Report to the Montana Healthcare Foundation

Overview of Alternative Schools and Education Programs

March 2015

ACKNOWLEDGMENTS

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Executive Summary

An alternative education program in Montana is defined as "A 'restructured' academic program to serve at-risk students and operated within an accredited public school." Twenty-eight alternative education programs that fit this definition currently exist in Montana, though there is no official tracking system for these programs, and local schools districts have full discretion over how these operate. The students served by alternative education programs report elevated rates of health risk behaviors, particularly related to mental health and substance abuse. However, alternative education programs in Montana are chronically underfunded and lack the staff and training needed to holistically address student health needs.

Despite these challenges, a number of evidence-based model programs exist at both the state and local levels that are helping address the complex health needs of students in alternative education programs. Projects like the Montana Behavioral Initiative, Mental Health 1st Aid, Project SUCCESS, and High Fidelity Wrap Around are being piloted in the state and could be adopted and expanded in alternative education settings with focused resources and training.

Methodology

This report contains information gathered about alternative schools in Montana by an independent consultant hired by the Montana Healthcare Foundation in March 2015. The methods utilized to gather information in this project include a review of existing documents, 13 semi-structured key informant interviews with a total of 19 individuals, an electronic Montana Alternative Schools and Health Survey, literature searches using PubMed and the SAMSHA National Registry of Evidence Based Programs and Practices, and funding searches using Grantwatch and the Foundation Center websites. Neither the key informant interviews nor the Montana Alternative Schools and Health Survey (n-=13) collected responses from all known alternative schools in the state, so these findings should be considered preliminary and not necessarily representative of the views and experiences of all existing alternative education programs. The conclusions and recommendations included in this report are solely those of the author and do not necessarily represent the view of the Montana Healthcare Foundation.

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Definitions

Alternative education is a difficult term to define. In a recent survey, Porowski et al. (2014)[1] found that 43 states and the District of Columbia have formal definitions of alternative education, but that these definitions vary widely related to whom alternative education programs primarily serve, what type of instruction or services are provided, and the location of the programs.

For reporting purposes the Montana Office of Public Instruction (OPI) defines an alternative education program as "**A 'restructured' academic program to serve at-risk students and operated within an accredited public school.**"[2] As in the national study sample, there are broad differences across Montana in the way that alternative education programs operate. Some are located on traditional school campuses, some are off-site. Some utilize live instruction while others rely almost exclusively on distance learning technology. A few alternative education programs are even operated by non-profits or public school-community college partnerships, though these programs do not fully fit the definition used by OPI. Montana also has a number of education programs in residential or day treatment facilities for mental health or substance abuse treatment, as well as educational facilities that are part of the juvenile justice system. In some states, these types of residential and juvenile justice-affiliated programs are also included in the definition of alternative education. Some alternative education programs in the state take a holistic approach to student health, providing wrap around services, case management or group therapy for students. However, other programs in Montana are simply designed to get the "bad kids" out of the classroom and into a program where they will be less disruptive and can finish their course work using distance learning. These types of programs may not even employ teachers, but instead utilize para-educators to monitor students using distance learning technology.

Federal statute and Montana Code Annotated (MCA) do not legally define alternative education. There is mention of "in-school and alternative education options" in Chapter 10.66.110 of the MCA which lays out the requirements for students who desire to take their High School Equivalency exam (e.g., GRE or HiSet). In this section, the code indicates that students wishing to take the HSE exam must be "advised of in-school and alternative education options." "Alternative Educational Options" are defined in this section as "a state-approved educational program designed to provide a secondary education outside a traditional high school setting (e.g., Job Corps, Youth Challenge)." Thus, it may be helpful for the purposes of this report to distinguish between three types of alternative education programs:

1. Alternative education programs operated by accredited public schools (the OPI definition used for reporting)

[1] Porowski, A. O'Connor, R. Luo, J.L. (2014). "How do states define alternative education?" National Center for Education Evaluation and Regional Assistance. U.S. Department of Education

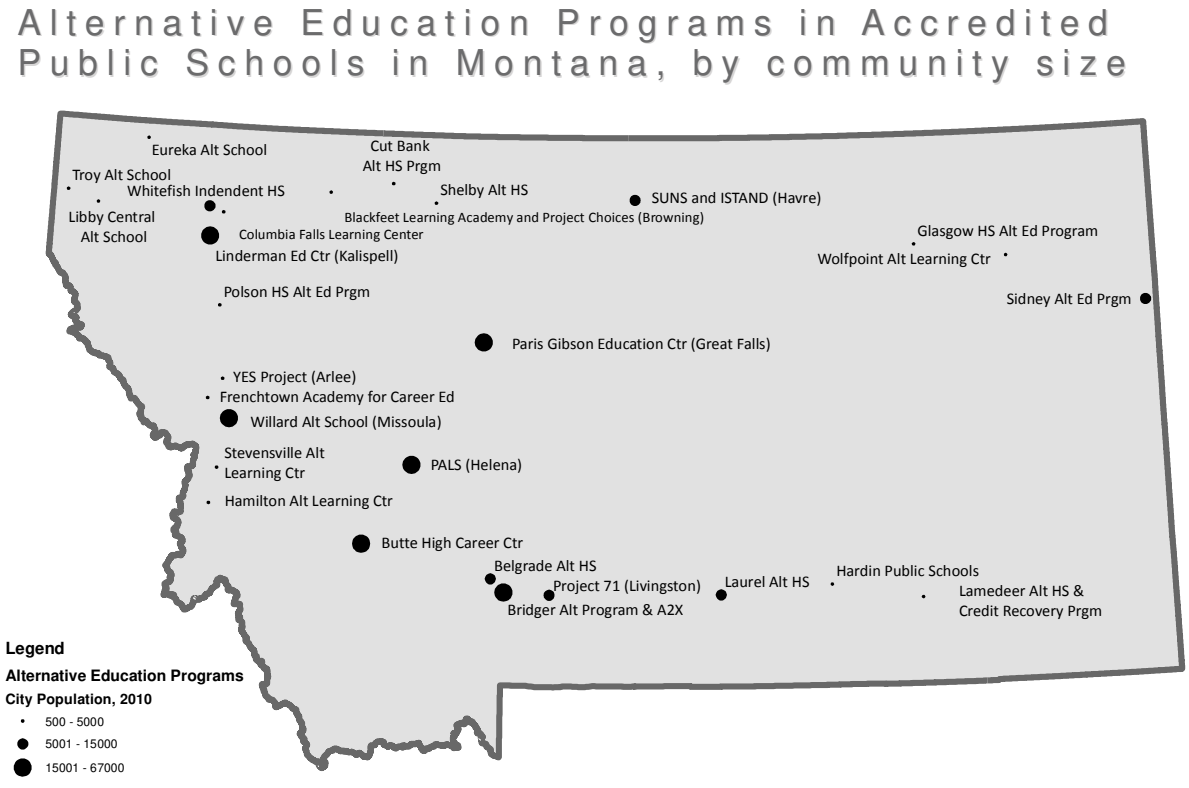
[2] http://opi.mt.gov/pub/pdf/ADC/FY09/09ADCGlossary.pdf and http://opi.mt.gov/pub/pdf/ADC/FY12/12AltEd.pdf

2. State-approved educational programs outside of the traditional high school (the MCA definition of Alternative Education Options)
3. Day treatment, residential treatment, and juvenile justice system programs that operate educational programs

This report includes contact information for and references to all these types of alternative education programs, while focusing on the programs that meet the OPI definition of alternative education -- those restructured academic programs operated within accredited public schools. Incidentally, the students in the programs that fit the OPI definition are also those included for analysis in the "Alternative Education" sample for the Youth Risk Behavior Survey (YRBS). For a list of contact information for schools that fit these three definitions, see Appendix A.

An overview of Alternative Education Programs in MT

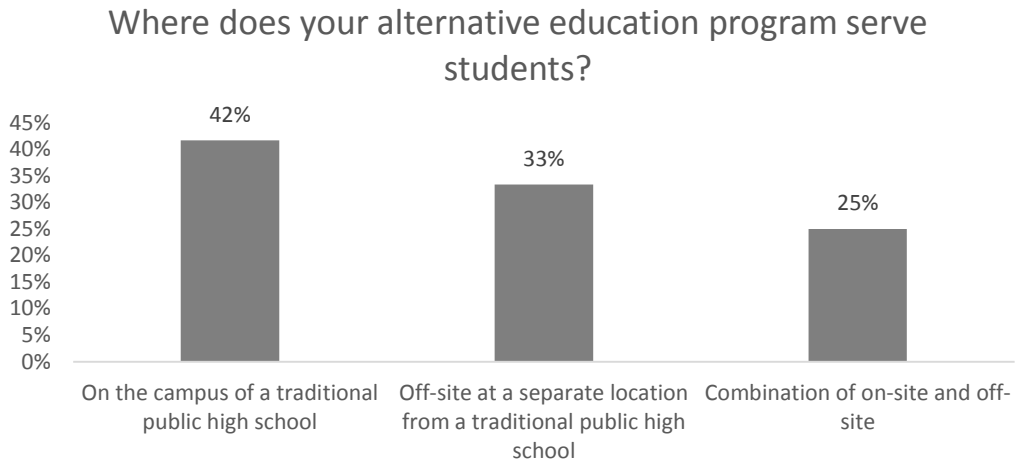
There is no official survey or databased used to enumerate Alternative Education Programs in Montana. A search of the OPI website indicates that the Accreditation Division attempted to systematically collect information on alternative education programs in Montana as recently as 2010-2011, but the data collected has not been made publically available.[3]



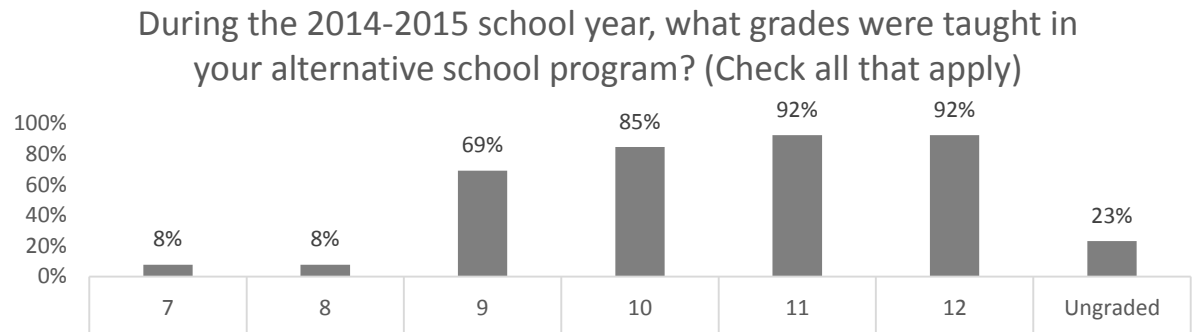
[3] http://opi.mt.gov/pdf/ADC/FY11/11AltEd.pdf

Stakeholder interviews conducted for this project, extensive internet searches, and document reviews identified 28 alternative education programs administered by accredited public schools (see map below and contact list in Appendix A), indicating that approximately 17.5% of the 160 K-12 or High School Districts in the state run some type of alternative education program. Six of the identified programs are located in larger Montana communities with more than 15,000 residents, six are located in midsized communities with 5,000 to 15,000 residents, but the majority of alternative education programs are operated in rural communities of fewer than 5,000 residents (see map above). Notably, the largest community in Montana, Billings, does not have an alternative education program run by an accredited public school. Only seven alternative education programs (25%) exist east of Great Falls, meaning that students in eastern Montana have very little access to alternative education programs within their public school systems.

Responses to the Montana Alternative Schools and Health Survey indicate that the number of students served by Montana alternative education programs varies widely. Of the 13 programs that responded, the number of students served ranged from six to 200 with an average of 113. Programs also varied as to where the program is housed (see graph below).



Most programs reported serving high schools students, though a limited number, served 7th or 8th graders or had an ungraded program (see graph below).



Governance

The governance of Montana Alternative Education Programs is best understood under the framework of local control. In the state of Montana, schools are governed at the local level by school boards that oversee a total of 413 budgeting and fiscal districts state wide. At the high school level, there are 160 distinct K-12 or high school budgeting or fiscal districts serving the 42,070 enrolled 9-12 graders in the state.[4] Each district receives a certain amount of funding per student and has discretion to apply that funding toward an alternative education program if they choose. Local districts also have discretion about how to structure their alternative education programs. Thus, key alternative education stakeholders report that, depending on resource availability and administrative priorities, small alternative education programs are regularly started but also shut down.

The Administrative Rules of Montana (ARMs) do provide a number of provisions that can be utilized by alternative education programs that exist in accredited public schools in Montana. The Montana ARM 10.55.906(3) & (4) allows local school board trustees to waive certain graduation requirements based on individual student needs and to allow students to receive credit for course work delivered through "correspondence, extension, and distance learning courses, adult education, summer school, work study, specially designed courses, and challenges to current courses."[5] Montana ARM 10.55.907 provides guidelines for schools allowing them to utilize distance, online, and technology-delivered learning programs. Online and distance learning is the basis of many programs in Montana. A review of the existing websites of alternative education programs in the state indicates that many rely heavily or exclusively on the Montana Digital Academy, which is a state-approved virtual public school located on the University of Montana campus.[6] In the Montana Alternative Schools and Health Survey, only one program reported modifying graduation requirements for alternative high school students but 75% of programs reported modifying attendance requirements for their participants. One hundred percent of programs reported utilizing distance, online or

[4] http://opi.mt.gov/PDF/Directory/2015Directory.pdf
[5] http://www.mtrules.org/gateway/ruleno.asp?RN=10.55.906
[6] http://www.montanadigitalacademy.org/

technology-driven programs or courses. Despite utilizing online or distance learning technology, 92% of programs report that students spend "all or almost all of their time" or "the majority of their time" on site.

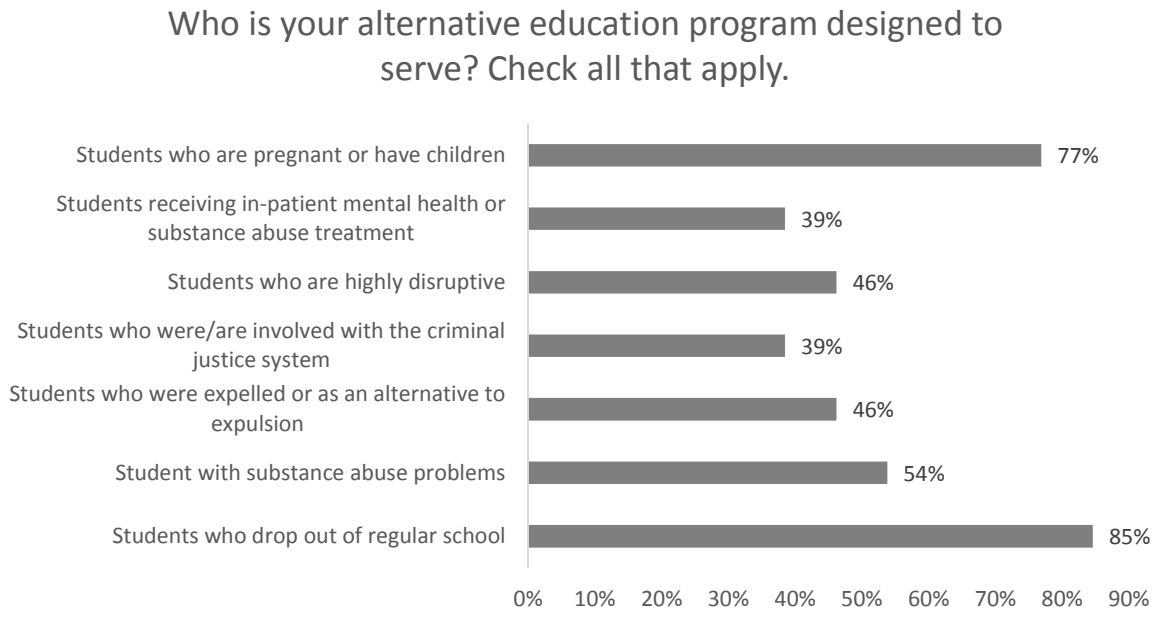
Structured interviews with stakeholders and reviews of alternative education websites in Montana revealed large differences in the governance of alternative education programs in the state. A few programs, like Bridger Alternative High School in Bozeman, admit any students who prefer a less structured educational experience than the traditional high school curriculum. Most programs, however, have specific requirements for students to enter. For instance, the Sidney High School Alternative Education Program requires that students meet one or more of the following criteria: 1) Has dropped out for at least 45 days 2) Is a 5th-year senior 3) Is at least two years behind in school.[7] Other programs in the state are available only to juniors and seniors, require that students be referred by a teacher or counselor, or show other signs of being at risk of educational failure. [8]

Alternative Student Demographics

Sociodemographic Characteristics

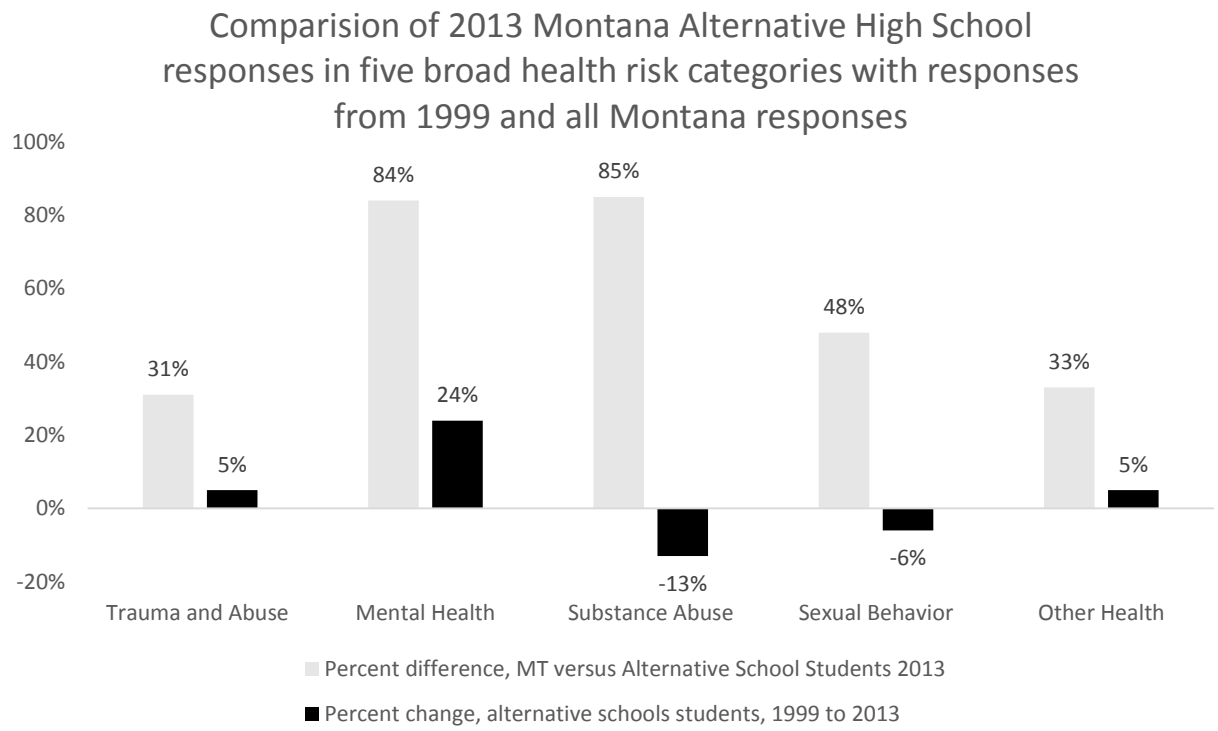
Responses to the Montana Alternative Education and Health Survey and structured interviews paint a picture of a student population at alternative schools at very high risk for negative health outcomes. Part of this is by design. Alternative education programs are structured to meet the needs of at-risk students, with the majority of programs indicating that they are designed to serve students who are pregnant or have children, students with substance abuse problems, and students who drop out of regular school (see graph below).

[7] http://www.sidney.k12.mt.us/Page/187
[8] http://www.polson.k12.mt.us/phs/departments/specialed/Pages/creditrecovery.htm



When asked to describe the health of their student population in the Montana Alternative Schools and Health Survey, some respondents reported that the health of their population was comparable to other high schools students while others reported poor eating habits, frequent sickness, lack of exercise, drug, alcohol use, or other substance use and mental health concerns. When alternative school stakeholders were asked to rank the health concerns for their student population, the most pressing concerns identified were trauma and abuse and risky sexual behaviors.

To rank the health needs according to the self-reported risk factors of alternative high school, student responses in the 2013 Youth Risk Behavioral Survey for key indicators in five broad areas (Trauma and Abuse, Mental Health, Substance Abuse, Risky Sexual Behavior, and General Health) were averaged and compared to the percent difference from the general high school population in Montana (see Appendix B). The largest differences between the two groups' responses were in mental health and substance abuse followed by sexual abuse, general health, and trauma and abuse. When the percent difference from the 1999 YRBS responses were averaged for these five areas, the trend data showed that mental health concerns are on the rise in this population (up 24% since 1999), while substance abuse and risky sexual behavior indicators are trending downward (down 13 and 6% respectively since 1999) (see graph below and Appendix B for the full analysis).



The high level of health concerns among alternative education students was underscored repeatedly in the semi-structured interviews with key alternative education stakeholders. Administrators reported that upwards of 70-90% of their student population was at or below the poverty level and/or qualified for free and reduced priced lunch. Grief, trauma, coping, trouble with basic life skills, and lack of resiliency were all themes that emerged from these conversations. Many reported that a high percentage of their student population comes from dysfunctional and troubled family situations where students are repeatedly exposed to trauma. Some students are already parents themselves and are struggling to finish high school while raising children of their own. One administrator noted that it seems like some families are "hit by lightning over and over" by ongoing and deeply traumatic life circumstances. She summed up her comments saying, "Sometimes kids are on the DSM V spectrum[9] -- but a lot of kids are just struggling."

School Performance and Graduation Statistics

Most alternative education programs in Montana are considered "attendance centers" which means that even though students are enrolled in the alternative education program (and may even attend classes in a completely separate building) they are technically still enrolled as students at their traditional high school. Thus, robust, statewide graduation or drop-out statistics are not available for alternative schools in Montana. Jane Bennett, the principal of

[9] "Diagnostic and Statistical Manual of Mental Disorders, version 5"

Willard School in Missoula reported that their program graduates about 80-90 students a year while another 25 drop out of the program (a 76-78% completion rate). Other alternative education programs, like Project Choices in Browning, are designed to catch students up using an individualized education plan so they can recover failed credits and eventually "re-join" the traditional high school. So the goal of the programs isn't necessarily to help a student graduate from his/her program, but to help the student catch up to the mainstream classroom.

Interaction with the Criminal Justice System

The Juvenile Justice System in Montana is split into 22 juvenile justice districts across the state.[10] Every judicial district submits a Prevention Incentives Fund (PIF) plan annually to the state Youth Court program and negotiates funding for alternative education, tutoring, or other preventive educational services needed in their area. Thus, in 2013-2014, the Youth Courts funded more than $350,000 worth of education activities for at-risk students across the state. Some funding goes toward programs structured more like adult basic education (e.g., HiSet and GRE preparation) and some goes to individual tutoring, but some districts structure their funding to support alternative education programs like the A2X Program in Bozeman and I-STAND in Havre Middle School. Thus, the Juvenile Justice System is not only receiving kids from alternative education programs that are charged with crimes, but is also actively funding alternative education programs to help prevent juvenile delinquency. Bob Peake, the Youth Court Services Director, notes that the Youth Court is very interested in prevention and restorative justice and has funded school trainings in partnership with the Department of Public Health and Human Services on ACE (adverse childhood experiences). He notes that there is a strong correlation between education and delinquency. If students drop out of school, they are four times more likely to be involved in the criminal justice system.

The Youth Court could not provide exact data related to the numbers of alternative high schools students involved in the juvenile justice system. Bob Peake did provide a snapshot of the number of youth involved with the juvenile justice system who have a mental health diagnosis: in 2014, 4,001 youth were involved in the juvenile justice system in Montana and 768 (19%) had a mental health diagnosis. The Youth Court believes that this reported percentage is lower than the actual percentage of youth they interact with who are mentally ill because of the stigma of a mental health diagnosis and the lack of mental health care access for this population.

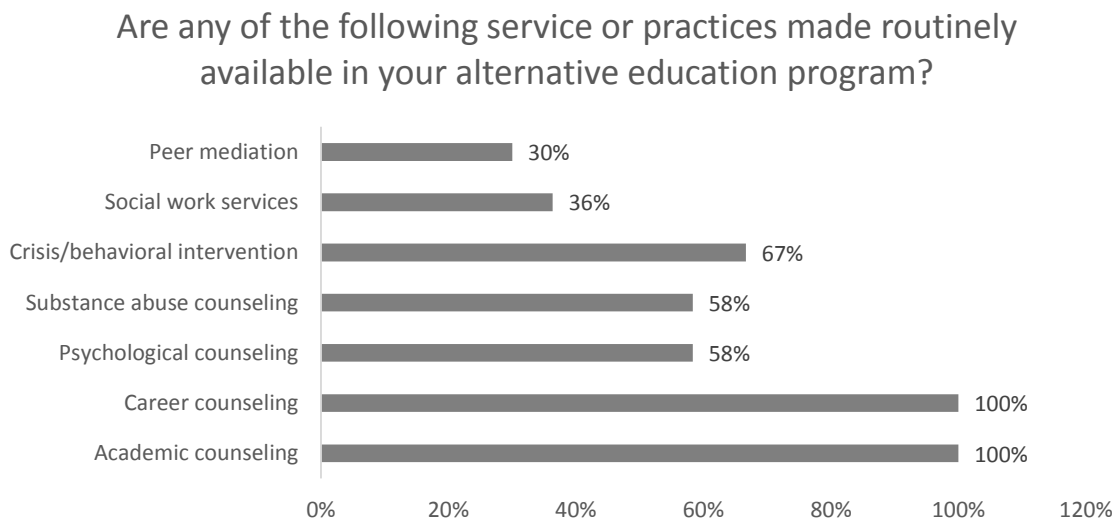
Because alternative education students are at such high risk of dropping out of school and have higher rates of mental illness and substance use than the general high school population, and because these factors are so strongly correlated with delinquency, it is very likely that alternative high school students interact with the juvenile justice system at much higher rates

[10] http://www.courts.mt.gov/content/dcourt/yth_court/docs/2013ReportCard.pdf

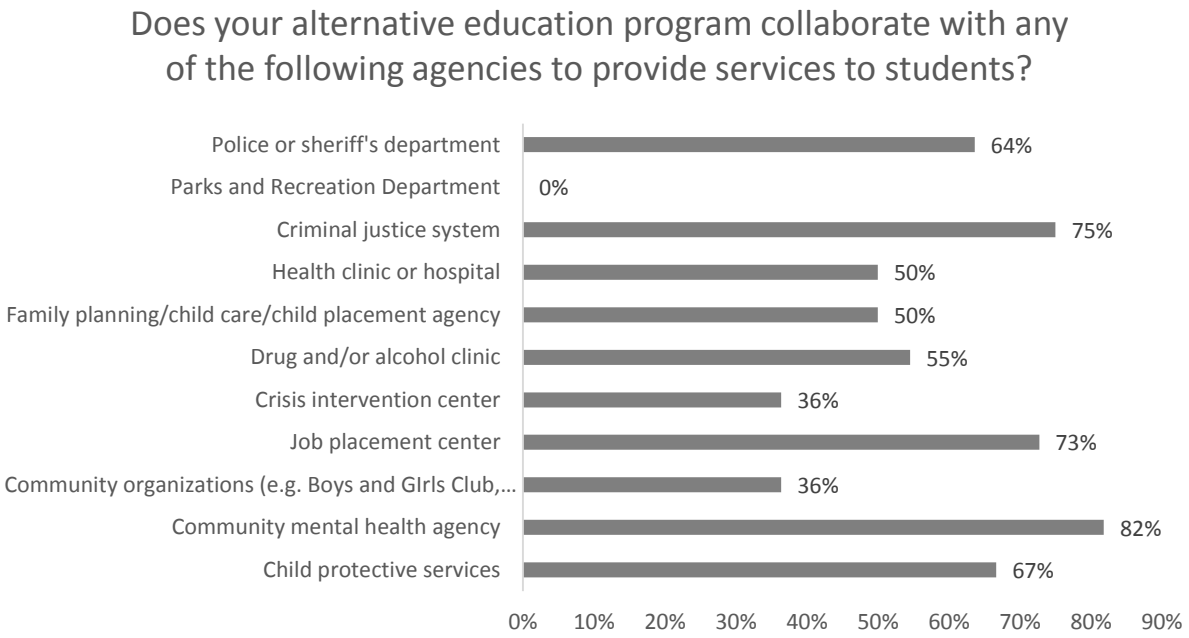
than the general student population. Further investigation of data sources with the Youth Courts might elucidate this line of inquiry further.

Services in Alternative Schools

Respondents to the Montana Alternative Schools and Health survey reported providing a range of services to students, despite having very few qualified staff (see graph in "Gaps in Services" section). However, the services made regularly available to students were more likely to revolve around career and academic counseling than those that address behavioral/mental health or substance abuse (see graph below).



Alternative education programs also appear to have strong community connections that are utilized to provide services to students. Community mental health, the criminal justice system, and job placement centers were the most common reported collaborative partners (see graph below).



State Initiatives

In Fiscal Year 2015, the Office of Public Instruction (OPI) received more than $4 million of federal funding and $138,000 of state funding to support mental health initiatives in schools. OPI and the Children's Mental Health Bureau use a framework of "tiered supports" to understand and target the mental health, substance abuse, and behavioral work in the state. This framework is based on the evidence-based Positive Behavioral Interventions and Supports (PBIS) model (See Appendix C for references). In the PBIS model, there are Universal Interventions for all students that support positive behaviors and resiliency. For students in crisis or with emerging behavioral issues, the model calls for Targeted Interventions that are directed toward at-risk students who are in crisis or who need short-term intervention. Finally, at the top of the pyramid are intensive, individualized interventions for high risk students who are in need of focused, longer-term support.

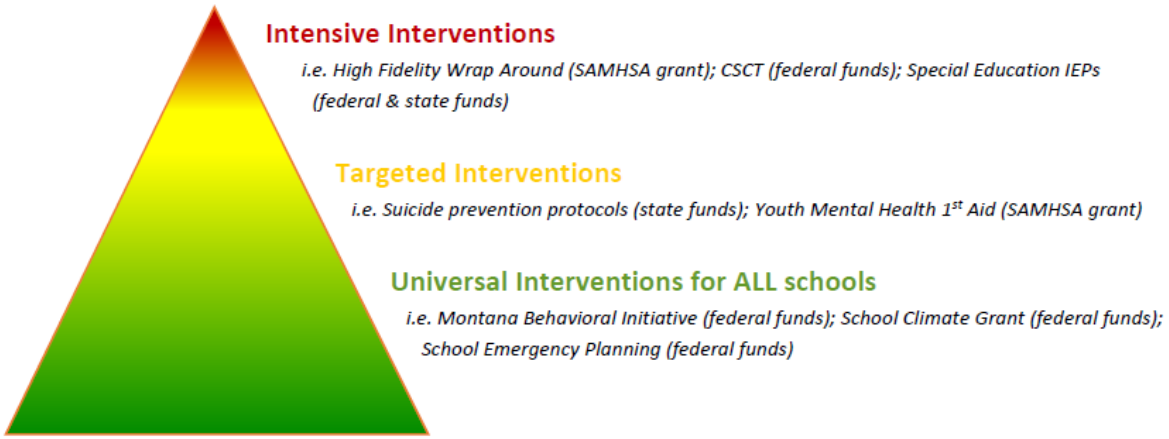
Montana Behavioral Initiative

In Montana, the PBIS Model is implemented through the Montana Behavioral Initiative (MBI). MBI assists schools in developing a tiered system of academic and behavioral supports to improve student achievement and health. Schools that sign up for MBI must apply through OPI, form a site team, and attend four days of free training funded by OPI. Schools using MBI receive technical support and a facilitator and coach to help them implement the program.[11] OPI sponsors a multi-day MBI Summer Institute every year for continued training and to allow programs to network and share resources.

[11] http://www.opi.mt.gov/pdf/MBI/MBIbrochure.pdf

In recent years, OPI has developed a "Community of Practice" for educational programs in residential, day treatment and juvenile justice facilities to help them utilize MBI in their settings. Keith Meyer, the educational director at Shodair Children's Hospital in Helena has participated in the Community of Practice and found the MBI framework to be transformative in his setting. "MBI has really provided a foundation for us at Shodair to look at each student individually. It provides the foundation of information and strategies for teachers to use in the classroom and the assessment is built in. It gives us common language, common expectations, common consequences, and rewards as a staff."

Participation in MBI by alternative schools has been low. This may be due to the low number of staff and funding constraints alternative schools face, as well as the small size of many programs. MBI does not cover the cost of staff time that is required for the site teams to meet or to travel to the MBI summer institute. Even the cost of substitutes needed to cover the site teams when they travel to the free trainings can be prohibitive for alternative schools. Laura McCrohan, an educator at Central School, the alternative high school in Libby, Montana, has gone to several MBI conferences and trainings and has found their resources to be pertinent their setting. The MBI model holds promise for alternative schools who want to implement systematic changes by building a system of supports for students.



Statewide Initiatives that Support Interventions at Various Levels of the MBI Tiered Support Model

Intensive Interventions (Tier 3)

High Fidelity Wraparound/Schools of Promise -- OPI has used funds from a federal school improvement grant (SIG) to incorporate high fidelity wraparound services in tribal communities with struggling schools. High fidelity wraparound is intensive, individualized care planning and management using a strength-based, student-centered approach to support youth and families. A four-year SAMHSA grant is supporting the implementation of high fidelity wraparound services in Frazer, Lame Deer, Wyola, and Pryor Schools. The National Native Trauma Center at the University of Montana has been a key partner in this initiative.

Comprehensive School & Community Treatment (CSCT) -- School districts across the state contract with mental health services that are reimbursable through Medicaid. CSCT teams included a licensed clinician and a support staff person who work to provide case management and treatment to very high-risk students on Medicaid with a DSM diagnosis. The program is administered through DPHHS.

Targeted Interventions (Tier 2)

Suicide Prevention protocols -- The 63rd Montana State Legislature allocated just over $200,000 to OPI to increase school-based mental health coordination in rural communities. Using this money, OPI has worked with three sites -- the Bitterroot, Fort Peck and the Bakken-impacted communities in Eastern Montana -- to develop school-community protocols to respond to youth mental health crises in rural Montana.

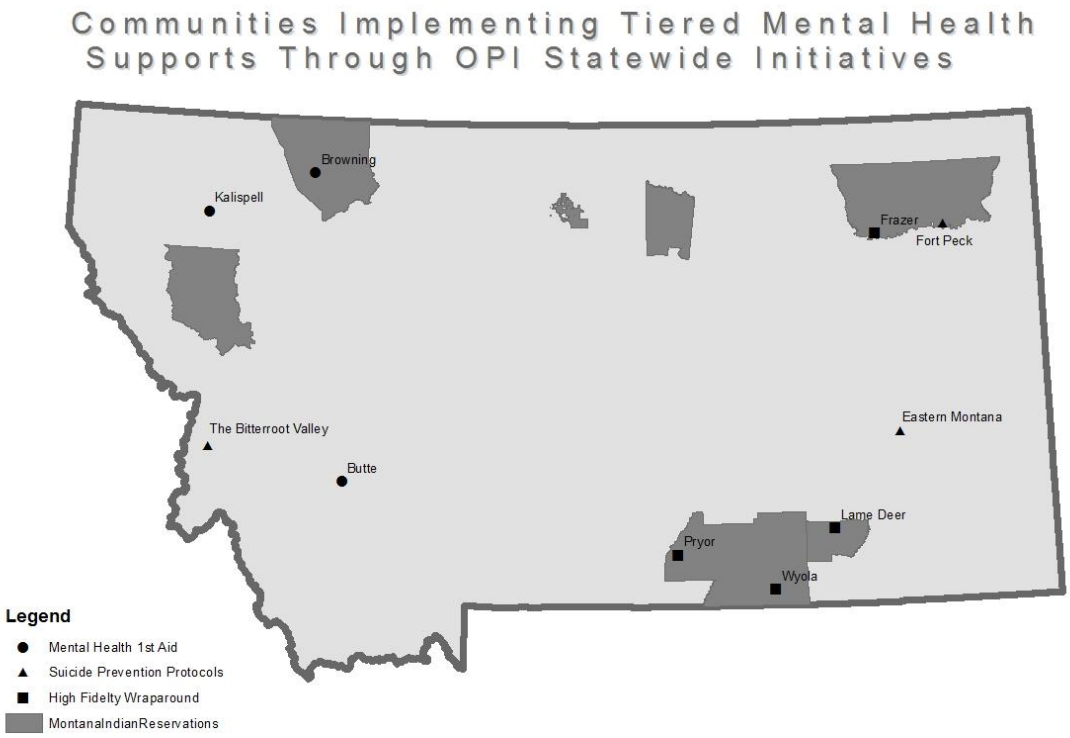
Mental Health 1st Aid -- Through the SAMHSA AWARE grant, OPI has funded training on Youth Mental Health 1st Aid to increase school staff capacity to address, identify, and properly respond to youth with mental health needs. In the first round of funding, Kalispell, Browning and Butte schools received AWARE funding to implement this training. Eventually, up to 650 school and community members per community will be trained to fidelity in the model.

Universal Interventions for All Schools (Tier 1)

MBI -- As stated above, the MBI program trains schools to assess and structure tiered behavioral supports for students. The Montana MBI program is one of the nation's longest-standing PBIS programs, with over 200 Montana schools implementing the framework. OPI currently has a $750,000 renewable school climate grant to support the work of MBI.

Emergency Planning Grant -- OPI currently has a one-time only $250,000 federal grant from Homeland Security to develop protocols to respond to crises including youth mental health.

Note: Mental Health 1st Aid and PBIS (aka MBI) are on the SAMSHA list of evidence-based programs and practices and High Fidelity Wraparound is an evidence-informed model that has positive research findings to support its use. See Appendix C for key references to research findings.



Local Initiatives

Though most alternative schools are under-resourced and lacking staff, a few model programs have found ways to provide innovative services to students in need.

Blackfeet Learning Academy and Project Choices

The Browning Public Schools supports one of the largest American Indian high schools in the country with over 600 students. The district also runs two innovative alternative education programs that serve over 150 students: The Blackfeet Learning Academy and Project Choices. The Blackfeet Learning Academy is a fulltime academic program serving 40 students in which students learn in classrooms taught with an emphasis on cooperative learning and the Socratic Method. Project Choices is an individualized program where each student is given a personalized learning plan and teachers guide students to recover credits and take courses at their own pace, attending either a morning or evening session. Matthew Johnson, the Educational Director for the two programs and Licensed Clinical Professional Counselor, reports that 90% of the students they serve qualify for free and reduced priced lunch. He is not aware of any students in their programs who live in a two-parent home. He reports alarmingly high rates of trauma, PTSD, and Adverse Childhood Experiences (ACEs) in his student population. Grief, drug and alcohol abuse, and co-occurring risk-taking behaviors are common among students.

To address these concerns, the program employs two fulltime school counselors who run therapeutic group counseling sessions for students. The counselors currently lead groups focused on grief, quitting tobacco and other substances, and life skills for young men. The Browning School District was recently a recipient of an AWARE grant from OPI, so almost 100% of the staff has been trained in Mental Health 1st Aid.

Bridger Alternative High School DBT Program

Bridger Alternative High School is located on the campus of Bozeman High School and focuses on granting credit to students based on proficiency and skill, allowing students to complete high school credits at a faster rate than the traditional educational program. The program used to serve 100% at-risk students but now has opened up to include those who prefer to have a less structured educational experience. About 58% of their current student population of 230 qualifies as "at-risk" based on being homeless (17%), receiving free and reduced priced lunch, or qualifying for special education.

Mike Ruyle, the director of the Bridger Alternative Learning Program, reports that many students in their program do not have access to basic medical, dental and mental health care. Even though there are many resources in the Bozeman community, students are uninsured or underinsured or do not have the resources to seek out services and coordinate appointments. To help meet the dental health needs of students, the school brings in a dental hygienist every year to do free check-ups.

To address the need for mental health and substance abuse treatment in its student population, the school has started a Dialectical Behavioral Therapy (DBT) Program in conjunction with two private DBT therapists in Bozeman. DBT is well researched for addressing concerns in the multi-problem adolescent (see Appendix C for key references). Nationwide, there is a rise in clinicians attempting to build DBT programs in schools because, historically, school-based counseling programs have not been research-based. To build the program at Bridger Alternative School, the school counselor has been meeting with the two DBT therapists in the community at least twice a month for training. The private counselors trained her in DBT practices and worked with her to start identifying students that accessed school counseling services most frequently for suicidal ideation, depression, self-harm, and a number of other risk factors. The school has developed a DBT consultation team and provides individual counseling to students along with a DBT skills training class and DBT-based crisis management services. Students who need a higher level of intervention are referred to the private DBT counselors in the community who are willing to see students regardless of their ability to pay. Bridger Alternative School has found this model to be an effective way to identify students and provide them with skill-based interventions that meet their needs. The community-based counselors supporting this program believe the model could be replicated in other parts of Montana using Skype and other forms of technology for long-distance training and support.

Project SUCCESS

Project SUCCESS was originally developed for and researched in alternative education settings (see Appendix C for references). Project SUCCESS has been implemented locally at the Project for Alternative Learning in Helena and at the Willard School in Missoula. The program is designed to reduce substance abuse and use among students through placing Project SUCCESS counselors in schools that provide education through an eight-session Prevention Education Series and time-limited counseling and referrals to students who use substances. The intervention is designed to be a Tier 2 intervention focused on prevention, education, and targeted, time-limited support to students. In Helena, the Project SUCCESS program had limited resources with very high-risk students so the counselor ended up doing a lot of triage and providing Tier 3 services to students. Though this was helpful, the program was not following the model with fidelity. When grant funding ran out, the school district did not continue to support the Project SUCCESS FTEs. At the Willard School, the 0.5 FTE Project SUCCESS counselor is employed by Montana Addiction Services (the local treatment center) through a number of cobbled-together funding sources that do not fully cover the cost of the position. The Willard School has found this position to be very effective, especially in getting students referred to substance abuse treatment because the Project SUCCESS coordinator is employed by the treatment center. To provide further mental health services to students, the Willard School shares a psychologist with Big Sky High School (only one half day per week) and has two interns from the family counseling program at the University of Montana serving in the school. They also have a Families in Transition Coordinator, which is a Title I-funded position that functions like a social worker -- helping youth in crisis with clothing, food, and other basic needs. Title I is the federal grant that provides additional funding for schools that have high percentages of low-income students. The Willard School also employs the MBI model as they seek to coordinate services.

Note: DBT and Project SUCCESS are on the list of SAMSHA Evidence Based Programs and Practices. See Appendix C for key references.

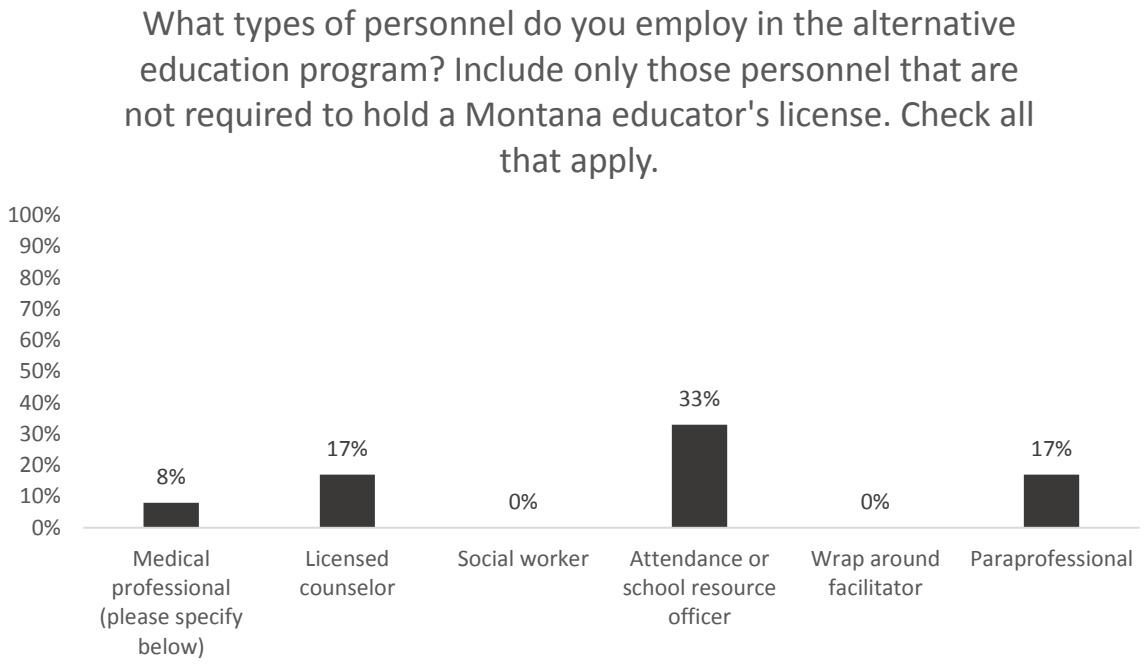
Gaps in Services

Despite the innovative, evidence-based work that alternative education programs are doing to improve the health outcomes of their student population, there are many gaps in services for alternative education students. The following themes emerged from the interviews and other data gathered for this project.

Lack of staff

Less than half of the alternative education programs in the Montana Alternative Schools and Health Survey sample reported employing any sort of case management, or mental health or medical professional in their programs (see graph below). Some alternative education programs

in the state do not even employ teachers, but instead use para educators that monitor students' use of distance learning technology.



Poorly Trained Staff

According to responses to the Montana Alternative Schools and Health Survey, 92% of programs do not have any specific requirements for teaching in their program (in addition to regular teaching requirements) and 67% do not have any ongoing professional development requirements for staff. In response to the professional development requirements question on the survey, one respondent commented, "We can barely keep the program running due to budget constraints." Several key stakeholders reported wanting more resources to train their staff. Matthew Johnson, the director of the Blackfeet Academy and Project Choices in Browning noted, "We could really use some professional development and resources. We need trauma and grief counseling. But we are only funded for 80 students but we serve 150 students. We would love to embed trauma response into our curriculum. We are always looking for curriculum but we cannot afford it. It's disheartening to find excellent curriculum but not be able to afford it. We would love to do something systemic and get our staff competent and make these systems culturally relevant."

Several interviewees discussed that even the skills of school counselors, if they are present, may not be well suited to address the complex needs of at-risk students. One key stakeholder at OPI reported, "If you look at the multi-tiered system of support services, the role of the school counselor looks different in different buildings, so as a result, some school counselors feel comfortable doing more the preventative role (teaching resiliency) versus some that are better with crisis management. As a result, in a tiered system of support, the gaps are varied

based on the skills of staff." This theme was reiterated in several stakeholder interviews -- school counselors were praised for their ability to respond to academic issues but were reported to often have little to no training in mental health or substance abuse prevention and treatment.

Lack of Community Resources

Different communities in Montana have varied access to mental health and substance abuse services. One key stakeholder reported, "Unmet mental health needs are huge, particularly in rural areas. We need to look at better coordinating community resources with school resources. The problem is when there are no resources in the community. Where there are resources, the question is, "How do you help the school and community resources speak the same language and coordinate better?" Where there aren't resources the question is, "How do we build capacity?" Even in communities with a lot of resources, sometimes the resources aren't right for the population of focus. For instance, interviewees from the Bridger Alternative School in Bozeman reported that there are many mental health therapists in Bozeman, but most are "talk therapists" and what students really need is skills-based therapy like Cognitive Behavioral Therapy or DBT.

Difficulty getting students to access resources, even if they are available

For alternative education students to be able to access mental health and substance abuse treatment, they often need two things: a mental health diagnosis and insurance. Jane Bennett from the Willard School in Missoula reported, "For students to receive CSCT or other services, they need a diagnosis. Part of the diagnosis requirement is that it leaves students out. Many students are a "B" code (for example, they are homeless), but they don't fully rise to the level of a DSM diagnosis so they are excluded from accessing the mental health treatment or services that could really help them." She went on to say, "The hardest thing is that a lot of the kids are underinsured. And even if they have Medicaid, a lot of the providers only take a few Medicaid clients so there is limited access." Lack of insurance and lack of appropriate, available providers who are willing to serve uninsured or underinsured students was a repeated theme throughout stakeholder interviews.

Difficulty with follow-through for highly disadvantaged students

Even if alternative schools are able to find community providers who are willing to serve their students and are able to make a referral, they still report that it is difficult for students to get to appointments because of transportation and scheduling issues, and because their lives are so chaotic. Again, Jane Bennett from Willard School reported, "We work very hard at referrals -- we do a ton of work to get students hooked up with services, but there is not follow-through with the parent or the student. Unless we take them to appointments, they often don't go. That is why we prefer to have our services on site when we can afford to do so." When asked about student barriers to accessing programs, respondents to the Alternative Schools and Health

Survey listed, “Lack of parental involvement, location and distance, and low personal motivation,” echoing the sentiments repeated by interviewees.

Penalties for Alternative Schools

Several alternative education program administrators reported being negatively penalized when trying to access resources for students because of their status as an alternative school. Administrators reported being excluded from a lot of grant opportunities because their programs do not fall into the traditional definition of a school. In addition, administrators reported that individual students can actually lose access to funding and services when transferring to alternative education programs. Some CSCT teams will not serve students at offsite alternative schools, and some districts do not allow alternative education programs to utilize Title I fund. So even though they are serving the most at-risk students in their school districts, alternative education program administrators report that they face barriers to accessing funding and resources that are available to traditional schools. These concerns are echoed in the national literature. In a 2006 report on alternative school funding by the American Youth Policy Form, authors Nancy Martin and Betsy Bran report that, “Many public schools view publicly-supported alternative education as a competitor for funding, even if they work through the same school district structure. Many have even stronger negative concerns about education dollars flowing to alternative education providers outside of the K-12 public education system.”[12]

All of these barriers, along with the chronic underfunding of alternative schools, create substantial gaps in services related to alternative high school students’ health needs. As one administrator put it, “Our program always feels under-resourced -- from sexual health, fundamental healthcare needs, dental/eye doctors, glasses, hearing needs, substance abuse, and access to healthcare -- our students have all of these needs and we do not always have the resources to address them.”

[12] Federal, State, and Local Roles Supporting Alternative Education. Martin and Bran. 2006. http://www.ncee.org/wp-content/uploads/2010/04/GovrolesAltEd.pdf

Grantmaking Opportunities and Recommendations

Based on the findings from this report, alternative education programs would be an excellent target for grantmaking. There is strong, consistent data indicating that these programs serve a population that suffers from health disparities, particularly in the areas of mental health and substance abuse. The administrators of these programs acknowledge the health challenges faced by their students but often lack the funding, training, and resources to address student needs in a holistic way. Additionally, alternative education programs are often excluded from grants and services simply because of their status as non-traditional schools, so targeted funding could serve to fill in some of these gaps. Despite these challenges, there are existing model program- and evidence-based practices for addressing mental health and substance abuse concerns for high risk adolescents in educational settings, a few of which are already being implemented at the state and local levels. These model practices could be an excellent fit for more alternative education programs in the state to implement, if given the opportunity, through targeted grantmaking.

Suggestions from Alternative School Stakeholders

When asked, "If you could do one thing to improve the health of students in your alternative education program, what would it be?" in the Montana Alternative Education and Health Survey, respondents said:

- Have alternative physical education and nutrition classes available, a better hot lunch program, and provide tasty, nutritional snacks weekly
- Stable, long-term mental health therapy, better counseling and support services, and more skills-based mental health assistance
- End drug use and address substance abuse
- Health coaching and better evaluation of health needs, especially mental health

In semi-structured interviews, alternative school stakeholders had many ideas about what kinds of funding would best help them meet the needs of students, including:

- Funding for training or to purchase curriculum for students related to life skills, preparation, and resiliency
- Staff training opportunities to help build teachers' capacity to serve this high-needs population. "Teachers really care about students but don't always know how to respond."
- Additional training for school counselors in evidence-based modalities like DBT or Cognitive Behavioral Therapy to expand their skill set beyond academic counseling
- An emergency needs fund to help students who are in crisis
- Funding to hire counselors whose positions could be sustained through Medicaid and other third-party billing

Recommendations

Based on the data gathered for this report and the feedback from alternative school stakeholders, the following recommendations are offered to help guide investments by foundations interested in addressing the behavioral health needs of students in Montana's Alternative Education programs:

- Data on alternative education programs is limited, so when developing alternative education grants, require and provide technical assistance to grantees to collect standardized baseline and outcome measures for their programs, such as student sociodemographic characteristics, graduation rates, student interaction with the juvenile justice system, and health outcomes. If alternative education programs begin to systematically collect data, they will be more competitive for additional grants and foundation funding in the future.
- Focus funding on evidence-based practices that address mental health and substance abuse concerns, because this is where the greatest disparity exists between the alternative school and general high school population.
- Consider opening grant opportunities to all three types of alternative education programs in Montana (those in accredited public schools, those state-approved programs run outside of public schools, and residential, day treatment and juvenile justice-affiliated programs), as they all serve a similar, high-risk population and could potentially benefit from the implementation of model practices.
- Provide funding to allow existing school counselors, teachers, and other key staff to increase their capacity to address substance abuse, mental health, and trauma.
- Support the implementation of evidence-based curriculum in alternative schools that addresses mental health, substance abuse prevention, trauma, risky sexual behavior, life skills, resiliency, and general health, as well as trauma-informed discipline policies.
- Consider working with OPI to create a Community of Practice for MBI specifically for Alternative Education Programs. Provide small, supplementary grants for those alternative education programs that participate in the Community of Practice to cover MBI start-up and training costs.
- Support pilot projects that expand upon and replicate model programs already being implemented at the local level, such as group counseling, DBT, High Fidelity Wrap Around, Mental Health 1st Aid, and Project SUCCESS, while also allowing alternative education programs to consider other evidence-based models that have not been implemented in the state (see Appendix C for key references and a list of evidence-based models).
- Because of the diversity of alternative education programs in the state, develop flexible proposals that will allow local programs to assess their most pressing needs and determine the evidence-based solution that will work best in their local setting.

- Facilitate the development of sustainable models for healthcare services in alternative schools, including developing the capacity to bill Medicaid and other third-party payers for services provided. Consider providing funding for training and technical assistance for alternative schools to establish systems to bill for services.
- There are many potential funding sources for alternative education programs, though few specifically earmark money solely for these programs. Continue researching these funding sources to determine if technical assistance could be provided to programs to access funding from other sources.

Appendix A Contact List

Alternative Education Programs Operated within Accredited Public Schools

*Starred names are those that participated in a structured interview, providing information to inform this report

YES Project Alternative Learning Center
Contact: Rhonda Kinney, Alternative Learning Teacher
Email: rkinney@arlee.k12.mt.us Phone: 406-726-3216 x 2328
Address: 72220 Fyant Street, Arlee, MT 59821
Website: http://www.arleeschools.org/

Belgrade Alternative High School
Contact: Patricia Ramler, English Teacher
Email: pramler@belgradeschools.com Phone: 406-570-0671
Address: 400 Hilsdale Road, Belgrade, MT 59714
Website: http://www.bsd44.org/

Bridger Alternative Program and A2X
Contact: Mike Ruyle, Director of the Bridger Alternative Program*
Email: mike.ruyle@bsd7.org Phone: 406-522-6100
Address: 205 North 11th Ave., Bozeman MT 59715
Website: http://bridger.bsd7.org/

Blackfeet Learning Academy and Project Choices
Contact: Matthew Johnson, Director*
Email: matthewj@bps.k12.mt.us Phone: 406-338-2841
Address: 105 US Highway 89, Browning, Montana 59417

Butte High Career Center
Contact: Cathy Cannon, Principal
Email: cannonkj@butte.k12.mt.us Phone: 406-533-2968
Address: 1050 S Montana Street**,** Butte, Mt 59701

Website: http://www.butte.k12.mt.us/bhcc.html

Columbia Falls Learning Center
Contact: Beverly Kahn
Phone: 406-892-6520 Email: kahnba@sd6.k12.mt.us
Address: 610 13th Street West, Columbia Falls MT 59912
Website: www.cfhighschool.org/home

Cut Bank Alternative High School Program
Contact: Rebecca Marinko, Counselor
Phone: 406-873-5629
Address: 103 3rd Ave SE, Cut Bank, MT 59427

Eureka Public Schools-Alternative School
Contact: Charline Smith
Phone: 406-297-5629 Email: csmith@teameureka.net
Address: 340 9th Street East, Eureka, MT 59917
http://www.lchigh.net/

Frenchtown Academy for Career Education
Contact: Jake Haynes, Principal
Phone: 406-626-2670 Email: haynesj@ftsd.org
Address: PO Box 117, Frenchtown, MT 59834-0117
Website: www.ftsd.org

Glasgow Highschool Alternative Education Program
Contact: Shawnda Zahara-Harris, Principal of Glasgow High School
Phone: 406-228-248 Email: zahara-harris@mail.glasgow.k12.mt.us
Address: PO Box 28, Glasgow, MT 59230
Website: http://glasgow.k12.mt.us/

Paris Gibson Education Center
Contact: Drew Uecker, Principal*
Phone: 406-268-6605 Email: drew_uecker@gfps.k12.mt
Address: 2400 Central Ave, Great Falls, MT 59401
Website: http://www.gfps.k12.mt.us/Schools/PGEC/web/PGECindex.html

Hamilton School District Alternative Learning Center
Contact: Bob Carmody, Alternative Learning Center
Phone: 363-2280 ext. 2500 Email: carmodyj@hsd3.org

Address: 327 Fairgrounds Rd, Hamilton, Montana 59840
Website: http://hsd3.org/

Hardin Public Schools
Contact: Jerry Guay, Director
Phone: 406-665-9391 Email: jerry.guay@hardin.k12.mt.us
Website: http://www.edline.net/pages/HardinPS

SUNS Havre Alternative High School and ISTAND Middle School Program
Address: 900 Eighteenth Street, Havre, Montana 59501
Website: http://www.havre.k12.mt.us

Project for Alternative Learning
Contact: Frank Jobe, Alternative Education Coordinator
Phone: 406-324-1630 Email: fjobe@helena.k12.mt.us
Address: 815 Front Street, Helena, MT 59601
Website: http://www.helena.k12.mt.us/schools/highscho/pal/index.dhtm

Linderman Education Center
Contact: Jodie Barber, Director
Phone: 406-751-2990 Email: barberj@sd5.k12.mt.us
Address: 124 3rd Ave East, Kalispell, MT 59901
Website: http://www.sd5.k12.mt.us/domain/538

Lamedeer Alternative High School and Credit Recovery Program
PO Box 96, Lame Deer, MT 59043
Phone: 406-477-8900
http://www.lamedeer.k12.mt.us/

Laurel Alternative High School
Contact: Paige Miller, Alternative High School Teacher
Phone: 406-670-2984 Email: paige_miller@laurel.k12.mt.us
Address: 410 Colorado Ave. Laurel, MT 59044
Website: http://www.laurel.k12.mt.us

Libby Central Alternative School
Contact: Laura McCrohan, Alternative School Educator*
Phone: 406-293-8905 Email: mccrohanl@libbyschools.org
Address: 724 Louisiana Avenue, Libby, MT 59923
Website: http://libbyschools.org/

Project 71
Contact: Sarah Mussetter
Phone: 406-422-0448 Email: sarah.mussetter@livingston.k12.mt.us
Address: Park High School, 102 View Vista Dr, Livingston, MT 59047
Website: https://sites.google.com/site/phsp71/

Willard Alternative School
Contact: Jane Bennett, Principal*
Phone: 406-728-2400 x 4750 Email: jabennett@mcps.k12.mt.us
Address: 901 South 6th Street West, Missoula, MT 59801
Website: http://www.mcpsmt.org/willard

Polson High School Alternative Education Program
Contact: Emily Johnson, Guidance Counselor
Phone: 406-883-6351 ext. 205 Email: ejohnson@polson.k12.mt.us
Address: 111 4th Avenue East, Polson, MT 59860
Website: www.polson.k12.mt.us/phs/departments/specialed/Pages/creditrecovery.htm

Shelby Alternative High School
Contact: Matthew Genger, Superintendent
Phone: 406-434-2622 Email: matt.genger@shelby.k12.mt.us
Address: 1010 Oilfield Ave, Shelby, MT 59747
Website: www.shelbypublicschools.org

Sidney Public School Alternative Education Program
Contact: Corinne Crowe, Alternative Education Instructor
Phone: 406-433-2330 Email: ccrowe@sidney.k12.mt.us
Address: 1012 4th Ave SE, Sidney, MT 59270
Website: www.sidney.k12.mt.us

Stevensville Alternative Learning Center
Phone: (406) 777-5137 Email:
Address: 254 Middle Burnt Fork Road, Stevensville, MT 59870
Website: www.stevensvilleschool.net

Troy Alternative School
Contact: Nancy Prieve, Teacher
Phone: 406-295-4606 Email: nprieve@troyk12.org
Address: PO BOX 867, Troy, MT 59935

http://www.troymtk-12.us/

Whitefish Independent High School
Contact: Jill Rocksund, Principal
Phone: 406-862-8640 Email: rocksundj@wfps.k12.mt.us
Address: 600 East 2nd St., Whitefish, MT 59937
Website: http://ihs.wsd44.org/index.jsp

Wolf Point Alternative Learning Center
Contact: Cookie Ragland, Teacher
Phone: 281-755-3610 Email: cookieragland@gmail.com
Address: 213 6th Avenue South, Wolf Point, MT 59201
Website: www.wolfpoint.k12.mt.us/

State Approved Educational Options Outside the Public School Setting
*Starred names are those that participated in a structured interview, providing information to inform this report

Access to Success
Contact: Jacque Boyd, Case Manager*
Phone: 406-447-6381
Address: Helena College Room 004, 1115 N. Roberts Street, Helena, MT 59601
Website: www.umhelena.edu/catalog/accesstosuccess.aspx

Kicking Horse Job Corps
Contact: Arlene Bigby, Director of Education
Phone: 644-2217 ext. 6334 Email: bigby.arlene@jobcorps.org
Address: 33091 Mollman Pass Trail, Ronan, MT 59831
Website: http://kickinghorse.jobcorps.gov

Anaconda Job Corp
Phone: (406) 563-8700
Address: 1407 Foster Creek Road, Anaconda, MT 59711
http://anaconda.jobcorps.gov

Trapper Creek Job Corp
Phone: (406) 821-3286
5139 West Fork Road, Darby, MT 59829-5139
http://trappercreek.jobcorps.gov

Montana Youth ChalleNGe Academy
790 E. Cornell Street, Dillon, MT 59725

Phone: 406-683-7556
Website: http://youthchallenge.mt.gov/

Impact on Learning, Inc.
Contact: Wendy Brassfield
Phone: 406-642-3232 Email: wendy@impactbv.org
Address: 1625 Hwy 93 North, Victor, MT 59875
Website: http://www.impactbv.org/

Residential Treatment Facilities and Day Treatment Facilities with Education Programs
*Starred names are those that participated in a structured interview, providing information to inform this report

Acadia Montana
Contact: Don Barryman, Education Director
Phone: 406-494-4183 Email: don.barryman@acadiahealthcare.com
Address: 55 Basin Creed Rd, Butte, MT 59701
www.acadiamontana.com

Pinehills Correctional Facility
Contact: Kimberly Leslie, Principal
Phone: 406-233-2203 Email: KLeslie@mt.gov
Address: 4 N Hayes, Miles City, MT 59301
http://www.cor.mt.gov/YouthServices/PineHills.mcpx

Riverside Youth Correctional Facility
Contact: Peter Halloran, Administrator
Address: 2 Riverside Road, Boulder, MT 59632
Phone: 406-225-4500 Email: PHalloran@mt.gov
Website: http://www.cor.mt.gov/YouthServices/Riverside.mcpx

Shodair Children's Hospital
Contact: Keith Meyer, Educational Director*
Address: 2755 Colonial Drive, Helena, MT 59604
Phone: 406-444-7564 Email: kmeyer@shodair.org
www.shodair.org

Ted Lechner Youth Services Center
Contact: Hank Richards, Educator
Phone: 406-256-6825 Email: rovel80@juno.com
Address: 410 S 26th Street, Billings, MT 59101

Intermountain
Contact: Marvin Williams, Education Director*

Phone: 406-457-4755 Email: marvinw@intermountain.org
Address: 500 S Lamborn, Helena, MT 59601
Website: www.intermountain.org

Yellowstone Boys and Girls Ranch
Contact: Mike Sullivan, Director of Education
Phone: 406-655-2011 Email: msullivan@ybgr.org
Address: 1732 South 72nd Street West, Billings, MT 59106
Website: www.ygbr.org

Other Stakeholders

*Starred names are those that participated in a structured interview, providing information to inform this report

Office of Public Instruction
Schools of Promise/High Fidelity Wrap Around
Deborah (Deb) Halliday*
Policy Advisor, Community Learning Partnerships
Montana Office of Public Instruction
PO Box 202501 Helena, MT 59620-2501

Susan Bailey-Anderson, Montana Behavioral Initiative
E-mail: sbanderson@mt.gov Phone: 444-2046
Montana Office of Public Instruction
PO Box 202501 Helena, MT 59620-2501

Erin Butts, School Mental Health Coordinator*
Email: ebutts@mt.gov Phone: 406-444-0688
Montana Office of Public Instruction
PO Box 202501 Helena, MT 59620-2501

Juvenile Justice-Youth Courts
Robert (Bob) Peake, Youth Court Services Director*
Phone: (406) 841-2961 Email: rpeake@mt.gov
301 S Park Ave, Suite 328
PO Box 203005, Helena, MT 59620-3005

Montana Medicaid
Sally Tilleman, Program Officer for Comprehensive School and Community Treatment (CSCT)
Phone: 406-444-6962 Email: stilleman@mt.gov
11 North Sanders/PO Box 4210
Helena, MT 59604

Children's Mental Health Bureau
Zoe Barnard, Chief of the Children's Mental Health Bureau*
Phone: (406) 444-1290 Email: zbarnard@mt.gov
111 North Sanders/PO Box 4210
Helena, MT 59604

School Based Dialectical Behavioral Therapy
Emily Krushefski, Licensed Clinical Professional Counselor*
Phone: 406-522-0410 Email: krushef@gmail.com
1940 West Dickerson, Suite 102, Bozeman, MT 59718
National Native Trauma Center
Institute for Educational Research and Service
The University of Montana
Missoula, MT 59812-6376
Phone: (406) 243-5344
http://iers.umt.edu/National_Native_Childrens_Trauma_Center

Montana Digital Academy
The University of Montana
32 Campus Drive
Missoula, Montana 59812
Phone: (406) 203-1812
http://montanadigitalacademy.org/

Appendix B

Health outcome comparisons for alternative high school students in Montana, 2013

Trauma and Abuse Indicators	MT Percent (95% CI)	Alternative Schools (2013)	Alternative Schools (2005)	Alternative Schools (1999)	Percent difference, MT vs. Alternative	Percent change since 1999
Carried a gun**	10.5 (9.4-11.7)	8.0	11.6	10.4	-27%	-23%
Carried a weapon on school property**	9.9 (8.8-11.1)	16.9	16.8	15.6	**52%**	8%
Were threatened or injured with a weapon on school property*	6.3 (5.6-7.1)	7.3	10.2	12.6	15%	-42%
Were in a physical fight*	22.8 (21.0-24.6)	40.3	51.1	58.4	**55%**	-31%
Did not go to school because they felt unsafe at school or on their way to or from school**	8.8 (7.8-9.9)	11.5	6.7	5.5	27%	**109%**
Were bullied on school property*	26.3 (24.9-27.6)	24.1	NA	NA	-9%	NA
Were ever physically forced to have sexual intercourse	8.7 (7.8-9.8)	23.1	24.2	22.8	**91%**	1%
Experienced physical dating violence (hit, slammed into something, or injured with an object or weapon on purpose)*	8.8 (7.7-10.0)	20.4	24.2	17.8	**79%**	15%
Experienced sexual dating violence (kissing, touching, or being forced to have sexual intercourse when they did not want to)*	11.1 (9.9-12.4)	10.4	NA	NA	-7%	
Average					31%	5%
Mental Health Indicators	**MT Percent (95% CI)**	**Alternative Schools (2013)**	**Alternative Schools (2005)**	**Alternative Schools (1999)**	**Percent difference, MT vs. Alternative**	**Percent change since 1999**
Felt sad or hopeless (for 2 weeks or more so that they stopped doing some usual activities)*	26.4 (24.7-28.3)	50.2	45.1	39.5	**62%**	27%
Seriously considered attempting suicide*	16.8 (15.4-18.3)	31.9	33.2	26.4	**62%**	21%
Made a plan about how they would attempt suicide*	13.6 (12.7-14.5)	27.3	28.7	25.3	**67%**	8%
Attempted suicide*	7.9 (6.9-8.9)	27.3	22.2	19.0	**110%**	44%
Attempted suicide that resulted in an injury, poisoning, or overdose	2.6 (2.2-3.1)	10.5	7.3	8.6	**121%**	22%

that had to be treated by a doctor or nurse*						
Average					**84%**	24%
Substance Abuse Indicators	MT Percent (95% CI)	Alternative Schools (2013)	Alternative Schools (2005)	Alternative Schools (1999)	Percent difference, MT vs. Alternative	Percent change since 1999
Ever tried cigarette smoking	41.1 (38.3-43.9)	84.4	90.5	95.8	**69%**	-12%
Currently smoked cigarettes**	15.2 (13.4-17.2)	68.9	70.4	75.4	**128%**	-9%
Currently used smokeless tobacco (chewing tobacco, snuff, or dip)**	13.4 (11.4-15.7)	19.3	20.9	19.0	36%	2%
Ever had at least one drink of alcohol in their lifetime	70.5 (68.5-72.4)	89.5	92.3	92.0	24%	-3%
Currently drank alcohol**	37.1 (34.8-39.5)	62.3	68.0	63.2	**51%**	-1%
Had five or more drinks of alcohol in a row (within a couple of hours)**	23.5 (21.6-25.6)	47.1	58.5	55.7	**67%**	-15%
Ever used marijuana	37.6 (34.5-40.9)	81.9	86.1	88.3	**74%**	-7%
Currently used marijuana**	21.0 (18.8-23.5)	62.5	65.5	62.1	**99%**	1%
Ever used cocaine	6.4 (5.6-7.3)	29.3	40.9	42.4	**128%**	-31%
Ever used inhalants	9.9 (8.7-11.2)	26.0	28.8	36.7	**90%**	-29%
Ever used ecstasy	8.2 (7.2-9.3)	35.1	23.6	NA	**124%**	49%
Ever used heroin	2.6 (2.1-3.2)	11.5	9.5	11.5	**126%**	0%
Ever used methamphetamines	3.6 (3.0-4.3)	17.9	40.2	51.2	**133%**	-65%
Ever took prescription drugs without a doctor's prescription	16.2 (14.7-17.7)	54.5	NA	NA	**108%**	NA
Ever injected any illegal drug	2.4 (1.9-3.0)	5.3	8.7	12.1	**75%**	-56%
Were offered, sold, or given an illegal drug on school property*	22.8 (21.4-24.2)	31.6	40.3	41.9	32%	-25%
Average					**85%**	-13%
Indicators for Sexual Behavior	MT Percent (95% CI)	Alternative Schools (2013)	Alternative Schools (2005)	Alternative Schools (1999)	Percent difference, MT vs. Alternative	Percent change since 1999
Ever had sexual intercourse	46.0 (42.9-49.2)	82.1	83.1	87.2	**56%**	-6%
Had sexual intercourse before age 13 years	4.3 (3.5-5.2)	16.2	17.5	28.8	**116%**	-44%
Had sexual intercourse with four or more persons (lifetime)	14.7 (12.8-16.8)	49.8	58.3	51.5	**109%**	-3%
Were currently sexually active (sexual intercourse during the past 3 months)	34.1 (31.6-36.7)	63.5	65.0	59.1	**60%**	7%

Did not use a condom (of sexually active students, during last sexual intercourse)	38.5 (35.2-41.9)	57.6	50.8	54.3	40%	6%
Did not use birth control pills (before last sexual intercourse to prevent pregnancy among students who were currently sexually active)	75.1 (71.3-78.4)	76.4	22.9	85.4	2%	-11%
Were never taught in school about AIDS or HIV infection	16.2 (14.3-18.4)	10.4	13.6	9.8	-44%	6%
Average					48%	-6%
Other Health Indicators	MT Percent (95% CI)	Alternative Schools (2013)	Alternative Schools (2005)	Alternative Schools (1999)	Percent difference, MT vs. Alternative	Percent change since 1999
Drank a can, bottle, or glass of soda or pop one or more times per day (not including diet soda or pop)***	18.2 (16.4-20.2)	33.3	35.5 (2007)	NA	**59%**	-6% (since 2007)
Did not eat breakfast***	11.7 (10.6-12.8)	17.8	NA	NA	41%	NA
Did not eat breakfast on all 7 days***	59.7 (57.4-62.0)	68.0	NA	NA	13%	NA
Were not physically active at least 60 minutes per day on 5 or more days***	45.2 (43.4-47.0)	71.0	85.2	NA	44%	-17%
Played video or computer games or used a computer 3 or more hours per day (not school related work)***	29.7 (28.3-31.1)	31.6	16.5 (2007)	NA	6%	**92% (since 2007)**
Did not attend physical education classes on 1 or more days (in average school week)	45.6 (41.7-49.5)	76.9	60.6	59.4	**51%**	29%
Did not play on at least one sports team (school or community)*	36.3 (34.3-38.3)	80.8	72.1	69.1	**76%**	17%
Described themselves as slightly or very overweight	27.7 (26.3-29.1)	37.7	31.6	31.8	31%	19%
Were not trying to lose weight	58.6 (56.6-60.7)	50.0	59.3	63.3	-16%	-21%
Did not eat for 24 or more hours to lose weight or keep from gaining weight**	11.7 (10.5-12.9)	19.7	16.3	18.1	**51%**	9%
Took diet pills, powders, or liquids (without a doctor's advice, to lose weight or to keep from gaining weight)**	5.1 (4.5-5.9)	7.6	9.1	11.2	39%	-32%
Vomited or took laxatives to lose weight or to keep from gaining weight**	4.4 (3.9-5.1)	4.8	7.1	6.7	9%	-28%
Had ever been told by a doctor or nurse that they had asthma	19.8 (18.7-21.0)	25.9	28.3	NA	27%	-8% (since 2005)
Used an indoor tanning device (sunlamp, sunbed, or tanning booth)*	13.4 (12.0-14.9)	19.1	NA	NA	35%	NA
Average					33%	5%

* During past 12 months ** During past 30 days *** During past 7 days

Appendix C

Annotated Bibliography of Model Programs and Evidence Based Practices to Improve Health Outcomes in Alternative Schools

Five evidence based or evidence informed models to address mental health or substance abuse are already being implemented in Montana by either state or local initiatives in schools. Using specific criteria to search the SAMSHA Registry of Evidence-based Programs and Practices, ten additional interventions model programs were identified that might be a good fit for implementation in alternative education programs in Montana. A short description of and references for each of these 15 model programs is listed below.

Evidence Based Models or Program Already Being Implemented in Montana

Dialectical Behavioral Therapy

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. DBT has been adapted for use in school settings and research indicates young adults treated with DBT see reductions in suicide attempts, non-suicidal self injury, psychosocial adjustment and drug use.

Key References

Leichtman, S. et al. Skills for Well Being: Integrating Dialectical Behavior Therapy Skills into School. http://middlesexpartnershipsforyouth.com/pdf/LS_Popwerpoint.pdf

Mazza, JJ, Dexter-Mazza, ET, Murphy, HE, Miller, AL, & Rathus, JH (In preparation). Skills Training for Emotional Problem Solving for Adolescents (STEPS-A): Implementing DBT skills training in schools. The Guilford Press, NY.

Miller, AL, & Glinski, J, Woodberry, K, Mitchell, A, & lndik, J. (2002). Family therapy and dialectical behavior therapy with adolescents: Part 1, Proposing a clinical synthesis. American Journal of Psvchotherapy, 56, 4, 568-584.

Ougrin D et al (Feb 2015). Therapeutic Interventions for Suicide Attempts and Self-Harm in Adolescents: Systematic Review and Meta-Analysis. Journal of the American Academy Child Adolescent Psychiatry. 54(2):97-107

Note: This reference identified DBT, CBT and mentalization-based therapy (MBT) as the most effective interventions for reducing suicide attempts and self-harm in adolescents.

Mental Health 1st Aid

Mental Health 1st Aid is an adult public education program designed to improve participants' knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing one or more acute mental health crises (i.e., suicidal thoughts and/or behavior, acute stress reaction, panic attacks, and/or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (i.e., depressive, anxiety, and/or psychotic disorders, which may occur with substance abuse).The intervention is delivered by a trained, certified instructor through an interactive 12-hour course, which can be completed in two 6-hour sessions or four 3-hour sessions.

Key References:

Kitchener, B. A., & Jorm, A. F. (2002). Mental Health First Aid training for the public: Evaluation of effects knowledge, attitudes and helping behavior. BMC Psychiatry, 2(10), 1-6.

Jorm, A. F., Kitchener, B. A., O'Kearney, R., & Dear, K. (2004). Mental Health First Aid training of the public in a rural area: A cluster randomized trial. BMC Psychiatry, 4(33), 1-9.

National Wraparound Initiative

Wraparound care planning and management is a primary component of a coordinated, community-based, family-driven, and youth-guided system of care. When communities and states invest in high-quality wraparound implementation, they also promote meaningful, progressive systems change on behalf of young people with complex needs and their families. Since 2004, the National Wraparound Initiative has worked to promote understanding about the components and benefits of care coordination using the wraparound practice model, and to provide the field with resources and guidance that facilitate high quality and consistent wraparound implementation.

Key References:

A COMPREHENSIVE REVIEW OF PUBLISHED WRAPAROUND LITERATURE, 1988-2012. Wraparound Evaluation and Research Team (WERT), University of Washington. http://www.nwi.pdx.edu/pdf/review-of-published-wrap-literature-08-2014.pdf

Suter, JC and Burns, EJ. Effectiveness of the wraparound process for children with emotional and behavioral disorders: a meta-analysis. Clinical Child Family Psychology Review. 2009 Dec;12(4):336-51. doi: 10.1007/s10567-009-0059-y.

Note: Suter and Burns conclude that the wrap around research is expanding and largely positive, but is still in the preliminary stages. The National Wraparound Initiative is not a SAMSHA approved evidence based practice.

Positive Behavioral Interventions and Supports Model

The Safe & Civil Schools Positive Behavioral Interventions and Supports (PBIS) Model is a multicomponent, multitiered, comprehensive approach to schoolwide improvement. Integrating applied behavior analysis, research on effective schools, and systems change management theory, the intervention is an application of positive behavior support (PBS), a set of strategies or procedures designed to improve behavior by employing positive and systematic techniques. The intervention focuses on guiding members of an entire school staff in developing a schoolwide environment that is safe, civil, and conducive to learning. The intervention provides tools and strategies to help educators in elementary, middle, and high schools establish proactive, positive (nonpunitive), and instructional schoolwide discipline policies, manage student misbehavior and foster student motivation, and create a positive and productive school climate. It also aims to boost teacher satisfaction, contributing to increased teacher retention, and to engage students in the educational process, increasing their connectedness to the school community.

Implementation involves delivery of professional development services (e.g., in-service training, workshops, conferences), ongoing on-site coaching and support, and materials (e.g., books, DVDs, CDs) by the program developer to all members of a school's staff, typically over a 1- to 3-year period. The various components address student behavior in the school, classroom, and individual student levels. The core component, Foundations, guides staff through the process of designing a positive and proactive schoolwide discipline plan affecting all students in all the school's settings. Other components are supplemental to Foundations and are used in various degrees based on a school's need. Components developed for the classroom guide teachers in improving their current classroom management plan, while other components are designed to help educators plan and implement tailored strategies to increase motivation and improve the behavior of individual students.[13] PBIS is recognized as an evidence based practice by SAMHSA. Studies indicate that schools using PBIS see improvements in student achievement and decreases in school suspensions and classroom disruptions.

Key References:

Barnoski, R. (2001). Foundations for learning: Safe & Civil Schools analysis documentation. Olympia, WA: Washington State Institute for Public Policy.

[13] http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=242

Madigan, K., & Cross, R. (2009). Determining the impact of Safe & Civil Schools' schoolwide positive behavior supports program on academic achievement: A nine-year study. Bethesda, MD: Accountability Works

Ward, B., & Gersten, R. (2010). A randomized evaluation of the effectiveness of Randy Sprick's Safe & Civil Schools' Foundations model for positive behavior support at elementary schools in a large urban school district: Interim results. Portland, OR: ECONorthwest

Project SUCCESS

Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) is designed to prevent and reduce substance use among students 12 to 18 years of age. The program was originally developed for students attending alternative high schools who are at high risk for substance use and abuse due to poor academic performance, truancy, discipline problems, negative attitudes toward school, and parental substance abuse. In recent years, Project SUCCESS has been used in regular middle and high schools for a broader range of high-risk students. The intervention includes four components:

- The Prevention Education Series (PES), an eight-session alcohol, tobacco, and other drug program conducted by Project SUCCESS counselors (local staff trained by the developers) who help students identify and resist pressures to use substances, correct misperceptions about the prevalence and acceptability of substance use, and understand the consequences of substance use.
- Schoolwide activities and promotional materials to increase the perception of the harm of substance use, positively change social norms about substance use, and increase enforcement of and compliance with school policies and community laws.
- A parent program that includes informational meetings, parent education, and the formation of a parent advisory committee.
- Individual and group counseling, in which the Project SUCCESS counselors conduct time-limited counseling for youth following their participation in the PES and an individual assessment. Students and parents who require more intensive counseling, treatment, or other services are referred to appropriate agencies or practitioners in the community.

Key References

Morehouse, E. R., & Tobler, N. S. (2000). Project SUCCESS final report: Grant number 4 HD1 SP07240. Report submitted January 26, 2000, to the Center for Substance Abuse Prevention, U.S. Department of Health and Human Services.

Vaughan, R., & Johnson, P. (2007). The effectiveness of Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) in a regular secondary school setting. Unpublished manuscript

Other Model Programs/Evidence Based Interventions to Consider

Using the SAMSHA Registry of Evidence-based Programs and Practices ten interventions were identified (in addition to Project SUCCESS, PBIS and Mental Health 1st Aid) that met the following criteria:

- Setting: School
- Area of Interest: Mental Health promotion or treatment, substance abuse promotion or treatment, and co-occurring disorders
- Ages: Adolescent 13-17
- In review of research, had at least two outcomes with an overall rating of 3.0 or above (out of 4.0)

CAST Coping and Training Support: CAST is a high school-based suicide prevention program targeting youth 14 to 19 years old. CAST delivers life-skills training and social support in a small-group format (6-8 students per group). The program consists of 12 55-minute group sessions administered over 6 weeks by trained high school teachers, counselors, or nurses with considerable school-based experience. CAST serves as a follow-up program for youth who have been identified through screening as being at significant risk for suicide.

Thompson, E. A., Eggert, L. L., Randell, B. P., & Pike, K. C. (2001). Evaluation of indicated suicide risk prevention approaches for potential high school dropouts. American Journal of Public Health, 91(5), 742-752.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS): The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a school-based group and individual intervention designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems; improve peer and parent support; and enhance coping skills among students exposed to traumatic life events, such as community and school violence, physical abuse, domestic violence, accidents, and natural disasters. Though CBITS has been tested primarily with children in grades 3 through 8, it has been implemented with high school students. Students who have participated in CBITS evaluations have been individually screened for trauma.

CBITS relies on cognitive and behavioral theories of adjustment to traumatic events and uses cognitive-behavioral techniques such as psychoeducation, relaxation, social problem solving, cognitive restructuring, imaginal exposure, exposure to trauma reminders, and development of a trauma narrative. The program includes 10 group sessions and 1-3 individual sessions for students, 2 parent psychoeducational sessions, and a teacher educational session. It is designed for delivery in the school setting by mental health professionals working in close collaboration with school personnel.[14]

[14] http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=153

Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., et al. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. Journal of Traumatic Stress, 23(2), 223-231.

Stein, B. D., Elliott, M. N., Tu, W., Jaycox, L. H., Kataoka, S. H., Fink, A., et al. (2003). School-based intervention for children exposed to violence [Reply]. Journal of the American Medical Association, 290(19), 2542.

Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., et al. (2003). A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial. Journal of the American Medical Association, 290(5), 603-611.

LifeSkills Training (LST): LifeSkills Training (LST) is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. LST is based on both the social influence and competence enhancement models of prevention. Consistent with this theoretical framework, LST addresses multiple risk and protective factors and teaches personal and social skills that build resilience and help youth navigate developmental tasks, including the skills necessary to understand and resist prodrug influences. LST is designed to provide information relevant to the important life transitions that adolescents and young teens face, using culturally sensitive and developmentally and age-appropriate language and content. Facilitated discussion, structured small group activities, and role-playing scenarios are used to stimulate participation and promote the acquisition of skills.

Botvin, G. J., Griffin, K. W., & Nichols, T. R. (2006). Preventing youth violence and delinquency through a universal school-based prevention approach. Prevention Science, 7(4), 403-408.

Motivational Enhancement Treatment/Cognitive Behavior Therapy (MET/CBT): MET/CBT was developed as a brief intervention to be tested at four treatment sites within the Cannabis Youth Treatment study. MET/CBT is a 5-session treatment. It comprises 2 individual sessions of motivational enhancement therapy (MET) and 3 group sessions of cognitive behavioral therapy (CBT). The MET sessions focus on factors that motivate clients to change. In the CBT sessions, clients learn skills to cope with problems and meet their needs in ways that do not involve turning to marijuana or alcohol. The program is designed for the treatment of adolescents between the ages of 12 to 18 and has been adapted in school settings.

Ramchand, R., Griffin, B.A., Suttorp, M., Harris, K.M., & Morral, A. (2011). Using a cross-study design to access the efficacy of Motivational Enhancement Therapy-Cognitive Behavioral Therapy 5 (MET/CBT) in treating adolescents with cannabis-related disorders. *Journal of Studies on Alcohol and Drugs, 72*, 380–9.

Reconnecting Youth: A Peer Group Approach to Building Life Skills (RY) is a school-based prevention program for students ages 14-19 years that teaches skills to build resiliency against risk factors and control early signs of substance abuse and emotional distress. RY targets youth who demonstrate poor school achievement and high potential for school dropout. Eligible students may show signs of multiple problem behaviors, such as substance abuse, aggression, depression, or suicidal ideation. RY incorporates several social support mechanisms for participating youth: social and school bonding activities to improve teens' relationships and increase their repertoire of safe, healthy activities; development of a crisis response plan detailing the school system's suicide prevention approaches; and parent involvement. The course curriculum is taught by an RY Leader, a member of the school staff or partnering agency who has abilities as a "natural helper," has healthy self-esteem, is motivated to work with high-risk youth, and is willing to comply with implementation requirements.

Thompson, E. A., Eggert, L. L., & Herting, J. R. (2000). Mediating effects of an indicated prevention program for reducing youth depression and suicide risk behaviors. Suicide and Life-Threatening Behavior, 30(3), 252-271.

Ripple Effects: Ripple Effects Whole Spectrum Intervention System (Ripple Effects) is an interactive, software-based adaptive intervention for students that is designed to enhance social-emotional competencies and ultimately improve outcomes related to school achievement and failure, delinquency, substance abuse, and mental health. The software for teens is called Ripple Effects for Teens (grades 6-10). The software presents students with peer-narrated tutorials that address social-emotional competencies (e.g., self-understanding, empathy, impulse control, emotional regulation, assertiveness, decision making, connection to community), present science-based information about group-level risk factors, and give each student personalized guidance to address risk and protective factors specific to the student's environment and personal goals. A draw back for alternative schools is that it may be targeted to younger students.

De Long-Cotty, B. (2008). Can computer-based training enhance adolescents' resilience? Results of a randomized control trial. Unpublished manuscript expanded from a poster presented at the 2007 annual meeting of the Society for Prevention Research, Washington, DC.

Say-it-straight: Say It Straight (SIS) is a communication training program designed to help students and adults develop empowering communication skills and behaviors and increase self-awareness, self-efficacy, and personal and social responsibility. In turn, the program aims to reduce risky or destructive behaviors such as substance use, eating disorders, bullying, violence, precocious sexual behavior, and behaviors that can result in HIV infection. SIS began as a school-based program for use in grades 3-12. Its application has been expanded to include students in detention and treatment, student mentors and mentees, parents, high-risk communities, adults in treatment, college students, and the homeless. In school settings, SIS is delivered in 5 to 10 sessions, each 45-50 minutes in duration. The sessions can be held once per

week or on consecutive days. One or two trainers facilitate the program with groups as large as 35 students.

Englander-Golden, P., Golden, D. E., Brookshire, W., Snow, C. P., Haag, M. S., & Chang, A. T. S. (1996). Communication skills program for prevention of risky behaviors. Journal of Substance Misuse, 1, 38-46

Teaching Kids to Cope (TKC) is a cognitive-behavioral health education program, based on stress and coping theory, for adolescents ages 12-18 with depressive symptomatology and/or suicidal ideation. This ten session group treatment program teaches adolescents a range of skills designed to improve their coping with stressful life events and decrease their depressive symptoms. During each group session, adolescents are first provided with information on topics such as common teen stressors, self-image, coping, family relationships, and communication. In the second portion of each session, they participate in experiential learning, identifying their problems and engaging in concrete problem-solving tasks.

Puskar, K., Sereika, S., & Tusaie-Mumford, K. (2003). Effect of the Teaching Kids to Cope (TKC) program on outcomes of depression and coping among rural adolescents. Journal of Child and Adolescent Psychiatric Nursing, 16(2), 71-80.

Teen Intervene: Teen Intervene is a brief, early intervention program for 12- to 19-year-olds who display the early stages of alcohol or drug involvement. Integrating stages of change theory, motivational enhancement, and cognitive-behavioral therapy, the intervention aims to help teens reduce and ultimately eliminate their substance use.The program is typically administered in an outpatient, school, or juvenile detention setting by a trained professional in three 1-hour sessions conducted 10 days apart.

Winters, K. C., Fahnhorst, T., Botzet, A., Lee, S., & Lalone, B. (2012). Brief intervention for drug-abusing adolescents in a school setting: Outcomes and mediating factors. Journal of Substance Abuse Treatment, 42(3), 279–288.

Trauma Focused Coping: Trauma Focused Coping (TFC), sometimes called Multimodality Trauma Treatment, is a school-based group intervention for children and adolescents in grades 4-12 who have been exposed to a traumatic stressor (e.g., disaster, violence, murder, suicide, fire, accident). The intervention targets posttraumatic stress disorder (PTSD) symptoms and other trauma-related symptoms, including depression, anxiety, anger, and external locus of control. TFC uses a skills-oriented, peer- and counselor-mediated, cognitive behavioral approach. The intervention is delivered in 14-18 weekly, 50-minute sessions, providing youth with gradual exposure to stimuli that remind them of their trauma. The sessions move from psychoeducation, anxiety management skill building, and cognitive coping training to activities involving trauma narratives and cognitive restructuring. Implementation of TFC requires a master's-level clinician and should include a cofacilitating school counselor when administered in a school setting.

Amaya-Jackson, L., Reynolds, V., Murray, M. C., McCarthy, G., Nelson, A., Cherney, M. S., et al. (2003). Cognitive-behavioral treatment for pediatric posttraumatic stress disorder: Protocol and application in school and community settings. Cognitive and Behavioral Practice, 10(3), 204-213.

Appendix D

Other Potential Sources of Funding

With the chronic underfunding of alternative education programs in Montana, one function the Montana Healthcare Foundation might play is to help programs in the state access other sources of public and private funding through grant writing and other types of technical assistance. A search of national funding databases revealed no targeted funding at the national or regional level specifically for alternative schools. In terms of federal funding, there is not one federal agency whose mission is designed to focus on all youth involved in alternative education. However, some of the larger Federal education programs that can be accessed by alternative education programs are the No Child Left Behind Act (NCLB), the Individuals with Disabilities Education Act (IDEA), and the Carl D. Perkins Vocational and Applied Technology Education Act (Perkins). Funding from other Federal programs, such as the Workforce Investment Act (WIA), should also be considered as potential sources of support for alternative education providers.[15]

The only targeted funding opportunities for alternative schools are at the state level are in places like Massachusetts and Colorado where legislatures have appropriated funding specifically for this purpose, but this type of funding is not available in Montana.[16,17,] There are some regional and national funding opportunities and foundations not specifically targeted to alternative schools that might still apply to alternative education programs. A number of these opportunities are listed below.

Findings from Grantwatch

The following grants were identified using the search engine at grantwatch.com utilizing the following criteria:

Grant interest: Students, Teachers, Mental Health and Substance Abuse
Geographic Focus: Montana

The search returned 113 matches, which were assessed for applicability to alternative schools in Montana and narrowed down to the 13 grants listed below. Some of these grants have due dates in the next weeks or months, meaning that alternative schools in Montana will likely miss

[15] http://www.ncee.org/wp-content/uploads/2010/04/GovrolesAltEd.pdf
[16] http://www.doe.mass.edu/alted/grants.html
[17] http://www.cde.state.co.us/cdefinance/altfundingpilotprogram

the deadline for funding, but the Montana Healthcare Foundation should be aware of similar possibilities for funding in the future.

Grantwatch ID	Name	Funder	Type	Award Range	Description
152031	Title II Juvenile Justice Formula Grant	Montana Board of Crime Control	State	$340K (total)	This grant supports state and local efforts in planning, establishing, operating, coordinating, and evaluating projects directly or through grants and contracts with public and private agencies for the development of more effective education, training, research, prevention, diversion, treatment, and rehabilitation programs in the area of juvenile 2 delinquency and programs to improve the juvenile justice system
143134	Grants to USA Organizations to Assist the Mentally Ill & Promote Academic Success	Margoes Foundation	F	Varies	Grants to promote access to higher education and academic success, and for programs that help people with mental illness live independently. Support for integrated programs that assist mentally ill youth or young adults to attend or complete college.
130369	Grants to U.S. Non-Profits to Reduce Substance Abuse	Hanley Family Foundation	F	Varies	Grants for programs and projects that reduce the problems of substance abuse. Grant monies may be used to advance the prevention, diagnosis, and treatment of alcoholism, chemical dependency, and addictive behavior, including support for related research and education.
133113	Grants to USA Non-Profits for Health & Wellness	Cigna Foundation	F	$5,000	Grants or projects that address an identified need in the areas of health, leadership development, social and environmental cooperation and breaking discriminatory barriers. An area of interest for funding is promoting wellness: building awareness and helping people manage their health challenges.
135674	Grants for Programs Related to Alcoholism Prevention and Education	Christopher D. Smithers Foundation	F	Varies	Grants for programs related to alcoholism prevention and education. Funds are intended to support efforts with an emphasis on high risk populations.
136078	Grants for Projects Related to Education, Health & Arts	Farrell Family Foundation	F	Varies	Grants to non-profit organizations that benefit their local communities. The health and human welfare focus is to improve the health, well-being and self-sufficiency of members of society who require a helping hand to get them out of difficulty.
136169	Grants to Improve the Health and Wellness of Children	RiteAid Foundation	F	Varies	Grants that are working to improve the health and well-being of children in communities.
137592	Grants for Education, Health, Children & the Arts	Charles Lafitte Foundation	F	$5,000 - $7,000	Grants that provide high-quality, innovative, and effective programs focusing on one of the following: children's advocacy, education, medical research, health initiatives and the arts.
144026	Grants to USA Non-Profits for Health, Education & Social Services	Halliburton Foundation	F	Varies	Grants to USA non-profit organizations, schools and other tax exempt organizations that provide programs and services in the areas of education, health and health-related social services.
146326	Grants for Civic, Human Services & Youth Programs	BNSF Railway Foundation	F	$1-10K	Grants to western USA non-profits for health and humans services, civic, social, educational, environmental, youth and other types of programs that benefit local communities.
147826	Grants to Non-Profits, Governments & Schools for Education,	RGK Foundation	F	$25K	Grants for organizations that are seeking financial assistance for projects and programs focusing on one or more of the following broad areas of interest: education, community, and health/medicine. The Foundation's current interests in the area of Health/medicine include programs that promote the health and well-being of children and programs that promote access to health services.

	Community, and Health & Medicine				
149336	Grants for Health, Human Services, Nutrition, Education and Disabilities	The Safeway Foundation	F	$2.5-10K	The foundation funds project is cities that have a Safeway store and that have a positive impact on the community in one of the following areas: health and human services, hunger relief, education, and helping people with disabilities.
151351	Grants for Education, Health, Human Services and Environment	General Motors (GM) Foundation	F	Varies	Grants to USA non-profit organizations for programs in the areas of education, health
149323	Grants to Idaho and Montana Non-Profits for Rural Education, Human Services, Conservation, Health and Arts	The Steele-Reese Foundation	F	$5K-$150K	Grants for programs, project and services benefiting rural communities in Idaho and Montana. Funding is intended to support proposals focusing on education, human/social services, conservation, preservation, health, and arts and humanities.

Other foundations

Using the Foundation Center search engine and other sources, the following foundations were identified organizations deserving more research related to providing funding for health related activities in alternative education programs in Montana.

Name	**Website**	**Focus**
First Interstate BancSystem Foundation, Inc.	https://www.firstinterstatebank.com/company/commitment/foundation/	This Billings-based foundation supports organizations involved with arts and culture, education, health, hunger, human services, community development, leadership development, and economically disadvantaged people. Support is given primarily in areas of company operations.
Dennis and Phyllis Washington Foundation	http://www.dpwfoundation.org/	This western foundation has provided more than $450,000 to the "Graduation Matters" project at OPI to improve graduation rates statewide, already showing strong support for at risk high school students in the state.
Jane S. Heman Foundation, Inc.		This Missoula Montana based foundation gives primarily in Montana with a focus on education.
Montana Community Foundation	http://www.mtcf.org	The foundation seeks to cultivate a culture of giving so Montana communities can flourish with a focus on education and American Indians.
Northwest Area Foundation	www.nwaf.org	Montana is one of eight states served by this foundation that is committed to allocating the majority of its grantmaking dollars to marginalized communities and at least 25 percent to social justice strategies, such as advocacy, community organizing, and civic engagement.
OP and WE Edwards Foundation	https://opweedwards.org	The O.P. and W.E. Edwards Foundation is a small, family foundation operating out of Red Lodge, MT. A key focus of the program is funding youth initiatives in rural tribal communities.
Paul G Allen Family Foundation	www.pgafamilyfoundvation.org	The mission of the foundation is to transform lives and strengthen communities by fostering innovation, creating knowledge, and promoting social programs. The foundation advances its mission through focusing on the following key areas: arts and culture, asset building, basic needs, libraries, innovations in science and technology and youth education.

This list of potential foundation funding sources is by no means comprehensive. There are numerous small foundations serving specific communities in Montana as well as large national foundations that might be tapped once model pilot projects with robust evaluation data are completed in alternative school programs. The Montana Healthcare Foundation should research other funding opportunities more thoroughly in the future.