Yellowstone County Behavioral Health Coalition

Strategic Plan (2026–2028)

“Working together for balanced and supported behavioral health”

Introduction

Like communities across our state and country, Yellowstone County continues to face the profound and growing impacts of mental illness and substance use disorders. While Yellowstone County benefits from strong regional assets, including an inpatient psychiatric unit, a community crisis receiving center, integrated behavioral health providers, and substance use treatment programs, community partners consistently report system challenges that prevent individuals from accessing the right care at the right time. Major challenges include system fragmentation, workforce shortages, limited step-down capacity, insufficient coordination between partners, and upstream factors including rising housing insecurity and food costs that exacerbate behavioral health challenges and complicate stabilization efforts.

The Yellowstone County Behavioral Health Coalition (YCBHC) was established to address these challenges through system-level coordination rather than direct service delivery. The coalition serves as a convening body, aligning partners, identifying gaps, strengthening pathways, and advancing shared accountability across the behavioral health continuum. This strategic plan reflects extensive local needs assessment findings, gap analysis, and input from behavioral health, healthcare, justice, housing, education, and community partners.

Mission: Through collaboration, innovation, and advocacy, we aim to build a responsive, sustainable, and integrated behavioral health continuum (prevention, crisis intervention, treatment, and recovery).

Vision: A resilient Yellowstone County where every individual has seamless access to compassionate, coordinated, and comprehensive behavioral health care—from prevention to recovery. Our community is safe, connected, and empowered to thrive through support, reduced stigma, and collaborative systems.

Purpose

The purpose of this strategic plan is to guide collective action from 2026–2028 to strengthen Yellowstone County’s behavioral health continuum by focusing on **four high-impact goals**: 1) Coordination and collaboration, 2) Prevention and early intervention, 3)

Crisis response system improvement, and 4) Sustainability through funding, workforce, and data.

Consistent with the Coalition Charter, this strategic plan focuses on system coordination, gap identification, alignment, and shared accountability. The Coalition does not provide direct services but instead strengthens the behavioral health continuum by convening partners, improving pathways, advancing data-informed decision-making, and supporting collective action. Rather than attempting to solve every problem simultaneously, the coalition prioritizes strategies that align with existing community capacity, state initiatives, and funding structures.

Implementation of this strategic plan will occur through the Coalition's established governance structure, including the Executive Committee and standing committees/workgroups (Prevention, Crisis, Treatment, Recovery, Re-Entry, and Data Coordination). Each committee will align its work plan to one or more strategic goals and report progress using shared metrics.

Strategic Approach

Coalition decision-making related to implementation priorities, advocacy positions, and partnerships will follow the criteria established in the Coalition Charter, including alignment with mission and scope, non-duplication, feasibility, sustainability, and community benefit. This plan is grounded in three principles:

- **Systems-building**: The coalition focuses on improving how systems work together across the continuum instead of duplicating services.
- **Diversion from crisis, jail, and emergency departments**: Emphasis is placed on early identification, community-based responses, and step-down options.
- **Data-informed accountability**: Shared measurement and transparent progress tracking will guide continuous improvement.

The four goals and corresponding objectives are aligned with best practices demonstrated in other Montana communities, including Flathead County and Gallatin County, while remaining responsive to Yellowstone County's unique context as a regional healthcare hub serving both urban and rural populations.

For tracking outcomes, work groups in the coalition will identify metrics of success for each objective. The coalition will use data and reports from community stakeholders such as the Community Health Needs Assessment and the statewide crisis dashboard in addition to local metrics on the behavioral health system.

Goal #1: Strengthen Coordination and Collaboration Across the Behavioral Health Continuum

Improve alignment, communication, and shared accountability among behavioral health, healthcare, housing, justice, and community partners so individuals experience a coordinated, organized, and person-centered system of care.

Goal Outcome:
Behavioral health systems in Yellowstone County operate with clear pathways, shared definitions and expectations, and coordinated transitions of care.

Objectives	Strategies
Objective 1.1: Improve system navigation and care coordination	• Develop and maintain a shared, vetted community behavioral health resource map (adult and youth), including prevention, crisis, treatment, housing, and recovery supports. • Explore development of a local bed and service registry as well as a closed loop referral system to improve real-time visibility into crisis, residential, step-down capacity, and connection to care. • Promote warm handoff protocols and standardized referral practices across crisis, inpatient, outpatient, and community-based providers. • Identify opportunities to embed or align care coordination roles (e.g., navigators, community health workers, case managers) across settings • Promote standardized protocols to provide continuity of care during transition periods for those with high-risk for negative outcomes (i.e. State Hospital discharge with Critical Time Intervention, inpatient care, crisis services, justice settings).
Objective 1.2: Strengthen diversion and reentry pathways	• Support development of formal diversion pathways from emergency departments, law enforcement, and detention into community-based services whenever clinically appropriate. • Improve pre-release and reentry coordination by aligning providers, corrections partners, and housing supports to ensure continuity of care. • Use shared data to identify individuals and families with frequent emergency department, crisis, or justice system involvement and develop coordinated, cross-system response strategies to reduce repeated crises (i.e. complex case conferencing). • Support cross-system planning between behavioral health and justice partners to improve assessment, decision-making, and diversion pathways during short-term holding, including clinically appropriate use of deferred prosecution and rapid connection to community services.

Objective 1.3: Clarify coalition roles and partnerships	• Clearly define the coalition's role as a systems convenor and problem-solver, to be used by city/county leadership and organizations. • Strengthen collaboration with existing coalitions and initiatives (e.g., Continuum of Care, advisory councils, prevention coalitions) to reduce duplication and improve alignment.

Goal #2: Promote Prevention and Early Intervention

Advance a shared, proactive approach to behavioral health prevention and early intervention that builds resilience, identifies needs earlier, and reduces reliance on crisis, emergency, and justice systems.

Goal Outcome:

Behavioral health needs are identified earlier, with strengthened resilience and reduced reliance on crisis systems.

Objectives	Strategies
Objective 2.1: Establish a shared prevention framework	• Create a shared definition and framework for prevention across the behavioral health continuum (primary, secondary, tertiary or other). • Map existing prevention and early intervention efforts to identify gaps, overlaps, and opportunities for collaboration. • Align prevention goals across youth, family, school, older adults, disabled population, Veterans, and community-based partners. • Analyze and pilot prevention practices and determine feasibility for local implementation.
Objective 2.2: Increase access and visibility of prevention efforts	• Improve communication and awareness of existing prevention programs, particularly for populations not already engaged in services (such as older adult serving organizations). • Support greater collaboration among organizations offering youth mentoring, school-based supports, wellness initiatives, and family services. • Explore expanded use of community health workers and peer supports in prevention, early identification, treatment, and recovery work. • Increase 988 and prevention campaigns regarding behavioral health prevention tools and availability in the local community to decrease stigma around asking for help.
Objective 2.3: Reduce barriers for youth and families	• Support initiatives that address crisis transportation, childcare, and scheduling barriers to participation in prevention and early intervention services (i.e. respite services, after-hours access) • Promote coordination between schools, healthcare providers, and community organizations to support early identification and referral.

	• Encourage follow-up through improved coordination after crisis or inpatient episodes to ensure youth and families are successfully connected to ongoing supports (Tertiary prevention). • Encourage shared problem-solving around prevention and early intervention gaps affecting families on the fringe of crisis.

Goal #3: Improve Community Crisis Response Systems

Build a responsive, integrated crisis system that ensures individuals experiencing behavioral health crises have someone to call, someone to respond, and somewhere appropriate to go—outside of jails and emergency departments whenever possible.

Goal Outcome:

Individuals in crisis receive timely, appropriate responses that minimize harm and reduce reliance on emergency departments and incarceration.

Objectives	Strategies
Objective 3.1: Strengthen mobile and community-based crisis response	• Support redevelopment and sustainability of a Mobile Crisis Response Team, integrated with existing crisis services. • Explore co-response models involving clinicians, peers, law enforcement, and EMS. • Identify sustainable staffing and funding approaches, including shared staffing models where appropriate. • Continue to support Crisis Intervention Team (CIT) training among law enforcement and emergency response professionals.
Objective 3.2: Integrate 988 and local crisis systems	• Improve coordination between 988, local crisis lines, local dispatch, and the Community Crisis Center to streamline triage and response. • Support community and provider education on appropriate use of 988 and crisis services. • Promote common language and protocols across crisis partners.
Objective 3.3: Expand receiving/ stabilization and step-down options	• Promote diversion pathways that include clinically appropriate subacute withdrawal management and stabilization options (e.g., ASAM 3.7) to reduce reliance on emergency departments. • Promote care coordination and follow-up across the behavioral health continuum of services to reduce repeat crisis episodes.
Objective 3.4: Strengthen engagement and low-barrier access points for individuals not connected to services	• Educate on definitions and encourage development or expansion of drop-in, recovery, and daytime safe spaces that provide low-barrier access to support, peers, and service navigation. • Strengthen housing-based crisis prevention and stabilization options, including low-barrier shelter, transitional housing, and recovery housing. • Promote culturally responsive, peer-led outreach strategies that improve engagement among vulnerable populations.

Goal #4: Advance Sustainability Through Workforce, Funding, and Data

Ensure the behavioral health system in Yellowstone County is sustainable, data-driven, and supported by a stable, well-trained workforce.

Goal Outcome:

The behavioral health system is supported by a stable workforce, sustainable funding structures, and transparent data.

Objectives	Strategies
Objective 4.1: Strengthen workforce capacity	• Track and communicate local workforce needs and barriers to state task forces and pilot initiatives. • Support workforce development incentives such as loan repayment, internships, training placements, and career pathways. • Expand use of peer support and community-based roles where appropriate. • Promote collaboration with educational institutions, healthcare partners, and local governments to strengthen workforce pipelines.
Objective 4.2: Improve funding stability and advocacy	• Advocate for sustainable Medicaid/Medicare reimbursement, timely enrollment, and payment processing. • Support blended and braided funding strategies across local, state, federal, and additional sources. • Align coalition messaging to support investment in prevention, crisis diversion, treatment, recovery, and re-entry supports. • Coordinate with state partners to improve local implementation of Medicaid processes, including redetermination education, care coordinator tools, and clear communication materials for clients and providers. • Engage in local, regional, and statewide conversations and planning regarding behavioral health improvement (i.e. Certified Community Behavioral Health Clinics (CCBHCs) and other associated topics).
Objective 4.3: Use data for accountability and improvement	• Develop and adopt a limited set of shared, intermediate system performance measures aligned with coalition priorities (e.g., diversion, access, transitions, crisis utilization) to guide collective action and track progress across partners. • Support development of a local or regional dashboard to track system performance and inform decision-making. • Use data to identify inequities, service gaps, and improvement opportunities. • Support exploration of data compatibility for integration across HMIS, healthcare EHRs, and crisis systems to improve real-time visibility into capacity, transitions, and outcomes. • Use shared data to identify recidivism drivers and cost impacts, particularly among individuals with frequent crisis, inpatient, and justice involvement, to inform system redesign and funding advocacy.