congregate or non-congregate shelter?
    Primarily congregate, with the possibility of non-congregate shelter also being explored, depending on community need and the cost involved.

12. How will you screen guests to ensure safety and security? If this service is provided by an outside entity or community partner, do you have an MOU or contract in place?
    YES. An MOU between the Community Crisis Center, Billings First Congregational Church, and the Continuum of Care has been drafted and is being finalized now.

13. Do you have processes in place for diverting guests to other service providers, when appropriate, as space is available?
    YES. Similar to past efforts to shelter unhoused neighbors on the coldest nights of the year, the Community Crisis Center will provide nightly assessment, screening, and diversion of all guests.

14. Are you a participant in the Homeless Management Information System? If not, how will data and success metrics be tracked and shared?
    YES. The Community Crisis Center is a participant in HMIS, with Billings First Congregational Church willing to be onboarded if necessary.

15. Are you a participant in the Coordinated Entry System? If not, are you willing to provide a Uniform Assessment to all shelter guests and participate in biweekly case conferencing?
    YES. The Community Crisis Center is a participant in Coordinated Entry, with Billings First Congregational Church willing to be onboarded if necessary.

16. Will you serve minors?
    NO. Unaccompanied minors will be diverted to Tumbleweed for services, with youth and families being diverted to Family Promise for services. This can be revisited as community need arises, based on the need of adult populations who cannot be served elsewhere.

17. Will you serve felons, sexual and/or violent offenders?
    YES

18. Will you serve people who do not meet sobriety requirements?
    Sobriety requirements are not part of the policies and procedures

19. Will you serve people who use assistive devices (wheelchair, walker, cane, etc.)?
    YES

20. Will you serve people who are accompanied by a trained Service Animal?
    Billings First Congregational Church is a Certified WISE congregation. WISE stands for Welcoming, Inclusive, Supportive, Engaged for the mental health community. As such, guest accompanied by trained Service Animals are welcome.

21. Will you serve people who are otherwise disabled, whether physically or mentally?
    YES

22. Will you serve people who do not meet employment requirements?
    Employment requirements are not part of the policies and procedures

23. Do you have a Diversity, Equity, and Inclusion policy of any kind? If not, will you commit to serving people regardless of race or ethnicity, gender or sexual orientation, or cultural background?
    The Continuum of Care and its partners at Billings First Congregational Church and Community Crisis Center are committed to serving people regardless of race or ethnicity, gender or sexual orientation, or cultural background. BFCC also has a non-discrimination policy in place.

24. Will you serve people of different faiths or religious beliefs?
    The CoC and its partners are committed to serving people of all faiths and religious beliefs. Chapel services and other forms of outreach will not be required to gain access to the CoC's low-barrier shelter.

25. Are there certain types of individuals or groups that you will not serve?
    When people are a danger to themselves or others, they will be referred for psychiatric care, treatment at the ER, or 9-1-1 will be contacted in the most extreme cases. When people are in need of immediate crisis care beyond the scope of basic sheltering, they will be referred to the Community Crisis Center. Additionally, every night during the screening and assessment process, guests will be referred to other service providers whenever appropriate, as space is available.

26. Do you maintain a no-services list? If so, what are the criteria for being put on the list or getting taken off the list?
    Neither the CoC or Billings First Congregational Church have a no services list. On a case-by-case basis, the Community Crisis Center reserves the right to deny service to clients who have caused harm to staff, other guests, or visitors.

27. How do you define "low barrier shelter?"
    Low barrier shelter is an option of last resort for unhoused neighbors with nowhere else to turn. The goal is to remove as many barriers to entry as possible, while providing a safe, warm, dry place for unhoused neighbors to obtain a full night's sleep.

LOW-BARRIER SHELTER QUESTIONNAIRE

1. Can you provide low-barrier shelter from October 1, 2022 – March 31, 2023? **Yes, provided we can obtain an adequate building.**

2. What is your monthly budget for doing so? **Depends on the building, however the monthly budget will be approximately $40,000/month.**

3. Where will low-barrier shelter services be located this winter? **OTS is currently searching for a building.**

4. What is the capacity that can be served nightly? **Based on the building obtained, we are planning to serve at least 100.**

5. Is the location compliant with building and fire codes OR are you willing to make modifications requested by the Fire Marshal and Building Inspector in order to bring the facility into compliance prior to October 1, 2022? **Compliance is unknown as we have not yet obtained a building. OTS is not in a financial position to remodel any building, nor is there time to complete most renovations. The building we obtain will need to be compliant.**

6. What hours of day/night will low-barrier shelter be open? **Open those hours Saint Vincent de Paul is closed.**

7. Do you have operational procedures developed and/or in place? **Will be utilizing an advisory committee to produce.**

8. How will you prevent liability and/or insure a low-barrier shelter? **OTS has an agreement with an insurance company to provide any necessary insurance coverage.**

9. Do you offer a warm handoff between service providers? **Yes, on a limited basis.**

10. Do you plan to provide transportation to/from other service providers? **Yes, on a limited basis.**

11. Do you plan to provide congregate or non-congregate shelter? **Based on the building OTS obtains, we would have both types of shelter accommodations.**

12. How will you screen guests to ensure safety and security? If this service is provided by an outside entity or community partner, do you have an MOU or contract in place? **OTS will rely on several agency partners to provide initial and ongoing screening of all guests. OTS will employ on site security and staff to ensure all guests are kept safe.**

13. Do you have processes in place for diverting guests to other service providers, when appropriate, as space is available? **OTS anticipates the need to divert guests to other service providers based on need and building limitations. The process will be finalized by an advisory committee that will be comprised (in part) of said service providers. MOU's will be necessary.**

14. Are you a participant in the Homeless Management Information System? If not, how will data and success metrics be tracked and shared? **OTS is currently not enrolled in HMIS but plans to do so prior to opening. In addition, OTS plans to utilize Unite MT as an additional data source.**

15. Are you a participant in the Coordinated Entry System? If not, are you willing to provide a Uniform Assessment to all shelter guests and participate in biweekly case conferencing? **OTS is currently not an active participant in the Coordinated Entry System but is willing to provide a Uniform Assessment to all shelter guests and participate in biweekly case conferencing.**

16. Will you serve minors? **Yes, depending on the building obtained, OTS plans to serve minors provided there can be adequate separation and they are accompanied by a parent or adult family member.**

17. Will you serve felons, sexual and/or violent offenders? **Yes, depending on the building obtained. OTS plans to serve these populations provided there**

can be adequate separation.

18. Will you serve people who do not meet sobriety requirements? **OTS will serve those actively using drugs or alcohol provided they can self-toilet, are not a danger to themselves or others and are not in crisis.**

19. Will you serve people who use assistive devices (wheelchair, walker, cane, etc.)? **Yes, based on the building obtained. OTS is planning to serve these populations.**

20. Will you serve people who are accompanied by a trained Service Animal? **Yes, based on the building obtained. OTS is planning to serve these populations.**

21. Will you serve people who are otherwise disabled, whether physically or mentally? **Yes, based on the building obtained. OTS is planning to serve these populations.**

22. Will you serve people who do not meet employment requirements? **OTS will not have employment requirements.**

23. Do you have a Diversity, Equity, and Inclusion policy of any kind? If not, will you commit to serving people regardless of race or ethnicity, gender or sexual orientation, or cultural background? **No. OTS plans to serve all peoples regardless of race, ethnicity, gender, sexual orientation, or cultural background.**

24. Will you serve people of different faiths or religious beliefs? **Yes, OTS will serve all people regardless of their faith or religious beliefs.**

25. Are there certain types of individuals or groups that you will not serve? **Yes, again, based on the building obtained and the ability to segregate populations. Ideally, OTS would only "not" serve those who are a danger to themselves or others.**

26. Do you maintain a no-services list? If so, what are the criteria for being put on the list or getting taken off the list? **Yes, OTS will have a no-services list.**

Ideally the list will be short or zero. An advisory committee will be charged with defining the ins and outs of the OTS no-services list.

27. How do you define "low barrier shelter?" **Provide sheltering to as many homeless individuals as possible by removing their obstacles (barriers) for entering an overnight shelter.**

7/19/22
To: Honorable Mayor Cole, Administrator Kukulski, and Members of Council
From: Matt Lundgren, Executive Director Montana Rescue Mission
Proposal: Addressing Public Safety Community Needs Through Emergency Sheltering Services

The Need: Billings has experienced a dramatic increase of individuals with mental health and substance abuse issues gathering at various locations throughout our community and becoming a public health and public safety issue. These individuals are negatively impacting law enforcement, public services and private businesses. This increase has been exacerbated by the pandemic and the legalization of marijuana. The community has expressed a desire to work toward addressing this issue by directing a portion of the public safety mil levy toward mitigating this impact.

The City Council also has an opportunity to direct some funds from the marijuana tax money to help mitigate these negative impacts on public safety driven by mental health issues and substance abuse. (In harmony with our proposal, a Mobile Crisis Response Team is also necessary to meet those in crisis on our streets that are not interested in pursuing solutions and directing them to services in ways that require special training and expertise beyond the training of law enforcement. We fully support this effort.) In addition to a Mobile Crisis Response Team, once people in mental health and substance abuse crisis's are stabilized, there is a need for housing these individuals beyond the confines of a costly jail cell or the Crisis Center, which is limited to 17 beds.

The Response: Montana Rescue Mission proposes that we use our 75 years of expertise, our facilities and our well-trained staff to help the city address this community need. In partnership with the Mobile Crisis Response Team, Law Enforcement and the Crisis Center, we will provide an emergency shelter for people whose mental health and substance abuse issues do not require hospitalization or incarceration. Provided people are not a danger to themselves or the other clients we serve, we will welcome guests nightly to our emergency shelter seven days a week, 365 days a year. We know that homelessness is not seasonal and the needs of law enforcement and public safety for mental health and substance abuse mitigation in our city do not cease with the warm weather.

We are asking the city to take an active partnership with us by helping fund a portion of our emergency shelter service and thereby expand our ability to meet the growing community need and offer a path forward to individuals experiencing mental health and substance abuse issues combined with homelessness. Due to both the pandemic and the legalization of marijuana, we have seen homeless individuals with mental health and substance abuse issues increase 40%. This increase is straining our resources and city help is needed to avoid a larger community crisis. As individuals who are a risk to public safety with mental health and/or substance abuse issues stay with us in our emergency shelter partially funded by city dollars, they will be provided avenues through which to access our long term shelter services which include licensed addiction counseling, mental health therapy, case management, food, clothing, spiritual care, and basic medical care.

The goal of Montana Rescue Mission in this partnership with the City is to promote Public Safety by working with individuals experiencing mental health or substance abuse issues combined with homelessness and to direct them towards healthier lifestyles, more productive decision making, and ultimately, stabilization which leads to reintegration into society, an enlarged workforce, and more productive taxpaying citizens. While other entities may want to take on this sheltering responsibility by providing a bed on a part time or seasonal basis, the Montana Rescue Mission will not only provide a bed but also access to our robust stable of resources (see attached) to help individuals end their homelessness and move forward out of addiction and mental health crises.

The Impact: As you are aware, Montana Rescue Mission's investment in our community is substantial. We have proven this by the work we have done for the last 75 years to successfully lead thousands out of homelessness. It is also proven by our current investment in a new campus which is a $22 million solution driven space to help aid in ending homelessness and promoting public safety in our community.

I invite you to see the attached "Services synopsis" and "Shelter Impact Data" that describes the fruit of our work at ensuring Public Safety in our community.

We know of no other organization that has our type of reach, history, housing, shelter, counseling, care, or commitment to invest in helping individuals who are a Public Safety risk and who are experiencing mental health and substance abuse issues combined with homelessness. It is our aim to honor taxpayer intent and steward taxpayer dollars to best mitigate impacts on Public Safety by providing emergency shelter services.

Proposed Budget: Addressing Public Safety Community Needs Through Emergency Sheltering Services

Category	**Annual Cost**
Staffing:	$373,300
Sheltering:	$ 60,000
Data/Admin/Overhead:	$ 76,700
Total Annual Budget/ Request	$510,000

Terms and Conditions:
-24 Month Contract.
-Payable in quarterly installments, net 30 days from invoice.
-We will operate our emergency shelter 365 days per year.
-We will accept those who are not a danger to themselves or others.
-We will accept qualifying referrals from Law Enforcement, Mobile Crisis Team, and Crisis Center, as well as walk ins.
-We will file quarterly reports with numbers served, numbers moved to our regular shelter, number of law enforcement, crisis center or mobile crisis unit referrals/hand offs as well as walk ins.
-We will meet with the City Administrator to deliver this data and provide quarterly updates.

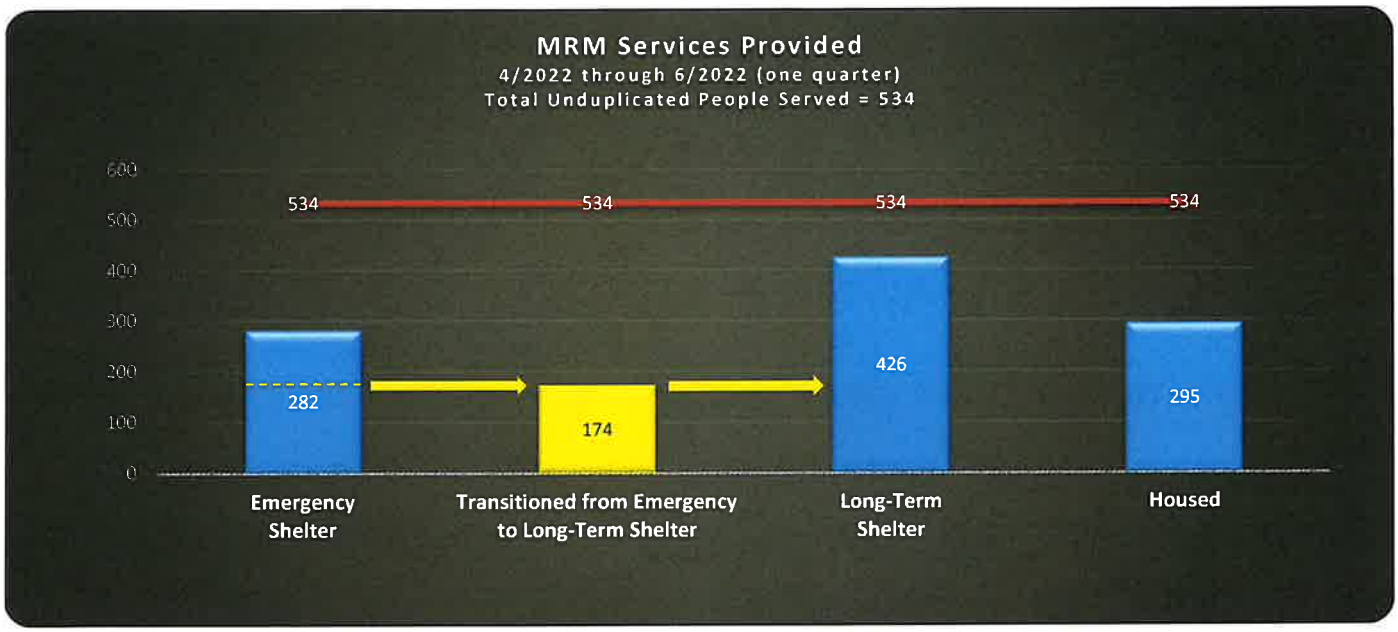
We invite you to consider our proposal as detailed in our budget (above), impact data and operational specifics (attached).

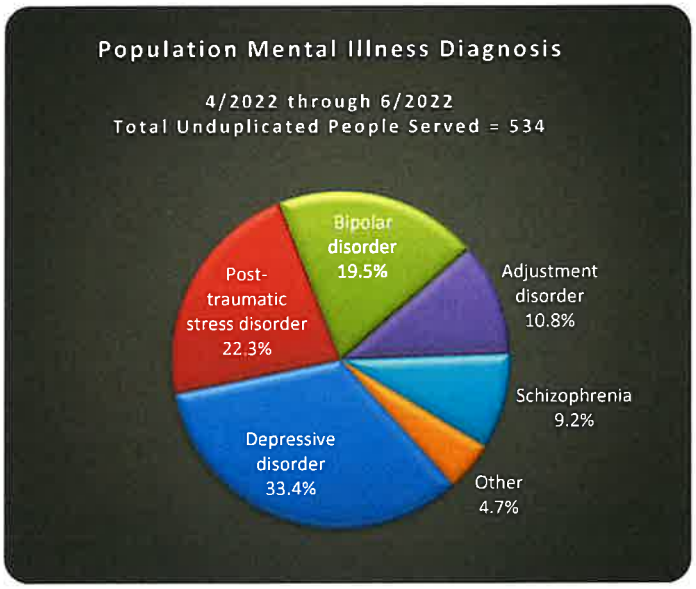
If you have any questions or concerns, please feel free to reach out to me.

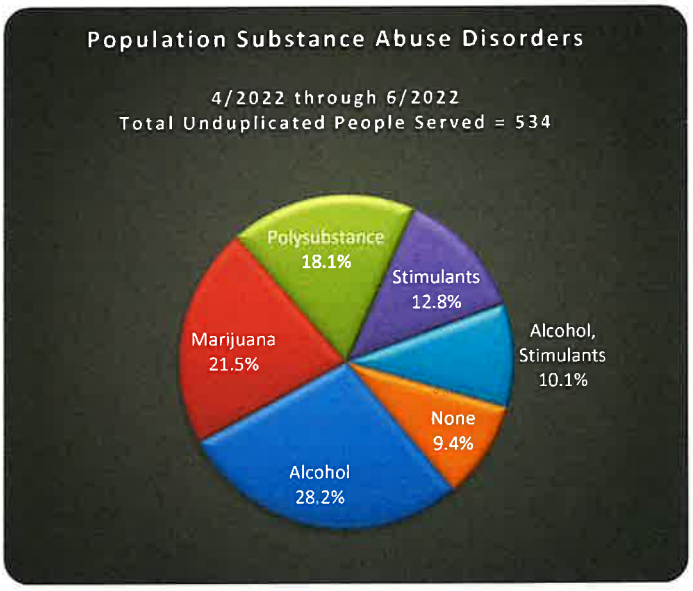
Thank you for this consideration.

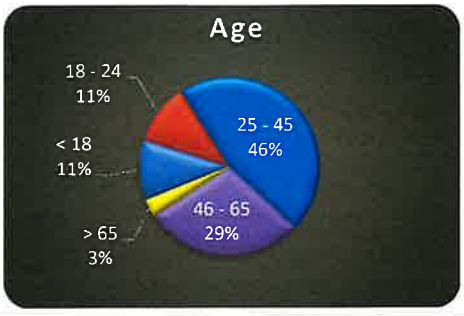
Best,

Rev. Matt Lundgren
Executive Director
Montana Rescue Mission

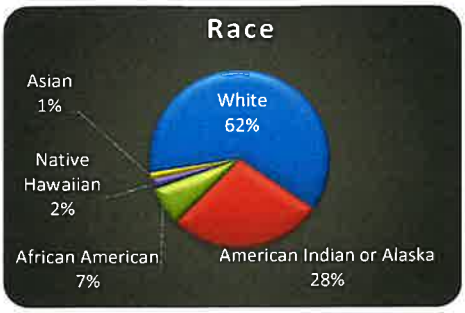

MRM Services Provided
4/2022 through 6/2022 (one quarter)
Total Unduplicated People Served = 534
600
500
400
300
200
100
0
534
534
534
534
282
174
426
295
Emergency Shelter
Transitioned from Emergency to Long-Term Shelter
Long-Term Shelter
Housed

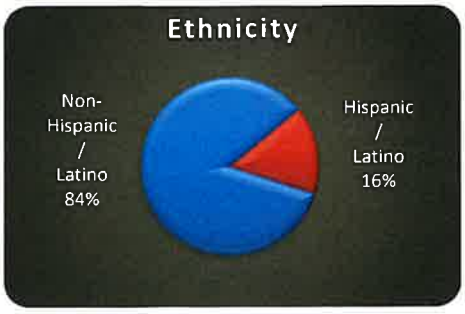

Population Mental Illness Diagnosis
4/2022 through 6/2022
Total Unduplicated People Served = 534
Bipolar disorder 19.5%
Adjustment disorder 10.8%
Schizophrenia 9.2%
Other 4.7%
Depressive disorder 33.4%
Post-traumatic stress disorder 22.3%

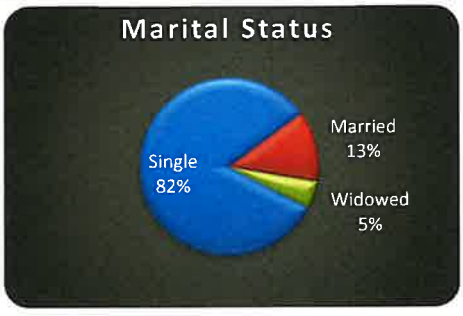

Population Substance Abuse Disorders
4/2022 through 6/2022
Total Unduplicated People Served = 534
Polysubstance 18.1%
Stimulants 12.8%
Alcohol, Stimulants 10.1%
None 9.4%
Alcohol 28.2%
Marijuana 21.5%


Age
18 - 24 11%
< 18 11%
> 65 3%
25 - 45 46%
46 - 65 29%

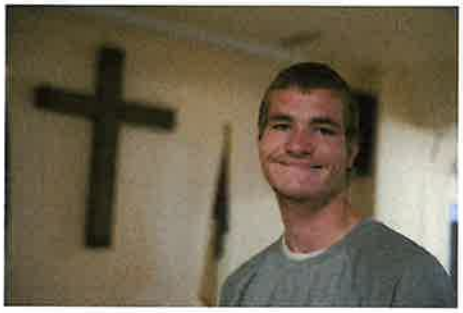

Sex
Female 39%
Male 61%


Race
Asian 1%
White 62%
Native Hawaiian 2%
African American 7%
American Indian or Alaska 28%


Ethnicity
Non-Hispanic / Latino 84%
Hispanic / Latino 16%


Marital Status
Single 82%
Married 13%
Widowed 5%

mrm
montana
rescue mission



Our Mission

To reflect the love of Jesus Christ, by providing emergency, temporary, and rehabilitative care for those experiencing hunger and homelessness.

Services for those in need. Men, Women, and Family Shelter

Basic Needs

We meet basic needs, such as, meals, showers, clothing, transportation, and laundry service.

Shelter

We offer safe emergency, temporary, and rehabilitative care facilities with secured entrances and surveillance systems. We provide 24/7/365 care with full support staff.

Behavioral Health/Case Management

We provide comprehensive mental health and addiction services which include peer support, group therapy, individual therapy, and clinical assessments.

Addiction Recovery

We provide substance abuse counseling through support and recovery groups. We offer chemical dependency evaluations.

Childcare/Youth Programs

We provide preschool/afterschool programs so families can work on themselves during their stay. We offer programs for youth ages 3-19, as well as, parenting education and support.

Vocational Training

We provide job skills training and internship programs to help guests gain experience to get back into the workforce.

Transitional Support

We provide rental assistance and transportation to allow guests to find safe, permanent, affordable housing and a means to get back and fourth to work.

Medical

We help with basic health check-ups and assist with referrals for medical support.

Education and Personal Growth

We offer adult education and training to help with financial skills, life skills and healthy living skills.

Housing

We help guests overcome housing barriers & assist with housing search & retention. Assist with essential housing needs, such as furniture and cookware and provide household management coaching.

LIVES • CHANGE • HERE

For More Information or to Learn About How We Can Help,

Please Visit us at 2822 Minnesota Avenue, Billings, MT 59101

www.montanarescuemission.org

LOW-BARRIER SHELTER QUESTIONNAIRE

Montana Rescue Mission Responses 7/20

1. **Can you provide low-barrier shelter from October 1, 2022 – March 31, 2023?**
   Montana Rescue Mission has been and will continue to provide our Emergency Shelter (AKA) low-barrier shelter. We will certainly offer it during this specified timeframe.

2. **What is your monthly budget for doing so?**
   Approximately $300,000 per year or $25,000 per month with current hours of operation and services.

3. **Where will low-barrier shelter services be located this winter?**
   Our Emergency Shelter will be located on our campus at 2822 Minnesota Ave.

4. **What is the capacity that can be served nightly?**
   We have enough space to accommodate as many people as needed. We can expand if necessary.

5. **Is the location compliant with building and fire codes OR are you willing to make modifications requested by the Fire Marshal and Building Inspector in order to bring the facility into compliance prior to October 1, 2022?**
   Yes.

6. **What hours of day/night will low-barrier shelter be open?**
   We can be open whenever we perceive the homeless community needs us. Currently we are open from 10PM to 6AM for Emergency Shelter. We can expand if there is a verified need.

7. **Do you have operational procedures developed and/or in place?**
   Yes.

8. **How will you prevent liability and/or insure a low-barrier shelter?**
   We have insurance and have safety training and safety procedures in place.

9. **Do you offer a warm handoff between service providers?**
   Yes.

10. **Do you plan to provide transportation to/from other service providers?**
    Yes.

11. **Do you plan to provide congregate or non-congregate shelter?**
    Depends on the individual guest's need. Both are available.

12. **How will you screen guests to ensure safety and security? If this service is provided by an outside entity or community partner, do you have an MOU or contract in place?**
    We screen guests in house. We have 75 years of experience screening guests.

13. **Do you have processes in place for diverting guests to other service providers, when appropriate, as space is available?**
    Yes.

14. **Are you a participant in the Homeless Management Information System? If not, how will data and success metrics be tracked and shared?**
    Yes. Both HMIS and other databases. Our state HMIS is not user friendly, provides inconsistent data reports, has HIPAA violation issues, and is not customizable to meet the need of an organization that does more than assessments. As a result, Montana Rescue Mission is still enrolled in HMIS, but adopted an additional database to meet the data needs that HMIS does not supply.

15. **Are you a participant in the Coordinated Entry System? If not, are you willing to provide a Uniform Assessment to all shelter guests and participate in biweekly case conferencing?**
    We find the Uniform Assessment to be a barrier to entry to our emergency shelter guests and MRM does not feel comfortable forcing guests to complete assessments in order to spend a night in a warm and safe place. If a guest would like to participate, they are welcome to. After basic needs are met, guests are more willing to share their basic information.

16. **Will you serve minors?**
    Yes, in their own space.

17. **Will you serve felons, sexual and/or violent offenders?**
    Yes.

18. **Will you serve people who do not meet sobriety requirements?**
    Yes.

19. **Will you serve people who use assistive devices (wheelchair, walker, cane, etc.)?**
    Yes.

20. **Will you serve people who are accompanied by a trained Service Animal?**
    Yes.

21. **Will you serve people who are otherwise disabled, whether physically or mentally?**
    Yes.

22. **Will you serve people who do not meet employment requirements?**
    Yes.

23. **Do you have a Diversity, Equity, and Inclusion policy of any kind? If not, will you commit to serving people regardless of race or ethnicity, gender or sexual orientation, or cultural background?**
    Yes.

24. **Will you serve people of different faiths or religious beliefs?**
    Yes.

25. **Are there certain types of individuals or groups that you will not serve?**
    No. However, individuals who are a threat to themselves or others will be served after evaluation, mitigation and release from a qualified entity.

26. **Do you maintain a no-services list? If so, what are the criteria for being put on the list or getting taken off the list?**
    Yes. Our no services list works the same way as the Crisis Center. If a person was placed on a no-services list, they can meet with staff to request admission.

27. **How do you define "low barrier shelter?"**
    Our Emergency Shelter/low barrier program has trauma informed and harm reduction service approach. People utilizing this service don't have sobriety, work or other "barrier" requirements, but rather behavioral expectations.

LOW-BARRIER SHELTER QUESTIONNAIRE

Montana Rescue Mission Responses 7/20

1. **Can you provide low-barrier shelter from October 1, 2022 – March 31, 2023?**
   Montana Rescue Mission has been and will continue to provide our Emergency Shelter (AKA) low-barrier shelter. We will certainly offer it during this specified timeframe.

2. **What is your monthly budget for doing so?**
   Approximately $300,000 per year or $25,000 per month with current hours of operation and services.

3. **Where will low-barrier shelter services be located this winter?**
   Our Emergency Shelter will be located on our campus at 2822 Minnesota Ave.

4. **What is the capacity that can be served nightly?**
   We have enough space to accommodate as many people as needed. We can expand if necessary.

5. **Is the location compliant with building and fire codes OR are you willing to make modifications requested by the Fire Marshal and Building Inspector in order to bring the facility into compliance prior to October 1, 2022?**
   Yes.

6. **What hours of day/night will low-barrier shelter be open?**
   We can be open whenever we perceive the homeless community needs us. Currently we are open from 10PM to 6AM for Emergency Shelter. We can expand if there is a verified need.

7. **Do you have operational procedures developed and/or in place?**
   Yes.

8. **How will you prevent liability and/or insure a low-barrier shelter?**
   We have insurance and have safety training and safety procedures in place.

9. **Do you offer a warm handoff between service providers?**
   Yes.

10. **Do you plan to provide transportation to/from other service providers?**
    Yes.

11. **Do you plan to provide congregate or non-congregate shelter?**
    Depends on the individual guest's need. Both are available.

12. **How will you screen guests to ensure safety and security? If this service is provided by an outside entity or community partner, do you have an MOU or contract in place?**
    We screen guests in house. We have 75 years of experience screening guests.

13. **Do you have processes in place for diverting guests to other service providers, when appropriate, as space is available?**
    Yes.

14. **Are you a participant in the Homeless Management Information System? If not, how will data and success metrics be tracked and shared?**
    Yes. Both HMIS and other databases. Our state HMIS is not user friendly, provides inconsistent data reports, has HIPAA violation issues, and is not customizable to meet the need of an organization that does more than assessments. As a result, Montana Rescue Mission is still enrolled in HMIS, but adopted an additional database to meet the data needs that HMIS does not supply.

15. **Are you a participant in the Coordinated Entry System? If not, are you willing to provide a Uniform Assessment to all shelter guests and participate in biweekly case conferencing?**
    We find the Uniform Assessment to be a barrier to entry to our emergency shelter guests and MRM does not feel comfortable forcing guests to complete assessments in order to spend a night in a warm and safe place. If a guest would like to participate, they are welcome to. After basic needs are met, guests are more willing to share their basic information.

16. **Will you serve minors?**
    Yes, in their own space.

17. **Will you serve felons, sexual and/or violent offenders?**
    Yes.

18. **Will you serve people who do not meet sobriety requirements?**
    Yes.

19. **Will you serve people who use assistive devices (wheelchair, walker, cane, etc.)?**
    Yes.

20. **Will you serve people who are accompanied by a trained Service Animal?**
    Yes.

21. **Will you serve people who are otherwise disabled, whether physically or mentally?**
    Yes.

22. **Will you serve people who do not meet employment requirements?**
    Yes.

23. **Do you have a Diversity, Equity, and Inclusion policy of any kind? If not, will you commit to serving people regardless of race or ethnicity, gender or sexual orientation, or cultural background?**
    Yes.

24. **Will you serve people of different faiths or religious beliefs?**
    Yes.

25. **Are there certain types of individuals or groups that you will not serve?**
    No. However, individuals who are a threat to themselves or others will be served after evaluation, mitigation and release from a qualified entity.

26. **Do you maintain a no-services list? If so, what are the criteria for being put on the list or getting taken off the list?**
    Yes. Our no services list works the same way as the Crisis Center. If a person was placed on a no-services list, they can meet with staff to request admission.

27. **How do you define "low barrier shelter?"**
    Our Emergency Shelter/low barrier program has trauma informed and harm reduction service approach. People utilizing this service don't have sobriety, work or other "barrier" requirements, but rather behavioral expectations.