MONTANA SENATE
2007 LEGISLATURE

ROLL CALL

PUBLIC HEALTH, WELFARE & SAFETY

DATE 1-10-07

NAMES	PRESENT	ABSENT	EXCUSED
SEN. JOHN COBB (R)	✓		
SEN. JOHN ESP (R)	✓		
SEN. KIM GILLAN (D)	✓		
SEN. LYNDA MOSS (D)	✓		
SEN. TERRY MURPHY (R)	✓		
SEN. JERRY O'NEIL (R)	✓		
SEN. TRUDI SCHMIDT (D)	✓		
SEN. CAROL WILLIAMS (D)			✓
SEN. DAN WEINBERG(D) CHAIR	✓		
LISA JACKSON (LSD)	✓		
PRUDENCE GILDROY, SECRETARY	✓		

COMMITTEE FILE COPY

TABLED BILL

The **SENATE PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE** TABLED **SB 2**, by motion, on **Wednesday, January 10, 2007**.

P. Gildroy
(For the Committee)

KF
(Secretary of the Senate)

_____ / 1-12
(Time) (Date)

January 12, 2007 Prudence E. Gildroy, Secretary Phone: 7855

SENATE STANDING COMMITTEE REPORT

Mr. President:

We, your committee on **Public Health, Welfare and Safety** recommend that **Senate Bill 48** (first reading copy -- white) **do pass as amended**.

Signed: _____
Senator Dan Weinberg, Chair

And, that such amendments read:

1. Page 3, line 28 through line 30.
Strike: subsection (9) in its entirety
Renumber: subsequent subsection

- END -

Committee Vote:
Yes 9, No 0
Fiscal Note Required ___

081309SC.ssc

SENATE STANDING COMMITTEE REPORT

Mr. President:

We, your committee on **Public Health, Welfare and Safety** recommend that **Senate Bill 90** (first reading copy -- white) **do pass**.

Signed: Dan Weinberg
Senator Dan Weinberg, Chair

- END -

Committee Vote:
Yes 9, No 0
Fiscal Note Required ___ KJ

SENATE STANDING COMMITTEE REPORT

January 12, 2007

Mr. President:

We, your committee on **Public Health, Welfare and Safety** recommend that **Senate Bill 94** (first reading copy -- white) **do pass**.

Signed: _____
Senator Dan Weinberg, Chair

- END -

Committee Vote:
Yes 9, No 0
Fiscal Note Required ___

KT

Jan 10, 2007

I give my proxy
to Ken Steinberg
or
Carol Williams

MONTANA STATE SENATE
2007 LEGISLATURE

VISITOR REGISTER

PUBLIC HEALTH, WELFARE, AND SAFETY

DATE 1/10/07

BILLS BEING HEARD TODAY _____

PLEASE PRINT

NAME	PHONE	REPRESENTING	BILL #	SUPPORT	OPPOSE
Kathleen McCarthy	444-4735	DPHHS	94	information	
Mary Kendrick	459-9440	Montana Women Vote	22	X	
John McCall	670-3084	MCI - ~~Billing~~ Billing Limit	22	X	
Jackie Kramis	452-4808	Self	22	X	
Pat Melby	442-7455	MT Med. Ass'n	22	✓	
Mike Foster	237-3038	SVH	22	✓	
Carolyn		MHA	22	✓	
Erin McGowan Fincham	444-4613	SAO	22	✓	
Bruce Deitke	444-5907	DPHHS			
Susan Kidd	495-0497	WEEL	22	✓	
Jennifer Harris	465-0326	WEEL - Self	22	✓	
Frank Cote	443-7079	AMIP	22	✓	
Mary Dalton		HRD - DPHHS	22	information	
Scott Martin	406-535-1483	MSU - Billings	22	✓	
Denver Henderson	406-237-3121	Aware - Missoula	22	✓	
Bill Kennedy	256-2701	Yellowstone Co. Co.	22	✓	
Joe Maguire	457-2030	Blue Cross Blue Shield	22	✓	
Mary Caferro			22	✓	
Elsie Arntzen	761-0310	OPI	22	✓	
Steve Yeakel	443-1674	MT Council For Maternal & Child Health	22	✓	
Jackie Fortin	444-5288	DPHHS	22		

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

Jackson, Lisa Mecklenberg

From: Fox, Susan
Sent: Tuesday, January 09, 2007 6:26 PM
To: O'Connell, Sue; Jackson, Lisa Mecklenberg
Subject: FW: Letter of support-SB22
Attachments: image001.png

Susan Byorth Fox
(406) 444-3066
sfox@mt.gov

From: Julie Serstad [mailto:Serstadj@ho.missoula.mt.us]
Sent: Tuesday, January 09, 2007 4:35 PM
To: dweinberg@centurytel.net; cwilliams@montanadsl.net; Moss, Sen. Lynda; cobbchar@3rivers.net; jesp@mcn.net; oneil@centurytel.net; trudi@in-tch.com; glonky@aol.com; Yeakel, Steve; Fox, Susan; Stoll, Linda
Subject: Letter of support-SB22

Good Afternoon-Our support for SB22. Thanks for all you do! jas

MISSOULA COUNTY

MISSOULA CITY-COUNTY H
DEPAI
HEALTH SI
301 WEST
MISSOULA, MONTANA 5
(406) 258-4750 FAX (406)

Dan Weinberg
Committee Chair
Public Health, Welfare and Safety
State of Montana Senate
Helena, MT 59620

Dear Senator Weinberg,

On behalf of the Missoula City-County Health Department, thank you for demonstrating your commitment to the public health and welfare of Montana's children by introducing Senate Bill No. 22. This bill will revise the eligibility requirements for the Children's Health Insurance Program (CHIP). We are pleased the Children, Families, Health and Human Services Interim Committee requested this legislation.

According to the 2006 Montana Kids Count Data Book, in 2004, 16% of children 18 and under in Montana did not have health insurance and the greatest percentage (17%) of these were between the

ages of 0 and 5 years of age. In 2004, 33% of all children in Montana were below 150 % of poverty.

Although enrollment in CHIP has increased each year the data demonstrate there are Montana children who are not covered. Raising the eligibility from at or below 150% of poverty to at or below 165% of the federal poverty level will enable more children to be covered.

We support SB 22 and understand it will require sufficient funding and should there be insufficient funding, the Department of Health and Human Services may lower the percentage of the federal poverty level established in order to reduce the number of persons who may be eligible to participate.

The Missoula City-County Health Department, Health Services Division provides services to high risk infants and children. In 2005 we were able to serve 30% of the children who make up 4 % of the population in poverty in Missoula County. This legislation will allow us to increase services to children and continue to improve the public's health through our endeavors.

Again, we thank you for introducing this legislation and support your efforts to serve the infants and children of Montana.

Sincerely,

Julie A. Serstad, RN, BSN, MSN
Health Services Director

Recent Increases in Uninsured Rate for Montana Children

BY
DR. STEVE SENINGER
DIRECTOR OF MONTANA KIDS COUNT
BUREAU OF BUSINESS AND ECONOMIC RESEARCH
THE UNIVERSITY OF MONTANA
MISSOULA, MONTANA
(406-243-2725)
steve.seninger@business.umt.edu
November 2006

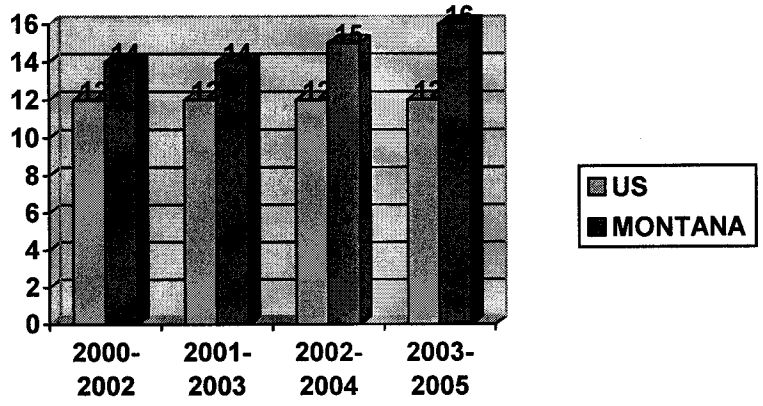
INTRODUCTION

Health insurance coverage for Montana kids decreased over the past four years according to US Census data. The percent of Montana children of all ages lacking private or public health insurance went from 14 to 16 percent over a four year period ending in 2005. Children below the federal poverty level had some of the biggest declines in health insurance coverage going from an uninsured rate of 19 percent four years ago to 29 percent by 2005, a change representing 4,000 more uninsured low income children joining the ranks of Montana's uninsured.

Double digit increases in health insurance and increased employee shares of premiums for working parents have contributed on the cost side to the increasing number of uninsured kids and families. The state of Montana has responded to higher uninsured rates through initiation of the Insure Montana Program for small employers and expanded coverage of the Children Health Insurance Program and for mothers with young children in the Medicaid program.

Chart 1 compares uninsured trends for Montana kids compared to the US using 3 year averages of Census Bureau survey data. The uninsured rate for kids nationally has been essentially constant over a four year period ending in 2005. Health insurance coverage for Montana kid's deteriorated over the same period with the state's uninsured rate for kids increasing from 14 percent to 16 percent by 2005, an uninsured rate representing 37,000 Montana children without private or public health insurance.

Figure 1: Percent of Montana Children 18 and under Without Health Insurance



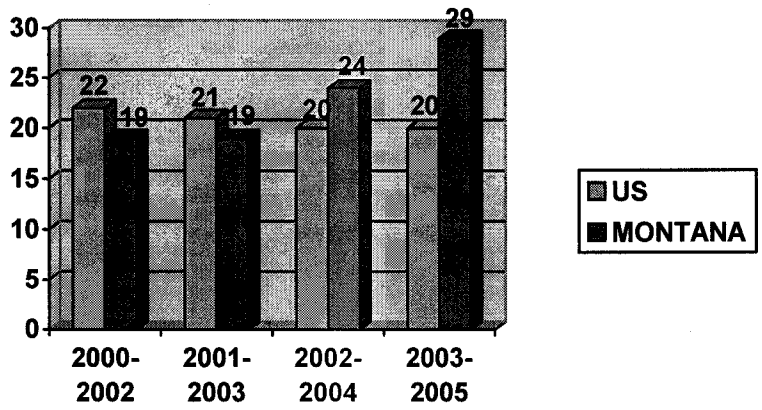
Source: US Census Bureau, three year averaging of Census Population Survey Data, Annie E. Casey Foundation, www.aecf.org

Steve Yealed 443-1674
MT Coalition for Maternal & Child Health

DECREASED INSURANCE COVERAGE FOR LOW INCOME CHILDREN

Declines in healthcare access have especially affected low-income kids in Montana. The uninsured rate for Montana kids living in households that are below the federally defined poverty level has increased from 19 percent to 29 percent, a state rate that is 1.5 times higher than the national rate. Montana's increase of 10 percentage points in the uninsured rate for kids below poverty is in contrast to twenty seven other states where the uninsured rate for kids below poverty decreased over the same period.

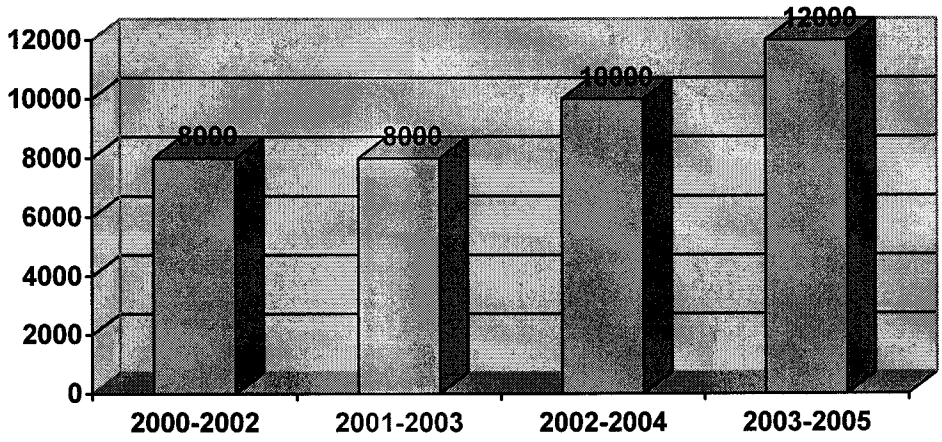
Figure 2: Percent of Montana Children 18 and under below the Federal Poverty Level without Health Insurance: Three Year Averages



Source: US Census Bureau, three year averaging of Census Population Survey Data, Annie E. Casey Foundation, www.aecf.org

Age breakdowns of the data show that many of the increases in the number of uninsured children are for those five years of age and under. Uninsured rates for children in these early, critical years of physical and mental development have increased from 13 percent in 2000 to 17 percent by 2005. About two thirds of the over 3000 children below poverty without health insurance are 5 years of age and younger.

Figure 3: Number of below poverty (<100%FPL) Montana Kids without Health Insurance: 3 Year Averages



Source: US Census Bureau, three year averaging of Census Population Survey Data, Annie E. Casey Foundation, www.aecf.org

BUDGET IMPACT OF EXPANDING COVERAGE

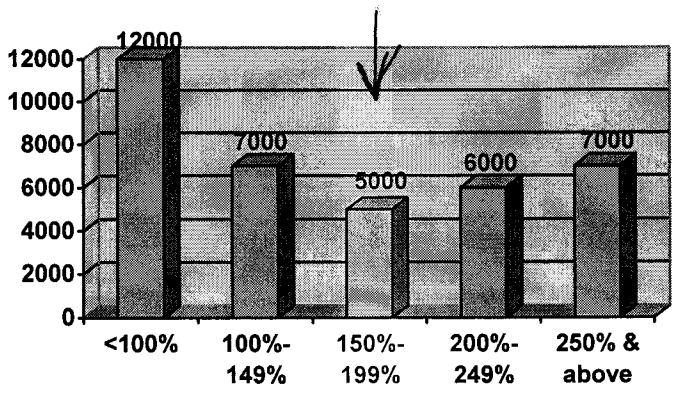
Low wage jobs and unaffordable health insurance contribute to the increased lack of health insurance for Montana kids and especially low-income kids. Although the state's unemployment rates are at historic lows, worker earnings have not grown dramatically during the state's recent economic expansion. This has been especially true in mining and oil and gas where they have not been a large number of new jobs even though these are usually well paying jobs.

Higher health insurance premiums and a shifting of those costs to workers by employers offering health insurance is another factor contributing to higher uninsured rates for Montana's children. A recent employer survey conducted by the UM Bureau of Business and Economic Research shows that employers experienced an 18 percent increase in health insurance premium costs. Workers had increases in their share of employer offered insurance plans go up by 2 to 3 times the employer's increase, a cost shift that makes job based health insurance increasingly unaffordable.

The state of Montana has initiated several positive responses to the state's high uninsured rate. Premium assistance and tax credits to small employers under the Insure Montana Program are designed to alleviate the health insurance premium cost squeeze confronting working parents. Planned expansions in the state's Children Health Insurance Program and increased access to Medicaid for children aged 6 to 19 should help lower the uninsured rate for Montana kids, especially kids in low income households.

These new initiatives, the results from which are only just beginning to unfold, will affect some but not all of the 37,000 children in Montana without health insurance. Significant expansions in CHIP would go a long way to improving health care access for Montana kids, particularly for the 24,000 children living in households below 200 percent of the federal poverty level.

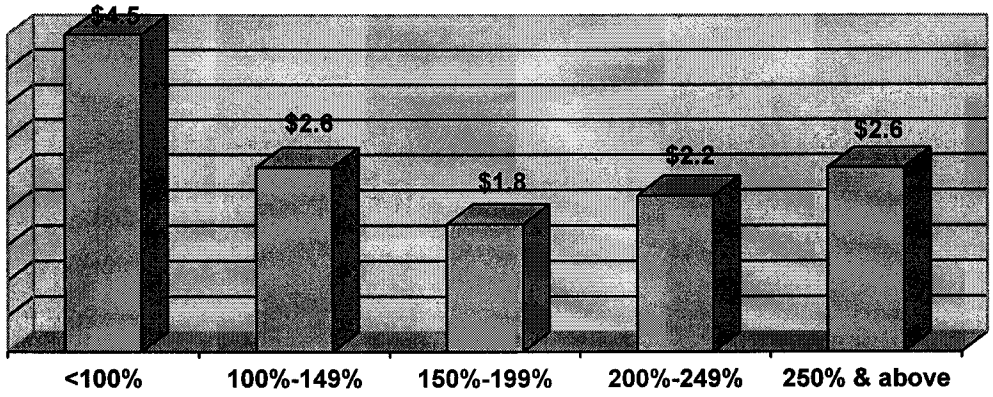
Figure 4: Number of Montana Children 18 at Different Poverty Levels Without Health Insurance: 2003-2005 Averages



Source: US Census Bureau, three year averaging of Census Population Survey Data, Annie E. Casey Foundation, www.aecf.org

State budget dollars required for providing health care access to the majority of children in Montana can be calculated using $1,734 per child, with Montana's match being $371. These amounts are based on state fiscal year 2006 CHIP program data. Thus, the cost to the state would be $4.5 million to insure the 12,000 children below 100% of the federal poverty level. To insure the 12,000 more Montana kids who are between 100 percent and 200 percent of the federal poverty level the cost to the state would be $4.4 million (Figure 5).

Figure 5: State Dollars ($Millions) Required to Expand CHIP for Montana Kids Without Health Insurance by Federal Poverty Level Thresholds: 2005



Source: Author's Calculations and Montana Children's Health Insurance Program, Fiscal Year 2006

Another 6,000 Montana children would have health insurance if the eligibility cutoff were raised from 200% to 250% of the federal poverty level and would cost an additional $2.2 million in state funds. Coverage of kids at 250% and above the federal poverty level would enroll another 7,000 children and cost another $2.6 million in state dollars. Extending coverage to all Montana children kids would eliminate lack of health insurance for all children 18 years of age at a total cost to the Montana treasury of $13.7 million dollars.

Economic Benefits

Lower health care costs for children, cost savings on employer based health insurance premiums, and positive impacts on the state economy through outside federal dollars are direct benefits from extending health insurance coverage to all of Montana's children.

A significant portion of the state's costs will be offset by savings from children receiving regular checkups and healthcare when it is needed and not when a health problem has become extremely serious. Stability in healthcare access and establishment of a 'medical home' for children will help reduce the need for expensive hospitalizations and emergency room visits that will save the state and consumers money. In some states with health insurance coverage for all children, cost savings are estimated at 70 percent of the combined federal and state dollar outlay for program expansion (www.familiesusa.org).

Health insurance premiums for families who have insurance through their employers are, on average, 17 percent higher due to the cost of health care for the uninsured according to 2005 estimates (www.familiesusa.org). If Montana expanded CHIP to cover all uninsured children, it

would reduce the number of uninsured persons in the state, which will in turn reduce premiums for employer-based insurance.

Expansion of children's coverage through CHIP brings in money in the form of federal matching dollars. These dollars contribute to economic growth just as visits by out-of-state tourists or the sale of manufactured products to customers outside Montana bring dollars into the state economy. The estimated $13.7 million in state outlays for covering all children would bring in almost $55 million in federal dollars providing a powerful positive stimulus to Montana's economy. These outside dollars would have a cumulative impact of $60 million on labor income throughout the Montana economy generating state income taxes that would offset part of the state budget outlay from expanding the Children's Health Insurance Program.

CONCLUSION

Expanding health insurance coverage to all Montana children offers benefits for everyone in Montana. It will offer immediate help to children in the state who are uninsured today, and contribute to their healthy development and future role as citizens and members of the labor force. At the same time, reducing the number of uninsured in Montana will reduce the premiums paid by workers who have employer-based coverage now. And finally, full coverage of all Montana children will provide a valuable economic stimulus to the state's economy.

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

BRIAN SCHWEITZER
GOVERNOR

JOAN MILES
DIRECTOR

STATE OF MONTANA

(406) 444-5900
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CHILD AND FAMILY SERVICES DIVISION
PO BOX 8005
HELENA, MT 59604-8005

January 19, 2007

Public Health, Welfare and Safety Committee
Montana State Senate
State Capitol
Helena, Montana 59602

Sen. Dan Weinberg, Chair

Re: SB 83

Dear Sen. Weinberg and Committee Members:

During the hearing on SB 83, Sen. Esp requested information on the process used by the social worker when placing with a kincare provider. He specifically asked about the evaluation conducted by the social worker. I indicated that the evaluation conducted by the Division depended on whether or not the kincare provider wanted to be licensed—foster care licensing studies take much longer than the evaluation of an unlicensed home.

In response to Sen. Esp's request, I have enclosed a copy of Child and Family Services Policy Section 402-4, Placement in Kinship Care. Pages 11-15 are the Kinship Care Agreement signed by the kincare provider in which the provider certifies to specific safety issues. You will also notice that the social worker must conduct specific background checks. The length of time this evaluation takes depends on the circumstances. The policy applies when the social worker is making the placement and the department is awarded temporary legal custody of the child.

You will notice that SB 83 amends a disposition applicable to relatives. The amendments on page 2, line 16 of SB 83 provide for the evaluation of a nonparent relative or other individual before the court can transfer temporary legal custody to that individual.

This situation is distinguishable from the situation addressed in the policy. The policy applies to placements made by the social worker, monitored by the social worker, and in which the department probably has been awarded temporary legal custody. The disposition amended in SB 83 applies to situations in which the kincare provider, not the

Department, is awarded temporary legal custody. In that situation, a more complete evaluation is needed.

I hope this information is helpful in your deliberations on SB 83.

Sincerely,

Shirley K. Brown, M.A., J.D.
Administrator
Child and Family Services Division

Child and Family Services Policy Manual: Substitute Care for Children
Placement in Kinship Care

Definition

A **kinship care home** is an unlicensed home in which substitute may be provided to children placed by the department when such care is provided by.

- a member of the child's extended family;
- a member of the child's or family's tribe;
- the child's godparents;
- the child's stepparents; or
- by a person to whom the child, child's parents and family ascribe a family relationship and with whom the child has had a significant emotional tie that existed prior to the agency's involvement with the child or family.

A **kinship foster home** is a licensed youth foster home) in which substitute care is provided to one to six children or youth other than the kinship parent's own children, stepchildren or wards.

The care may be provided by:

- a member of the child's extended family;
- a member of the child's or family's tribe;
- the child's godparents;
- the child's stepparents **if the child is placed with the stepparent by the department**; or

a person to whom the child, child's parents and family ascribe a family relationship and with whom the child has had a significant emotional tie that existed prior to the agency's involvement with the child or family.

Emergency Placements

In emergency removal situations the policy and procedures to be followed are outlined in Section 302-1, Immediate Protection and Emergency Protective Services, of this manual.

Placing Worker Responsibility

When a social worker and his or her supervisor decide a child must be placed, the child will be placed with the child's family (or other kin) **when it is in the best interest of the child and the**

home is approved by the Department. The worker should proceed with the same care he or she takes when placing a child in any foster care placement. Although the placing worker carried the authority and responsibility for making an agency placement, the worker will want to consult with the parents and other family members, whenever feasible.

The department must give preference to the use of kinship caregivers when placement with kin is in the best interests of the child and the caregiver's home meets the requirements for the type of care the kin wishes to provide. Kinship care is intended to:

- preserve the continuity of family relationships and connections for children;
- minimize the loss of family;
- reduce the trauma of placement
- provide permanency for children within their families; and
- support families so they can protect and nurture their children.

Best Interests of the Child

The placing worker must determine if placement with kin is in the best interests of the child. The worker will document in the case record the reason(s) the worker believes that placement is in the best interests of the child. The best interests should regularly be assessed to determine if the placement continues to be in the best interests of the child. If it is determined that the placement is not the optimal placement for the child, a more appropriate placement should be sought.

Selection of Family

The process for selecting a kinship provider will vary depending on the situation and local agency practice. The Department encourages placing workers to involve the birth family, kinship family and other relatives and interested persons in the selection of the home. A family group decision-making meeting or use of family preservation services may help to determine the best placement for the child.

When selecting a kinship placement for the child, the child's safety and well being must be of paramount consideration. Placement should be based upon consideration of the best interest of the

child. Factors to be considered in selecting a placement are:

- the services the child will need, based on an assessment of the physical, educational and psychological needs of the child and the ability of the kinship provider to meet these needs;

- the child's race and the role racial identity has played in the child's life (if the child is Indian, the requirements of ICWA must be met; refer to section 301-5, Indian Child Welfare Act);

- placement with siblings is based on the needs of the individual child. If placement with siblings is determined not to be in the best interests of the child, the reasons must be documented and submitted to the supervisor for approval;

- the location of the child's family and the need to maintain contact with other family members;

- identification of the child's religion and the role that religion has played in the child's life;

- other factors particular to the child and the child's circumstances.

The worker should also consider the following factors when determining whether a particular kinship home should be approved for a child:

- the nature and quality of the relationship between the child and the prospective kinship provider;

- the ability and desire of the prospective kinship provider to protect the child from further abuse or neglect and any family dynamics in the home related to the abuse or neglect of the child;

- the safety of the home and the ability of the prospective kinship provider to provide a nurturing environment for the child;

- the nature and quality of the relationship between the child

and the prospective kinship provider;

- the willingness of the kinship family to accept the child into their home;
- the nature and quality of the relationship between the birth parents and the prospective kinship provider, including the birth parent's preferences about placement of the child with kin;
- the prospective kinship provider's ability and willingness to cooperate with CFSD; and
- the existing support system of the prospective kinship family.

If it is determined that the child has been placed in a setting that is determined not to be optimal, consideration should be given to moving the child to a more appropriate placement as soon as possible.

Review of Options Licensing v. Approval

The worker must discuss with the kinship family that is selected for placement the options of licensed or unlicensed care, the services to be provided and the financial assistance available.

If the family chooses to be approved and not licensed, the worker is responsible for assessing the family's ability to provide for the child's safety and well-being. Consideration must be given to the family's ability to meet the child's needs on both a short and long-term basis.

The placing worker must make a visit to the kinship home within 48 hours of the time the child is placed with the kin providers, excluding weekends and holidays. The purpose of the visit is to assess the safety and appropriateness of the home for the child. A visit by the placing worker is required even if the family has been referred to an FRS and is pursuing licensing.

The visit must be documented in the child's file.

Release of Information and Background

The worker will obtain a signed copy of the DPHHS-CFS/LIC-018, Release of Information and will ensure that a criminal background, Montana motor vehicle and protective services check is completed on each adult member of the household for a family

Checks

under consideration for placement.

If the family chooses to become licensed, it is the responsibility of the social worker to conduct a protective services check and to refer the kin family to the appropriate FRS within three working days. A referral may be made via e-mail.

Criminal Background Check

The purpose of the criminal check is to determine whether any adult in the home has been convicted of a crime, which might affect their ability to provide safe care. If a child is placed with a kinship family prior to the completion of a criminal records check, a check of the violent offender and criminal history registries (if such registries are available in states in which adults in the kinship home have lived) must be completed within 3 days.

Fingerprint cards must be provided to each kinship applicant and adult member of the applicant's household. The applicant should be provided information on the local process for obtaining fingerprints. The applicant should be advised if there is a fee charged for taking the prints, how this cost is to be paid and the expectations for returning completed fingerprint cards.

The kinship provider and other adults in the home are required to provide completed fingerprint cards to the department as soon as possible, but not more than 10 days after the placement is made. The applicant should return the completed fingerprint card to the placing worker within 3 days if a child has been placed in a kinship home. If a child has been placed in a kinship home and all adults in the **home have not returned** completed fingerprint cards within 3 days of placement, the placing social worker must ensure that a name based criminal records check is requested prior to the end of the third day. A request for a name-based check may be made via e-mail.

Name-based Check

A criminal records check via fingerprints is still required even if a name based check is completed and must be requested as soon as the fingerprint cards are returned.

The placing worker will ensure that the fingerprint card is reviewed for accuracy and completeness prior to being sent to the Department of Justice.

There is cost of $10 for a Montana fingerprint check only (for applicants who after the age of 18 have lived in **Montana, Alaska,**

Idaho, Nevada, Oregon, Utah or Wyoming) or a cost of $34 for a Montana and Federal fingerprint check (for applicants who after the age of 18 have lived in a state other than those listed above **or have lived on a reservation).**

NOTE: Felonies committed on reservations are federal crimes. As with any criminal check, all crimes may not have been reported and may not appear on a criminal record.

Payment in the form of check or money order made out to Criminal Records and Identification must accompany the request for a fingerprint check unless the Department has agreed to cover the cost of the fingerprint check. If the Department has agreed to cover the cost of the fingerprint checks, a memo should be attached to the fingerprint card(s) indicating this.

The Department will only cover the costs of fingerprint checks if court action has been initiated on behalf of the child(ren) to be placed.

Fingerprint cards are to be sent to the Department of Justice, Criminal Records and Identification, P.O. Box 201403, Helena, MT, 59620.

If the family lives or has lived on a reservation, a check with tribal law enforcement should also be conducted.

A child shall not be placed in a kinship home in which there is anyone residing who has at any time been convicted of a felony for any of the following:

- child abuse or neglect;
- child sexual abuse;
- partner or family member assault;
- any crime against children (including child pornography); or
- for a crime involving violence, including rape, sexual assault, or homicide.

In addition, no child shall be placed in a kinship home where there is anyone residing who has been convicted of a felony for any of the following if the offense for which they were convicted occurred within the past 5 years:

- physical assault;
- battery; or
- a drug related offense, including alcohol related convictions.

If the results of the criminal records check reveal a conviction for one of the crimes listed above within the past five years, the child must be moved to another placement.

If the results of the criminal checks reveal convictions that do not fall into the above categories that does not mean the applicant must be approved. The worker must assess the criminal history and the potential effect on the child.

Exceptions

If the prospective kinship provider (or other adult household member) is missing ALL of their fingers, a criminal check by name must be completed. If the applicant (or other adult household member) is missing some, but not all of their fingers, a fingerprint check must be completed. The person taking the fingerprints will note on the fingerprint card the fingers that are missing.

In rare instances, useful fingerprints cannot be obtained from an individual.

If the FBI rejects fingerprint cards on the same individual twice, a national name based check can be conducted on that individual. (The cards will have a white paper stapled to them.) The requesting worker should fax the person's name, date of birth and social security number to the DOJ (444-0689) and request that a name based check be completed based on the FBI rejections. DOJ will fax the results of a name-based search to the person making the request.

If after three attempts to obtain useable fingerprints from an individual to whom the FBI rejections do not apply, a name check must be used to obtain the criminal record. Since a national name based check will not be completed if the request is not the result of

FBI rejections, an attempt must be made to obtain criminal records from all states in which the applicant has lived.

In both of the above situations, information must be attached to the results of the check explaining why a fingerprint check was not used.

Protective Services Checks

The placing worker shall conduct a CPS/APS check by checking first on CAPS and then with the county CFSD office in the county(ies) where the family has resided within three days of the time the child is placed in the kinship home. If the provider or other family member is listed as a person in CAPS, the placing worker **must** check with the CFSD office in the appropriate county to determine if there is information available which would preclude placement.

If the provider or other family member has lived in another state or states, the placing worker must check with that state or states to determine if there is CPS information available, which would preclude placement.

If the applicant or other household member has received services for substantiated abuse or neglect, the worker must justify why placement of the child in that particular home is in the child's best interests. The written approval of the regional administrator must be obtained in order to continue the placement or to place the child in the home.

Montana Motor Vehicle Check

Motor vehicle checks may be completed on-line and must be completed within three days of the time a child is placed in a kinship home. The worker may contact the local FRS or FRS supervisor to find out whom in the region has access and can complete these checks.

Kinship Care Agreement

The placing social worker and the family must sign a DPHHS-CFS-055, Kinship Care Agreement. If the social worker and family use a family group decision-making meeting, the written agreement developed may supplement the Kinship Care Agreement.

It is important that there be written understanding among the kinship care family, the child's parents (and the child when appropriate), the social worker and his or her supervisor as to

what will be done by each of the parties to protect and care for the child, resolve concerns, and reunite the family.

Placement Prior to Completion of Required Checks

Kinship Care Agreement

At the discretion of the Department and pending receipt of the results of a criminal, protective services or motor vehicle background check, the placing worker may enter into a written agreement with the kinship family in which the kinship parent(s) affirm that no one residing in the home has been convicted of a crime involving harm or threatened harm to a child and that no one residing in the home has a prior history of child abuse or neglect. This self-affirmation signed by the parties in the DPHHS-CFS-055, Kinship Care Agreement and the worker's documentation that the placement is in the best interest of the child will suffice for the worker's initial approval of the kinship home.

CPS/APS and motor vehicle checks

The placing social worker is responsible to ensure that CPS/APS and Montana motor vehicle checks are completed within 3 working days of the child's placement in the kinship home.

Criminal records checks

The kinship providers should be advised of the local fingerprinting process and informed that they have 3 days following placement to be fingerprinted and to return the completed fingerprint cards to the department. Failure to return the completed cards to the department within the 3 days may result in the child's removal from the kinship home.

- If all adults in the home have returned completed fingerprint cards to the department within 3 days of the placement, the placing social worker must ensure that a criminal records check via fingerprints is promptly requested.

- If all adults in the home have not returned completed fingerprint cars to the department within 3 days of the placement, the placing social worker must ensure that a name based criminal records check is requested prior to the end of the third day and a criminal records check via fingerprints requested promptly when the fingerprint cards are returned.

A name based criminal records check is obtained through the Department of Justice. The requesting worker must send the name, date of birth and social security number of the person for whom a check is being requested to:

Criminal Records
P.O. Box 201403
Helena, MT 59620-1403

The request must indicate that it is for CFSD and indicate to what address the results are to be sent.

References

Mont. Code Ann. § 41-3-101
Mont. Code Ann. § 52-2-102

Rev. 10/03
Rev. 04/04
Rev. 10/04
Rev. 10/05

Child and Family Services Policy Manual: Substitute Care for Children Placement in Kinship Care

DPHHS-CFS-055
(New 01/2002)
State of Montana
Department of Public Health and Human Services
Child and Family Services Division

KINSHIP CARE AGREEMENT

Agreement Between _____
(Agency)

and _____
(Kinship Provider(s))

Regarding the Placement of: _____
(Child(ren))

AGENCY RESPONSIBILITIES:

1. The social worker, in consultation with family members, has a responsibility for overall planning for the child(ren). The social worker has the responsibility to ensure that placement of the child is in the child's best interests.

2. The Department shall provide Medicaid eligible child(ren) with a Medicaid card as soon as possible following placement.

3. The Department will assure that payment is made for approved medical treatment of eligible children. Non-Medicaid services to be paid by the Department must be pre-approved by the Department except in emergency situations.

4. The Department, supervising agency and/or child's legal parent must give prior approval for any medical treatment or care.

5. The Social Worker will provide you with all relevant information about the child, including the expected length of placement.

6. Whenever possible, the social worker will provide advance notice to you before the child(ren) is/are removed from your care.

7. The social worker will recognize you as a member of the decision-making team and a vitally important component of the plan for the care of the child placed in your home.

8. If the Department receives a referral alleging abuse or neglect of a child placed in your home, the Department will investigate the allegation.

KINSHIP PROVIDERS' RESPONSIBILITIES:

1. I/We understand that the Department has the responsibility to reunite the child(ren) with the birth or legal family, and I/we agree to participate in the reunification process as requested by the Department.

2. I/We understand that I/we have no legal right to the child(ren) placed in my/our care without the

explicit consent of the Department. If the permanent placement of the child with a family other than the birth or legal parents becomes the plan for the child, we understand that the continued placement of the child in our home will be reassessed.

3. I/We will respect and support the child's connection with his/her birth or legal parents and significant others.

4. I/We agree to participate as members of the decision-making team and will be involved in the development of the case planning for the child(ren), including participation on the foster care or citizen review board committee.

5. I/We will be responsible for the care of the child(ren) placed in our home. I/We will share information with the Department concerning the child's progress at our home and at school.

6. I/We will be responsible for seeking emergency medical treatment and notifying the Department as soon as possible.

7. I/We will report to the placing worker within 48 hours (excluding weekends and holidays) any change of address, major sickness in the family or changes in family composition.

8. I/We will not take money for the care of the child except with the knowledge of the Department.

9. I/We will respect the child's cultural traditions and religious beliefs.

10. I/We agree to hold confidential any information pertaining to the child and the birth or legal parents.

11. I/We will comply with orientation/training requirements established by the Department.

12. If I/we cannot continue to keep the child(ren) or properly care for him/her/them, I/we will notify the placing agency so they will be able to make other plans for the child. I/We further agree to allow the placing agency adequate time (at least 72 hours/three work days) to arrange alternate placement of the child except in emergency situations or other situations where it is not in the child(ren)'s best interest to remain in our home.

13. I/We will cooperate with any investigation of abuse or neglect involving a child placed in our home.

14. I/We shall report any incidents of known or suspected child abuse or neglect to the Department of Public Health and Human Services at 1-866-820-KIDS (5437).

15. I/We understand that I/we must secure the permission of the Department before making plans for taking the child(ren) out of the county, state or country. Travel authorization is as follows:

---

16. I/We certify that:

No one residing in my/our household has been convicted of felony child abuse or neglect, child sexual abuse, partner-family member assault, any crime against children including child pornography, or for a crime involving violence, including rape, sexual assault or homicide.

No one residing in my/our household has ever been convicted of any crime involving serious harm to child(ren).

No one residing in my/our household has a felony conviction within the past 5 years for physical assault, battery or a drug related offense, including an alcohol related conviction. No one residing in my/our household has been the subject of a deferred prosecution involving any of the crimes listed above.

No one residing in my/our household has ever been investigated for alleged child or adult abuse or neglect.

Comments, if any: _____

_____

_____

- **The Department will be conducting a criminal records check including a motor vehicle check and a child and adult protective services check of your validity in these statements.**

- **If you have been convicted in the past, are currently charged with a crime, or have been investigated for child or adult abuse or neglect, do not sign this document before discussing the conviction, charges or investigation with the social worker.**

- **If you have not already done so, you are responsible for getting completed fingerprint cards to the department within 10 days of the date _____were placed with you. You have until_____ to return completed fingerprint cards to the department.**

  Failure to get completed fingerprint cards to the department on or before this date may result in the removal of _____ from your home.

THE SOCIAL WORKER AND KINSHIP FAMILY AGREE:

1. Contact between the Social Worker and the Kinship Family will be as follows:

_____

_____

_____

2. Visitation and contacts between the child(ren) and the birth or legal family will be as follows:

_____

_____

_____

3. Ongoing medical or psychological needs of the child(ren) will be met in the following manner (i.e. scheduling, transportation, information, etc):

4. The following support services may be necessary to ensure stability for the child's placement and are subject to management approval and funding availability:

Respite Plan: _____

Clothing Allowance: _____

Diaper Allowance: _____

Supplemental Services Allowance Plan: _____

Other: _____

At the discretion of the Department, the child(ren) may be moved upon receipt of a report of neglect or sexual or physical abuse in your home. The removal of the child(ren) does not mean the Department believes you are guilty. The removal of the child(ren) is a procedure used by the Department for the protection of the child(ren) until the validity of the report can be checked out.

I/We agree to report any problems regarding care of this child(ren)

to the Social Worker: _____
Name Phone

OR...

If unable to contact the Social Worker, I/we will contact his/her

Supervisor: _____
Name Phone

I/We have read, understand and agree to perform my/our outlined responsibilities and abide by the contents of this agreement.

Child and Family Services Policy Manual: Substitute Care for Children
Placement in Kinship Care

Social Worker (Signature)	Date	Kinship Provider (Signature)	Date
Supervisor (Signature)	Date	Kinship Provider (Signature)	Date

Original - Paper Case file
Copy - Kinship Parent(s)

Montana Strategic Suicide Prevention Plan

The Montana Department of Public Health and Human Services
January, 2001

REVISED May 2005

This project was supported by Grants #MCH-304002-01-0 & #1 H33 MC 00094 01 EMS for Children Program Administered by HRSA, MCH Bureau and MCH Health Block Grant #93.994

ACKNOWLEDGMENTS

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Critical Illness and Trauma Foundation, Inc.

The Montana Mental Health Association

Morton Silverman, MD, Consultant

Bryan Tanney, MD, PhD, Consultant

Strategic Health Concepts, Inc., Consultant

Participants from public and private agencies

SUICIDE PREVENTION IN MONTANA: AN ON-GOING PLAN

Introduction

Suicide persists as a major public health problem in Montana.[1] There are many individuals and organizations that are working to address this issue. These include: survivors, youth, law enforcement officers, tribal members, mental health professionals, health care providers, community volunteers, schools, not-for-profit agencies, spiritual leaders, clergy, state, local and federal government officials, and many others.

Wanting to die and feeling suicidal is a primary symptom of an untreated brain disorder, a medical condition for which treatment is available.

Brain disorders or mental illness are a physical illness, not a character flaw or weakness.[6]

The individuals and agencies that are currently addressing suicide often do so from their own unique perspective and to meet their own special needs, in part, not collaboratively. Until 2000, there had been no statewide, strategic effort to link these many assets and to build a stronger network of resources to address suicide as a major statewide public health priority.

In the spring of 2000, the Montana Department of Public Health and Human Services invited a group of private organizations, concerned citizens and government officials to begin the development of a statewide plan for suicide prevention. With consultation from international experts in suicide prevention, the Montana Suicide Prevention Steering Committee began works that lead to the development of this statewide strategic plan. This document is the result of the initial planning effort, and originally outlined a 5-year strategic direction and an action plan.

This plan was updated in the spring of 2005 by key stakeholders committed to reducing suicide in Montana. Accomplishments and ongoing challenges were delineated. Strategic directions for prevention, intervention, postvention and coordination among providers were expanded.

Update and Accomplishments to Date

Since the inception of the Montana Suicide Prevention Plan in 2001, Montana has made progress toward several goals pertaining to suicide prevention. Namely, progress has taken place in suicide prevention training, increased knowledge and awareness about the problem of suicide and mental illness, expansion of provider networks and systems of care, and state funding was provided to several communities for suicide prevention projects.

1. The Stakeholders have conducted suicide prevention and awareness training via several venues
    - Nationally recognized QPR (Question, Persuade, Refer) training program was used to train gatekeepers in a number of Montana cities and communities,
    - QPR training for law enforcement personnel in some areas of the State
    - Suicide Survivor Support Facilitators trainings – up to 15 people have trained to facilitate healing for suicide survivors

2. Progress toward improving public awareness of the issue of suicide and mental illness through the following partnerships:
    - The Montana Mental Health Association's Public Awareness Campaign, including training in the SOS protocol for Montana high schools.
    - The Montana Chapter of the American Foundation for Suicide Prevention's outreach program which includes:
        - Certified QPR Instructor Training,
        - QPR Gatekeeper Training and Community Outreach,
        - Community-based Suicide Prevention Groups,
        - AFSP Survivor Support Group Facilitator Training,
        - AFSP Survivors of Suicide Day Teleconference,
        - Community Mental Health Services Resource Banks,
        - AFSP 'Out of the Darkness' Community Walk
3. Montana has begun to address the lack of crisis response services across the state. Two community pilot programs and the recent legislature have formed an interim study group to look at this issue.
    - Several agency websites now prominently address the issue of suicide and link to the national Suicide Prevention Resource Center.
4. Increased capacity from the collaboration and formation of provider networks
    - A Crisis line for suicidal individuals, Voice of Hope based in Great Falls, has been accredited by the American Association of Suicidology and is now part of the National Suicide Prevention Lifeline (1-800-273-TALK)
    - Community coalitions addressing suicide have been formed in local communities across the state
    - A Native American Teen Suicide Prevention training curriculum has been implemented
    - Kids Management Authorities (KMA) has been established in each of the five children's Mental Health management regions. KMA's are charged to identify issues and solutions, and facilitate coordination of multiple agencies resources to improve mental health for kids.
    - Local Advisory Councils were created for oversight of adult mental health care.
5. In addition, there have been several grants obtained to help improve and/or understand the issue of suicide in Montana.
    - The Governor's Initiative provided funding for several local suicide prevention networks, including one tribal initiative and three local community prevention projects.
    - A Systems of Care Grant

- A grant to the Voices of Hope to provide training and library services to increase the competency of mental health and social service providers
- Fetal, Infant, Child Mortality Review Grant
- Early Childhood Comprehensive Systems Grant

Challenges

Though we have made progress since the initiation of the Suicide Prevention Plan, Montanans are still faced with many challenges. Montana's suicide rate remains among the highest in the Nation. Suicide is the second leading cause of death for adolescents and young adults in our state.[1] We have identified many areas where improvements can be made.

Suicide is the most preventable form of death in America. The vast majority of all suicidal people want to live, if only they can be shown the way.

Research shows the great majority of those who attempt suicide give some warning signs, verbal or behavioral, of their intent to kill themselves, often during the week preceding a suicide attempt.[4]

Lack of statewide coordination

- Systems collaboration between tribal entities, counties and state government, especially for adolescent and young adult populations are inadequate
- Coordination between community levels and state systems is inadequate. Local communities may not know about initiatives in other parts of the state or in state government. State government agencies are often not aware of prevention efforts related to suicide in other agencies
- Development of suicide prevention strategies often occurs without the involvement of youth in the planning process
- Screening for mental illness and suicide does not consistently occur in public schools, juvenile justice systems, or other child-serving agencies. Screening is inconsistent in the medical community

Montana demographics and geography

- Montana is a large frontier state with many isolated communities
- Ongoing stigma towards seeking mental health services and concerns of maintaining confidentiality in small communities inhibit individuals from seeking needed treatment[4]
- A large percentage of Montana's population lacks health coverage[11]
- Montana has a high availability of lethal means, especially firearms, that increase the lethality of impulsive suicidal behaviors[1]
- Montana has high rates of alcoholism and other drug addictions; including the current devastating epidemic of Methamphetamine use
- Montana has high rates of sexual and physical abuse as well as domestic violence affecting both children and adults

- The farm and ranch economic crisis and the difficulty in attracting industry to provide a stable employment market in Montana are ongoing stressors.

Lack of mental health providers and treatment facilities

- There is a shortage of inpatient mental health treatment facilities. The availability of this vital resource is diminishing with the closure of inpatient psychiatric beds
- There is a severe lack of appropriate comprehensive outpatient services
- There is insufficient integration of traditional and culturally specific interventions
- Montana has a severe shortage of psychiatrists, especially child and adolescent psychiatrists
- There is a lack of physicians capable of providing appropriate psychiatric medication treatments
- There is a lack of postvention services

Suicide – The Magnitude of the Problem

United States

Overall, suicide rates have remained fairly stable over the last 20 years. However, increases in the rates of suicide among certain age, gender, and ethnic groups have changed. Suicide rates among adolescents and youth in some areas of the nation have increased dramatically. At the other end of the age spectrum, suicide rates remain the highest among white males over the age of 65. Differences are also occurring in some racial groups with the rates of suicide among young African American males showing significant increases.

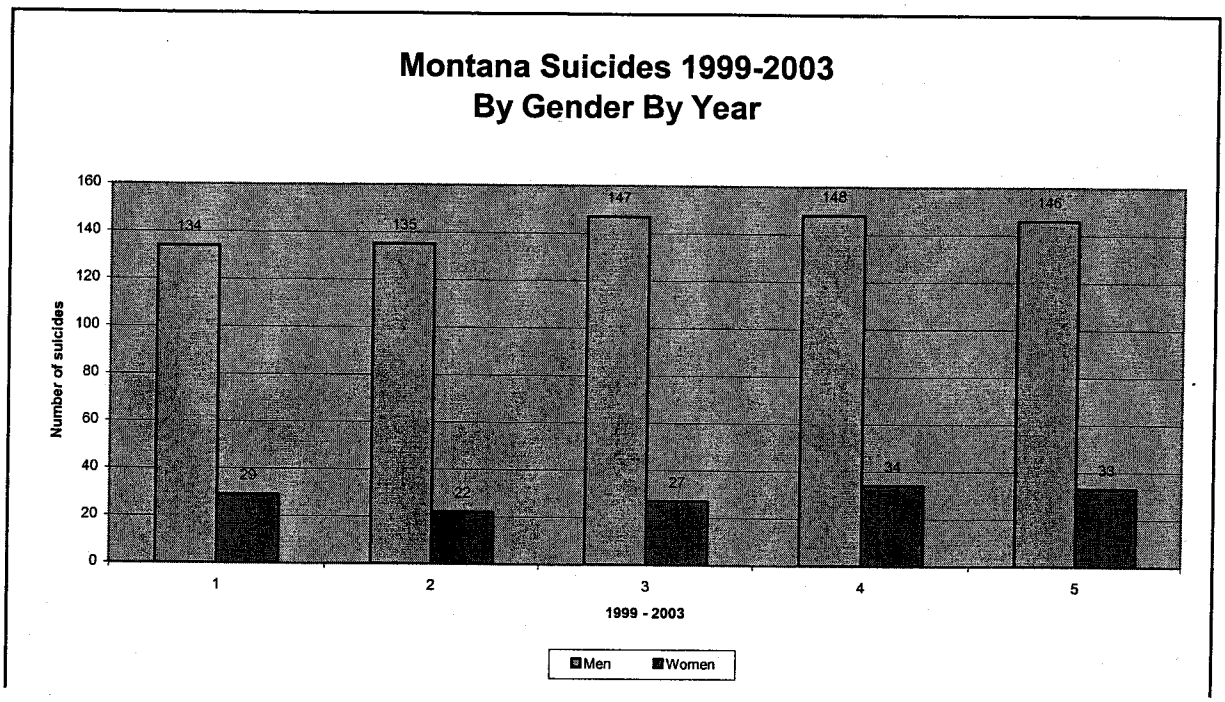
Suicide is a serious complex issue. In 1998, suicide was the 8th leading cause of death in the United States accounting for nearly 31,000 deaths. This number is 50% higher than the number of homicides during that same year. [2]

Approximately 500,000 people a year in the United States require emergency room treatment as a result of a suicide attempt.[3] Suicide has a devastating and, often lasting, impact on those that have lost a loved one as a result of suicide. While suicide rates in the U.S. place it near the mean for industrialized nations, the rates within the U.S. are highly variable by region and state.[4] The intermountain western states have the highest rates of suicide as a region and Montana ranks persistently at the top of the rate chart annually.[1]

Montana

Unfortunately, Montana has ranked among the top 5 states with the highest rates of suicide for the past 20 years, along with other mountain states. For a number of years, Montana has been number two on the yearly charts second only to Nevada. This is not a new trend. It dates back to the earliest recorded data concerning suicide in the U.S.[4] Suicide in Montana is a serious public health crisis. The following graphs illustrate the prevalence of suicide in Montana across gender, race and age from 1999 to 2003.[1]

Figure 1



Gender

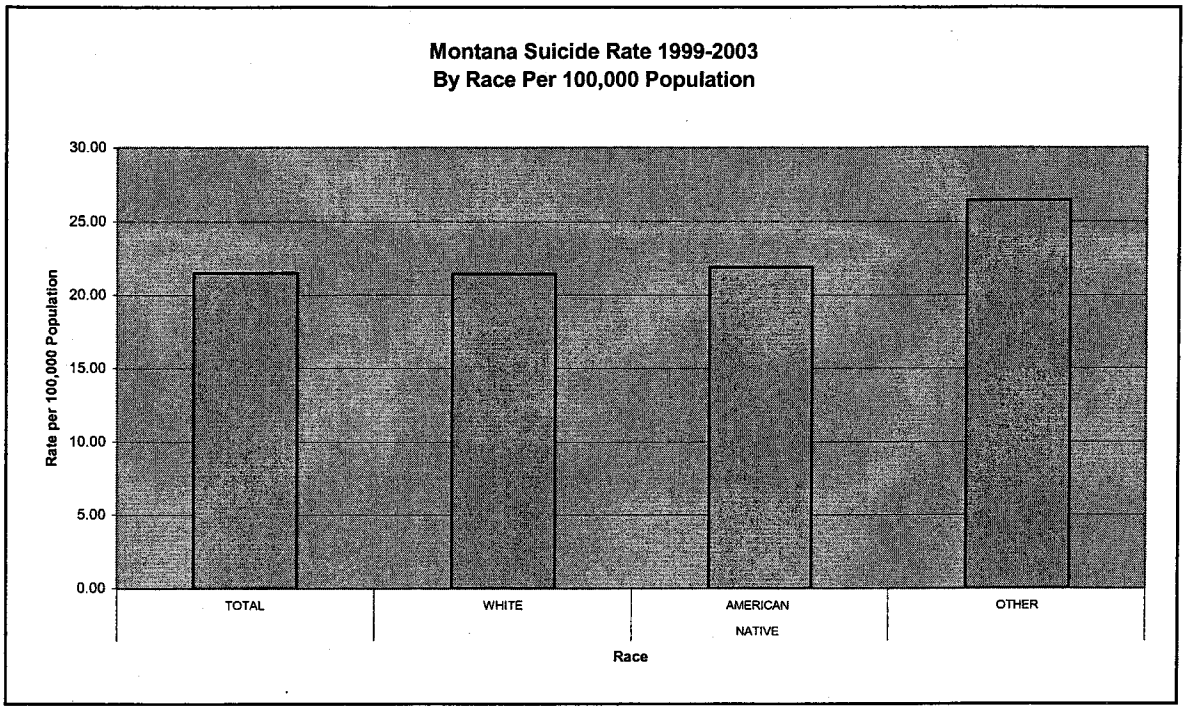
Montana is consistent with the rest of the U.S. in that suicide deaths vary by gender with males at greater risk than females. Montana females are five times more likely than males to attempt suicide. More females choose *reversible* means such as poison; more males choose *irreversible* means such as fire arms. Figure 1 documents the differences in risk of suicide by gender.

Race

Suicide in Montana also varies, to some degree, by race. The small population of American Indian[±] residents in Montana results in highly variable rates by year. A small increase in the actual numbers of deaths can have, what appears to be, a catastrophic impact on the rate for that year. Taking into account this rate variability due to small populations, the difference in rates between American Indians and Caucasians in Montana is minimal when considered over time. Both rates are much too high. Figure 2 documents the similarities in rates by race.[1]

[±] The term American Indian is used throughout this document with the greatest respect for the indigenous people of Montana. We acknowledge that some nations, bands, tribes, clans and individuals prefer other nomenclature including Native Americans, First Nations and indigenous people. The term American Indian was selected based upon the majority input received by Native representatives on the steering committee and is used exclusively throughout the document to provide continuity.

Figure 2



While Figure 2 does not break down the American Indian population into the various subdivisions of nations, tribes, bands and clans, for any given time period there is a high degree of variability among these classifications, just as there is similar variability among the Caucasian population when stratified by counties, cities and towns. What is clear from Figure 2 is that it is important to track the rates of suicide over time since any one year period may demonstrate marked deviation from the mean.

Specific cultural factors for Native American communities contribute to the suicide rates for this population. These include high unemployment rates, alienation and varying cultural views on suicide.

Age

Suicide rates in Montana vary widely by age. When all ages are combined, suicide is ranked the 9th leading cause of deaths for Montanans for more than two decades. However, when those rankings are examined by age group the risk of suicide varies considerably.

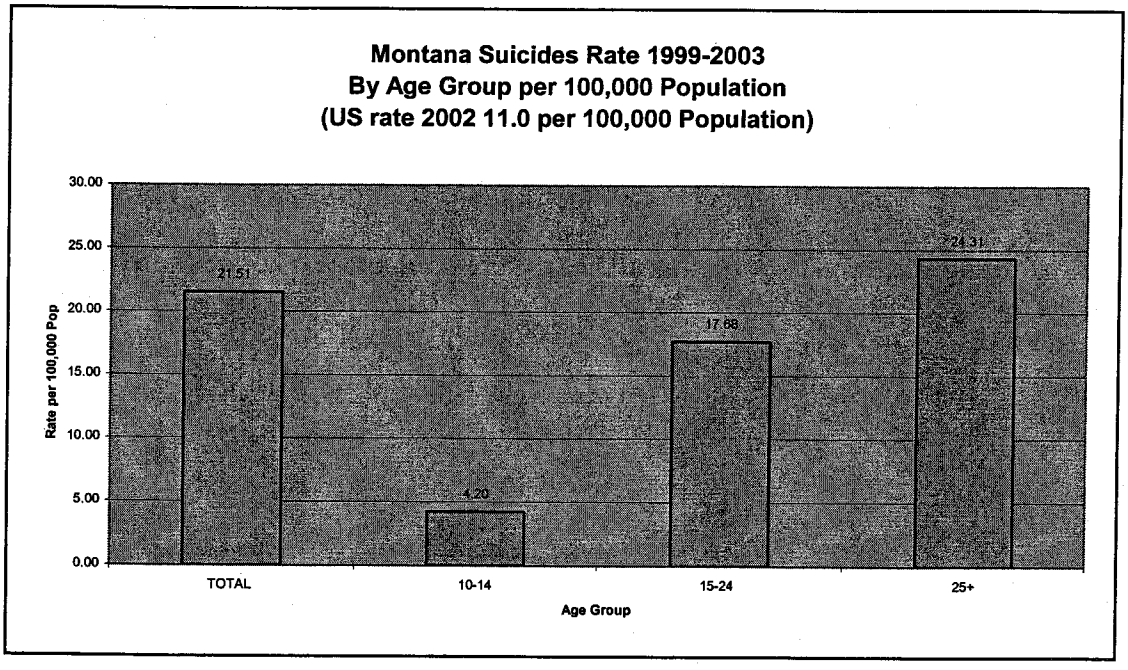
Montana's youth suicide rate is *higher* than the National youth suicide average.[1]

Death by suicide is significant cause of mortality among youth and young adults in Montana. It is the leading cause of preventable death for the ages 10 to 14 and the second leading cause of death for the ages 15 to 24 and 25 to 34.[1]

There are many aspects to the adolescent developmental stages that heighten suicide risk. One of the most significant is the importance of peer relationships and the need to "fit in" which can put pressure on adolescents to not disclose suicidal feelings. In addition, there is a "conspiracy of silence" among adolescents to not disclose to adults when a friend expresses suicidal ideation. Fragmented families, drug and alcohol use, sexual identity questions, bullying, and the negative influences of popular media also contribute to the increased risk of suicide in adolescents and young adults.

Other risk factors include a previous suicide attempt, mental disorders—particularly mood disorders such as depression and bipolar disorder; co-occurring mental and alcohol and substance abuse disorders; a family history of suicide; hopelessness; impulsive and/or aggressive tendencies; barriers to accessing mental health treatment; relational, social, work, or financial loss; easy access to lethal methods, especially guns; unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts; influence of significant people—family members, celebrities, peers who have died by suicide—both through direct personal contact or inappropriate media representations; cultural and religious beliefs—for instance, the belief that suicide is a noble resolution of a personal dilemma; and isolation, a feeling of being cut off from other people.[5]

Figure 3



Compared nationally, Montana's rate of suicide from 1999 – 2003 for 15 – 24 year olds was 17.68 per 100,000 while nationally is was to 10.01 per 100,000.

In Table 1 the magnitude of the threat from suicide for adolescents and young adults, as well as older Montanans becomes readily apparent. What is truly disturbing is that for Montana's children and teens suicide is among the leading causes of death.

Table 1

10 Leading Causes of Death, Montana 2002, All Races, Both Sexes

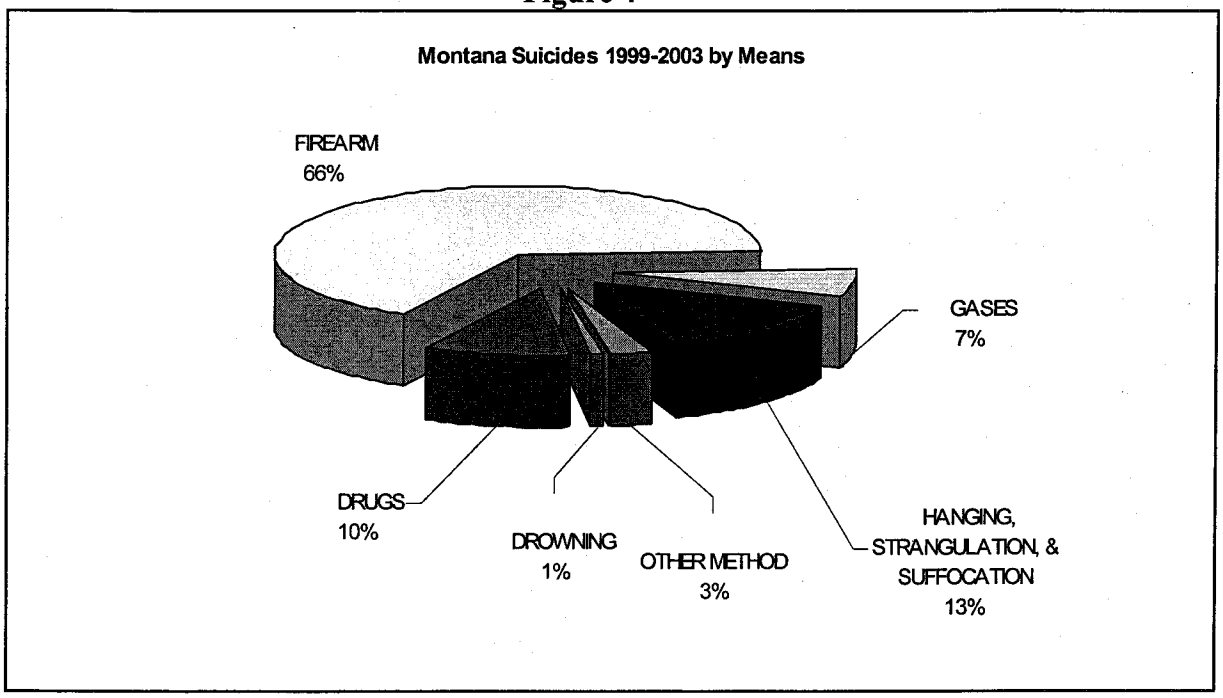
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury	Malignant Neoplasms	Malignant Neoplasms	Heart Disease	Heart Disease
2	SIDS	Congenital Anomalies	Malignant Neoplasms	Homicide	Suicide	Suicide	Malignant Neoplasms	Heart Disease	Heart Disease	Malignant Neoplasms	Malignant Neoplasms
3	Short Gestation	Heart Disease	Homicide	Congenital Anomalies	Malignant Neoplasms	Malignant Neoplasms	Suicide	Unintentional Injury	Chronic Low. Respiratory Disease	Cerebro-vascular	Cerebro-vascular
4	Maternal Pregnancy Comp.	Acute Bronchitis		Influenza & Pneumonia	Homicide	Liver Disease	Heart Disease	Liver Disease	Unintentional Injury	Chronic Low. Respiratory Disease	Chronic Low. Respiratory Disease
5	Placenta Cord Membranes	Homicide		Suicide	Heart Disease	Heart Disease	Liver Disease	Suicide	Cerebro-vascular	Alzheimer's Disease	Unintentional Injury
6	Circulatory System Disease	Malignant Neoplasms			Congenital Anomalies	Homicide	Diabetes Mellitus	Diabetes Mellitus	Liver Disease	Influenza & Pneumonia	Alzheimer's Disease
7	Birth Trauma	Septicemia			Diabetes Mellitus	Congenital Anomalies	Influenza & Pneumonia	Cerebro-vascular	Suicide	Unintentional Injury	Influenza & Pneumonia
8	Ten Tied					Diabetes Mellitus	HIV	Influenza & Pneumonia	Diabetes Mellitus	Diabetes Mellitus	Diabetes Mellitus
9	Ten Tied					Five Tied	Homicide	Chronic Low. Respiratory Disease	Influenza & Pneumonia	Nephritis	Suicide
10	Ten Tied					Five Tied	Septicemia	Septicemia	Septicemia	Pneumonitis	Liver Disease

Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC Data Source: National Center for Health Statistics (NCHS) Vital Statistics

Lethal Means

A number of means are used in the act of suicide in Montana. Of these, firearms and hanging are the most common. Other lethal means include: carbon monoxide, overdose, motor vehicle crashes, jumping from heights, etc. Figure 4 verifies the preponderance of firearms and hanging in Montana suicides.[1]

Figure 4



Opportunities for Prevention Activities

The variations in suicide rates by age groups and gender provide a wide array of opportunities for prevention and intervention activities. Prevention strategies can cover a wide variety of target groups (e.g., population at large, those who have ever thought of suicide as an option, those who have made previous attempts at suicide, and those in immediate crisis who are contemplating suicide as well as those who have experienced the death of a family member or close friend). Such activities can also range from a broad focus such as addressing risk and protective factors to a more narrow focus such as preventing imminent self-harm or death. Although the data on effectiveness of various programs and interventions is limited, certain strategies are beginning to emerge as more effective than others.[6] Clearly, a singularly focused intervention strategy such as a crisis line or gatekeeper training program will not have a lasting impact in isolation. Each program needs to be tightly integrated and interlinked with other strategies to reach the broadest possible range of persons at risk.

The following activities are recommended for the various demographic groups:

Youth – Ages 15 - 21

Although males are more at risk of dying from suicide, females make more attempts. Among the leading causes of hospital admission for women in this age group are poison-related suicide attempts.

Possible measures for this group include:

- Home visitation to high risk young families by Public Health personnel,
- Therapeutic Foster Care for high needs youth to provide a safe environment in which "wrap around" services could be provided,
- Inclusive, drug free, violence free, after school activity programs ran between 3pm – 8pm; offering a wide array of activities including the arts, volunteer opportunities and sports which will appeal to youths of varied backgrounds. These programs need to provide adult supervision by both qualified staff and volunteers and provide a forum for community resiliency and mentoring,
- School-based mentoring programs provided by older students and/or adults for at-risk youth as well as students transitioning to high school,
- Gate Keeper/QPR training for adults who work with youth to reduce stigma around suicide and raise awareness of risk factors and provide referral information,
- Although a recent review of firearm restriction laws by a group of CDC researchers rated them "insufficient evidence to determine effectiveness," Grossman and others from Harborview Center, Seattle have indicated lock boxes, gun locks and storing firearms and ammunition separately has some efficacy in terms of restricting lethal means. Restricting lethal means has reduced suicides in Australia markedly over the last 30 years. Advocating for safe gun storage and also gun removal away from the home in the case of unstable or depressed youth may result in reduced suicides,
- Reducing illegal drugs (methamphetamine, marijuana, etc.), alcohol and lethal prescription drugs would decrease the impact of this risk factor for suicide,
- Continue development of youth areas of our www.montanasuicide.org website based at CIT; youth are likely to go to websites before using a crisis telephone line,
- Enhance protective factors and provide coping skills for youth in all arenas of life, and
- There is a correlation between smoking and suicidal behavior in people of all ages. The Journal of Adolescent Medicine (2004) reported that teenagers who smoke had a rate of suicide attempts four times higher than teens who do not.

Older Adults – Ages 20 - 44

This group represents the biggest actual number of suicides in Montana; most suicides in this group are male and completed with use of a gun. Interventions for this group are especially difficult.

- There is evidence that having physicians receive gatekeeper training subsequently assessing all patients for depression and suicide risk factors and making appropriate and timely referrals for mental health services could have positive effects with this group,
- There is a correlation between smoking and suicidal behavior in people of all ages,
- Crisis lines - in survey data from Australia, fully 40% of callers felt the crisis line saved them. However, not many men use crisis lines. We need to continue improving our statewide crisis line options with campaigns to reduce "use stigma," and
- Development of lay provider crisis intervention teams, creating more hospital beds designated for mental health, and suicide stigma reduction campaigns would increase intervention possibilities for suicidal individuals.

Senior Caucasian Males, Over Age 55

This group has one of the highest rates of suicide within Montana demographics. Rural isolation, lack of access to mental health resources and access to lethal means are major risk factors with this age group.

- The development of lay provider calling trees set up among senior volunteer groups to reduce isolation establishing gatekeeper type interventions among this group would be beneficial in reducing suicide risk,
- The medical community serving this population could be trained in gatekeeper training and universally screen patients for depression, mental illness and or drug/alcohol abuse, and
- Senior suicide is related to severe illness and chronic pain. Improved pain management and increased resiliency among this group could reduce suicide.

Protective Factors

Some individuals and communities are more resistant to suicide than others. Little is known about these protective factors. However, they might include genetic and neurobiological makeup, attitudinal and behavioral characteristics, and environmental attributes. According to the Surgeon General's Call to Action to Prevent Suicide[6], protective factors include:

- Effective and appropriate clinical care for mental, physical and substance abuse disorders,
- Easy access to a variety of clinical interventions and support for help seeking,
- Restricted access to highly lethal methods of suicide,
- Family and community support,
- Support from ongoing medical and mental health care relationships,
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes, and

- Cultural and religious beliefs that discourage suicide and support self-preservation instincts, including American Indians practice of non-separation of culture, spirituality, and/or religion.

As with prevention and intervention activities, when programs to enhance protective factors are introduced, they must build on individual and community assets. They must also be culturally appropriate. As an example, protective factors enhancement in any one of Montana's American Indian communities must capitalize on the native customs and spiritual beliefs of that nation, tribe or band.

The Vision

We value human life. We encourage all people and organizations in Montana to deal openly, collaboratively and with sensitivity for all cultures to minimize suicide. We are working to create an environment where everyone will have access to qualified resources for help when they are in need.

The Mission

There will be a sustained reduction in the incidence, prevalence and rate of suicide and non-lethal suicidal behavior in Montana.

The Goals

To accomplish our mission and move towards the realization of our vision, there are several key goals which must be accomplished in Montana.

- To systematically pursue promising and best practices related to prevention, intervention, and postvention strategies to implement statewide,
- To dedicate sufficient personnel and fiscal resources to address the issue of suicide prevention activities in a structured and long-term manner,
- To increase public awareness and concern around the issue of suicide as a leading cause of death and significant public health problem in Montana,
- To strive to develop and implement replicable rural and frontier strategies,
- To work together in a collaborative, coordinated manner at the local, regional, tribal and state levels to best implement strategies and practices for suicide prevention, and
- To continually assess and evaluate progress towards our mission.

The Environment for Suicide Prevention in Montana

The State Strategic Suicide Prevention Steering Committee has identified factors that could impact the implementation of this plan. These factors include: assets that could have a positive and supportive impact on the implementation of the plan; barriers and challenges to carrying out the plan; and finally, near term opportunities that could be leveraged to aid in the successful implementation of the plan.

A social stigma is attached to suicide that promotes silence, apathy and disinterest in the issues.[4]

Attitudes

- To date there has been a lack of community awareness and acceptance of the problem.
- The debate continues in some groups about whether suicide is an individual or community problem. It is, for some, easier to tackle the "individual" problem (acute care or after the fact intervention) and more difficult to take on the "community problem" (primary prevention and encouraging protective factors).
- There is a lack of cultural awareness and sensitivity by suicide prevention staff and in prevention materials and programs.
- In many communities, there is insufficient expertise and capacity and often they must rely on expertise from outside of the local community to guide plans and activities. This lack of local capacity may result in the purchase of commercial products and programs that are without proven efficacy.
- The actual number of suicides within a given community is low; therefore, the problem is easy to ignore or dismiss.
- Sustaining interest in suicide prevention activities is difficult after a crisis situation or a completed suicide fades into the distant past.
- Changes in leadership often mean changes in public health agendas and priorities.

Montana's Unique Characteristics

- Much of Montana epitomizes geographical isolation, accentuated by the harsh winter climate.
- Since the arrival of the earliest white settlers, there has been an ingrained social culture that has accepted suicide as a part of life in Montana.
- Montana's rate of suicide has proven resistant to improvement from previous prevention efforts.
- There is a lack of availability and access to mental health services in many areas in the state, in part due to the state's remoteness.
- There is a prevalent and proud "western" culture and attitude among the Caucasian majority in Montana - 'we can take care of ourselves.'

Studies suggest there is a correlation between the rates of alcohol consumption and suicide.[7,8 & 9]

- Frequently, there is access to firearms that are not properly stored.
- There is a lack of transportation services for some people that inhibits their ability to seek or receive help.
- There is a lack of communication infrastructure (phones, cellular service, and Internet access) in some areas, including American Indian reservations, frontier and rural areas.

- Montana ranks high in alcohol and substance abuse when compared to other states in the U.S.

Strategic Directions

Due to the diversity of the State, the Steering Committee considers the most important direction to focus resources and attentions is promoting and working towards implementation of programs specific to communities and/or statewide.

Prevention

- Increase awareness of youth suicide prevention
- Develop community provider networks
- Conduct gatekeeper training
- Provide screening programs

Intervention

- Increase access to mental health and substance abuse services including smoking cessation programs
- Develop and implement clinical screening programs and standard screening tools with appropriate referral and follow-up
- Develop a statewide crisis response system

Postvention

- Reduce access to lethal means with affected circles of suicide survivors
- Improve services for survivors
- Provide support and resources to families of persons at high risk or who have attempted

Coordination

- Improve communication and community linkages with mental health and substance abuse service systems serving youth and young adults
- Designate a state lead
- Demonstrate collaboration

Assuring Support for the Plan

Key personnel, organizations and stakeholders were contacted for their review and comment throughout the process. The steering committee members were encouraged to have their organizations and constituents review and comment on the plan after it was posted on the web site (http://www.montanasuicide.org).

The Montana State Strategic Suicide Prevention Plan was presented to the Montana Public Health Association (MPHA) to keep them apprised of the ongoing efforts to reduce suicide in Montana.

After the final review and approval of the plan by the steering committee, the suicide prevention plan was reviewed and approved by the Montana Department of Public Health and Human Services.

Ongoing presentations of this Suicide Prevention Plan shall take place for mental health providers, advocacy agencies, and other individuals/agencies with concern about Montana's high suicide rates.

Progress Review and Plan Updates

As a way to assess and evaluate progress towards the goals, the Steering Committee will conduct a quarterly plan review and progress update on the plan. These reviews will include data from the various programs activities and practices suggested in the plan implementation strategy and exploration of funding opportunities.

Ongoing Activities

The reader is invited to visit http://www.montanasuicide.org to review ongoing activities, identify resources and explore links to prominent state and national organizations dedicated to addressing the many faces of suicide prevention.

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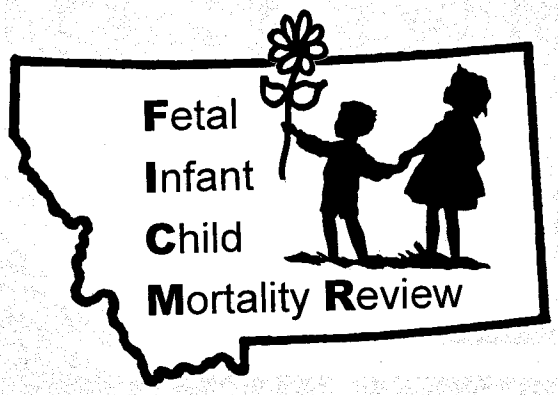
Summary of 2003-2004 Mortality Reviews

December 2006



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