

MONTANA CANRC

Montana Child Abuse and Neglect Review Commission Report

July 1, 2018 – June 30, 2020



Introduction

Dear Fellow Montanans:

Preventing child abuse and neglect requires vigilance by everyone — from friends, family and neighbors, to caregivers, teachers, and medical professionals. In 2015, Governor Steve Bullock launched the Protect Montana Kids (PMK) Commission to improve systems serving children and families in Montana. One of the PMK Commission's key recommendations was the creation of the Child Abuse and Neglect Review Commission (Commission).

The Commission was created during the 2017 legislative session with bipartisan support. To participate in a Commission meeting is to witness the heart of change. The room is full of committed and professional people who, throughout their daily activities, impact the safety and permanency of kids across the state.

Each meeting involves an in-depth, multi-generational analysis of the many factors that led to a traumatic, often fatal event for a child and family in Montana. The story of the family and their lives unfolds in the meeting room, revealing the complex set of circumstances that led to the abuse and neglect of the child. Neither the stories nor the solutions are simple. However, this process of analyzing each link allows the Commission's multidisciplinary team members to share their diverse perspectives in order to help find solutions for children, families, and systems across Montana.

As Co-Chairs, we believe there is great value in bringing together individuals from nearly every discipline involved with child abuse and neglect to examine, discuss, and compile specific recommendations for change, under the guiding principle of "no blame, no shame." We have found that some of the most powerful forces for recommending and enacting change are community members and professionals involved with each case who share their expertise and guidance at the Commission meetings.

The result of these efforts is our second Commission report* of data, findings, and recommendations. Though we are a Commission early in our duties, it is our mission to walk hand-in-hand with community stakeholders to recommend and lead meaningful changes across systems to keep kids safe.

Like all systems, our work has been impacted by the global pandemic. However, this report illustrates that the issues the Commission addresses continue, and it is the hope of our team that this report spurs change by encouraging conversations in communities about how we can all work together to prevent abuse and neglect in Montana. One of the most prevalent issues linked to child abuse and neglect is substance use disorder, which has been amplified throughout the pandemic as a result of additional stress and social isolation.

Because the kids of Montana are counting on all of us, our work continues.

Sincerely,

Katherine Curtis and Laura Weiss Smith
Child Abuse and Neglect Review Commission Co-Chairs

**The first Commission report covered May 2017 – June 2018, which is significantly shorter than the reporting period for this document. The 11-month difference in the two reporting periods should be considered when comparing data between the two reports.*

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SECTION 1

Section 1

Overview of Committee and Review Process

In 2017, as a result of the recommendations from Governor Steve Bullock's Protect Montana Kids Commission, the Montana Legislature passed House Bill 303 to enact MCA 41-3-123 establishing the Child Abuse and Neglect Review Commission (Commission). The purpose of each review by the Commission is to conduct a detailed and systematic examination into the events that led up to and followed a child fatality or near fatality. The Commission is charged with providing recommendations based on these extensive reviews.

The Commission is a team committed to sharing these responsibilities and recognizes that when families and communities collaborate, the opportunity for success increases. The Commission is comprised of professionals from across the state of Montana with expertise in various fields, including judicial and legal, child abuse and neglect, domestic violence, sexual assault, mental health, medical, tribal services, foster care systems, and survivors of childhood abuse and neglect. This team works in partnership with the Department of Public Health and Human Services and the Child and Family Services Division.



Mission Statement, Vision Statement, and Guiding Principles

Mission Statement

The Montana Child Abuse and Neglect Review Commission is a multidisciplinary, statewide team of experts who study child fatalities and near fatalities attributable to abuse and neglect.

The team works in a positive, collaborative, supportive, and culturally sensitive manner and makes recommendations for community and systemic change.

Vision Statement

Because we are committed to keeping children safe and families strong, the Commission will drive:

- **Community Change**
Montanans are educated and recognize child abuse and neglect and become part of the solution.
- **Systemic Change**
Child abuse and neglect interventions occur early, often, and successfully. Effective collaboration and education will increase positive outcomes for children, families, and communities in Montana.

Guiding Principles

- **Clear Objectives**
We commit to offering clear and focused recommendations to improve outcomes for children and families that are based on a thorough review. Team recommendations and actions are recorded in our biennial report.
- **Leadership**
We impact positive change for Montana children and families. We have a clear understanding of who we are as a Commission and how we lead our individual communities to move recommendations forward.
- **Teamwork**
We approach our work with the Commission in an engaged and empowered manner. Team members recognize their role and responsibility to participate.
- **Stability**
We value Child and Family Services Division (CFSD) staff to promote retention, mentorship, and longevity in their workforce.
- **Continuous Improvement**
We acknowledge members' expertise and use each individual's knowledge and experience to champion a system-wide approach to keeping children safe.

Commission Framework

In accordance with MCA 41-3-123, the Montana Department of Public Health and Human Services submits this second biennial report of child abuse and neglect fatalities and near fatalities to the Children, Families, Health and Human Services Interim Committee, the Law and Justice Interim Committee, the Governor, and the Chief Justice of the Montana Supreme Court, as well as all Montanans.

This report outlines the processes established by the Commission, provides insights into the demographics of the victims of abusive or neglectful deaths and near deaths, and offers policy and programmatic recommendations aimed at systemic improvement.

The Mission Statement, Vision Statements, and Guiding Principles provide the framework for the Commission. The Commission aims to advance community awareness and systemic growth, to create positive impact for children and families and the systems that support them, to improve safety, permanency and well-being outcomes for children, and to reduce child fatalities and near fatalities.

The Commission met on six separate occasions since it was established in 2017. First, the team laid a legal foundation for the Commission, consulted with the Department of Justice's existing fatality review team leaders, and began building the framework for the future.

During the inaugural meeting, the committee developed the following short-term and long-term outcomes:

Short-Term Outcomes

- Review two statewide cases involving a child fatality or near fatality per state fiscal year.
- Further develop and refine the process used by the team to review a case.
- Examine trends and patterns of child abuse and neglect.
- Extend the legislative mandate for the Commission.

Long-term Outcomes

- Report findings and recommendations in writing.
- Create sustainability for the Child Abuse and Neglect Review Commission and its positive community impact.
- Educate the public, service providers, and policy makers about child abuse and neglect through a well-developed and planned media and education campaign.
- Make recommendations that encourage collaboration, communication, and education to keep Montana children safe and families strong.

In the second meeting, the statewide team conducted its first child fatality review. In the third meeting, the team reviewed its first near child fatality, as well as analyzed trends and patterns to develop recommendations.

Information contained in this report pertains to the following three meeting instances during the July 2018 – June 2020 reporting period:

October 2018	Great Falls	Near Fatality Case Review
June 2019	Bozeman	Fatality Case Review
October 2019	Butte	Near Fatality Case Review

Review Process

Each year, the Commission reviews two cases where a child fatality or near fatality occurred as a result of abuse or neglect. The Commission operates under the philosophy of “no blame, no shame.” The goal of the review is to learn from these adverse events to create a proactive culture that values and protects the safety of Montana’s children.

The Commission uses the following types of information for the review:

- Public information
- Confidential case records (Child and Family Services, criminal, medical, mental health, etc.)
- Personal interviews of family members, friends, co-workers, clergy, school personnel, and other individuals related to the case who provide insight into the case review

Approximately two days are reserved to review a fatality or near fatality. On the first day, the Commission creates a timeline of the case, beginning at the birth of those involved and continuing through the events surrounding the fatality or near fatality. The following morning, the Commission invites local professionals involved in the case to provide further detail and insight regarding the timeline.

The reviews are held in or near the town where the incident occurred to draw from the knowledge of professionals and others who touched the case. By conducting the review in the community where the incident occurred, the Commission more thoroughly understands the specific dynamics and area resources.

Following the local review, the Commission generates a list of trends and recommendations identified over the course of the review. These insights are aggregated and evaluated over the biennium to create tangible, achievable recommendations for stakeholders to improve direct services and outcomes for youth and families.



SECTION 2

Section 2

Characteristics of Child Fatality and Near Fatality Cases

The first Commission report had a reporting period of May 2017 – June 2018, which is significantly shorter than the reporting period for this document. The 11-month difference in the two reporting periods should be taken into account when comparing data between the two reports.

Child Abuse and Neglect Reporting in Montana

During the reporting period, citizens called Centralized Intake (CI) 63,722 times; 41,477 of the calls contained information that required the report to be entered into the CFSD automated database. Of the 41,477 calls logged in the automated system, 21,027 required investigation by a member of the Child and Family Services (CFSD) field staff.

The remainder of the calls entered into the system were either requests for services referrals or information only, meaning reports that do not cross the legal threshold to warrant further assessment.

Centralized Intake (July 2018 – June 2020)

Total Calls Received	63,722
July 2018 to June 2019	31,020
July 2019 to June 2020	32,702
Total Reports Entered	41,477
July 2018 to June 2019	20,629
July 2019 to June 2020	20,848
Total Requiring Investigation	21,027
July 2018 to June 2019	10,538
July 2019 to June 2020	10,489

Of the 21 cases,



From July 1, 2018, to June 30, 2020, of the 21,027 reports that required investigation, 21 child fatality and near fatality cases were identified as the result of maltreatment by a caregiver in Montana. Of the 21 cases, 9 involved previous reports of child abuse or neglect pertinent to the child abuse or neglect that led to the fatality or near fatality.

Child Victim Demographics

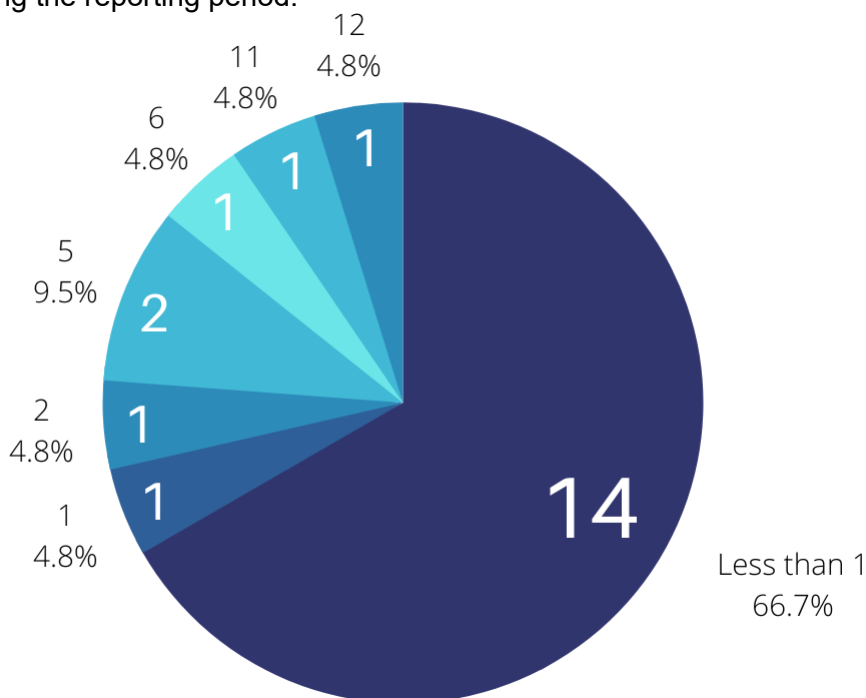
Age

According to the 2018 Administration for Children and Families (ACF) Child Maltreatment Report 2018¹, 70.6% of children who died from maltreatment were under the age of three. The ACF report does not include near fatal maltreatment, but one can see that this national data is reflected in both fatal and near fatal maltreatment in Montana.

During the 2018-2020 reporting period in Montana, children under the age of three comprised 76% (16 out of 21) of the maltreatment deaths and near deaths. Children under one year of age are the most vulnerable, and this age group comprised almost 67% (14 out of 21) of the fatalities and near fatalities.

This chart reflects the age of victims during the reporting period.

Age	Number of Children
Less than 1	14
1	1
2	1
5	2
6	1
11	1
12	1
Total	21

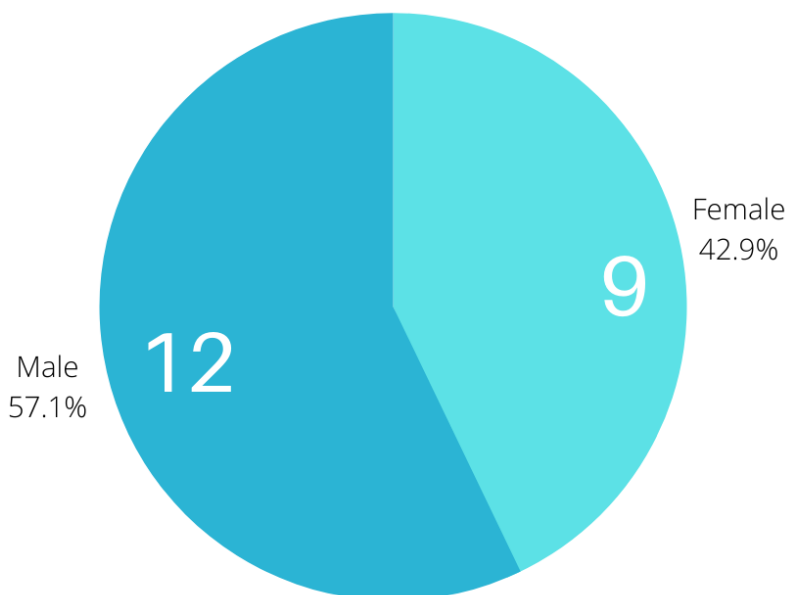


Gender

During the 2018-2020 reporting period in Montana, 12 male children and 9 female children suffered a fatality or near fatality attributable to abuse and neglect.

This chart reflects the gender of victims during the reporting period.

Gender	Number of Children
Female	9
Male	12
Total	21



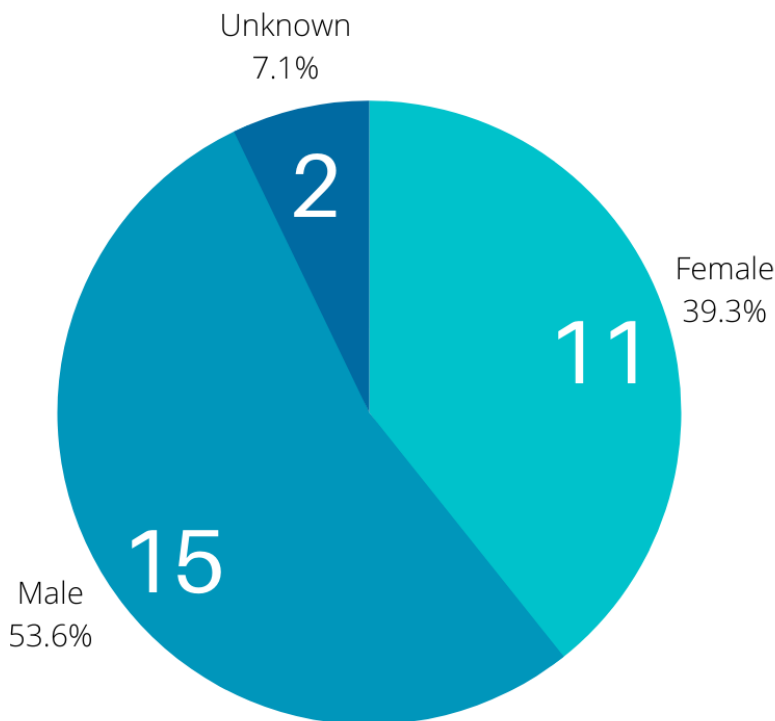
¹ U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2020). Child Maltreatment 2018. Available from <https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment>.

Perpetrator Demographics

The National Child Abuse and Neglect Data System (NCANDS) defines a perpetrator as a person who is determined to have caused or knowingly allowed the maltreatment of a child. The majority of perpetrators are caregivers of their victims.

Of the **21 cases** that are the subject of this report, there are **28 primary perpetrators**. This chart reflects the gender of all primary perpetrators during the reporting period.

Primary Perpetrators – all cases	
Gender	Number of Perpetrators
Female	11
Male	15
Unknown	2
Total	28

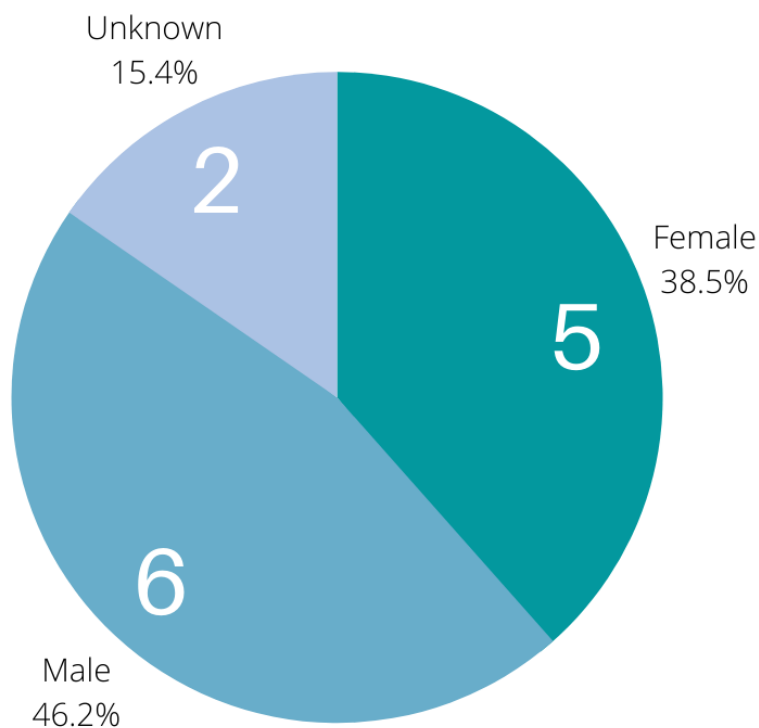


Perpetrators of Physical Abuse

There are **10 physical abuse cases** involving **13 primary perpetrators**:

This chart reflects the gender of all physical abuse perpetrators during the reporting period.

Primary Perpetrators – physical abuse cases	
Gender	Number of Perpetrators
Female	5
Male	6
Unknown	2
Total	13

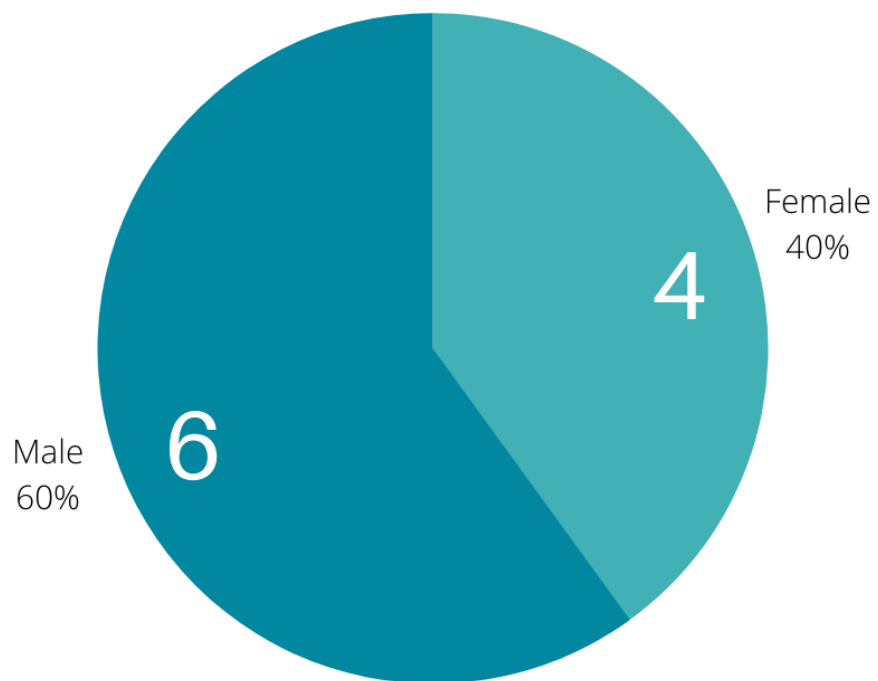


Perpetrators of Physical Neglect

There are **9 physical neglect cases** involving **10 primary perpetrators**:

This chart reflects the gender of all physical neglect perpetrators during the reporting period.

Primary Perpetrators – physical neglect cases	
Gender	Number of Perpetrators
Female	4
Male	6
Total	10

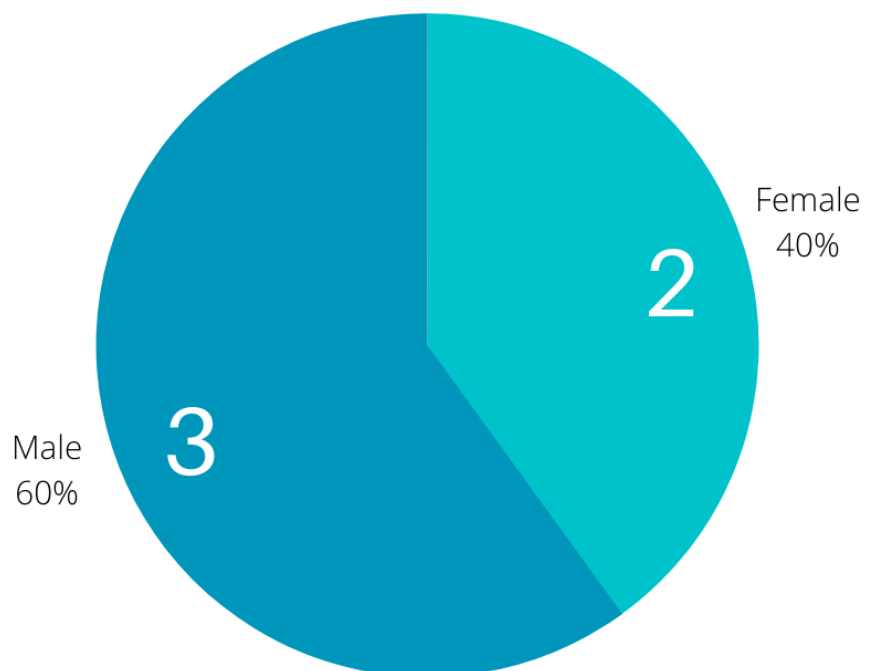


Perpetrators of Multiple Maltreatment Types

There are **2 cases involving both physical abuse and physical neglect** with **5 primary perpetrators**:

This chart reflects the gender of all perpetrators of both physical abuse and physical neglect during the reporting period.

Primary Perpetrators – multiple maltreatment types	
Gender	Number of Perpetrators
Female	2
Male	3
Total	5



Section 3

Recommendations

A number of key recommendations emerged from the examination of circumstances surrounding the cases the Commission reviewed. These recommendations serve as a basis to create and implement child abuse and neglect interventions in order to increase positive outcomes for children, families, and communities in Montana.

Multi-generational trauma, poverty, domestic violence, substance use disorders, and abuse and neglect were present and impacted the cases in this report.

The following recommendations are based on the results of the cases reviewed during this reporting period.

Support Care Coordination and Knowledge Sharing Among Stakeholders

- Strengthen community and statewide collaboration to encourage cross-sector service provision as a proactive approach to preventing child abuse and neglect
- Work in partnership with Tribes to strengthen communication, collaboration, and culturally informed services to children and families
- Utilize local and national experts to increase the knowledge base for all entities providing support and education to parents and children
- Focus on strengthening protective factors to promote overall child and family well-being
- Foster social norms that support parents and positive parenting, enhance parenting skills, and promote healthy child development

Increase Access to Medical and Behavioral Health Services for Children and Families

- Identify medical and behavioral health partners and ensure collaboration across programs and entities to provide resources, support, and accessible medical and behavioral health opportunities
- Establish multidisciplinary care coordination teams for at-risk newborns prior to their discharge from the hospital to ensure management and implementation of services to meet the needs of the infant and caregiver
- Examine barriers to receiving necessary medical and behavioral health, including substance use disorder, care and treatment and target efforts on how to outreach and support those families and children

Highlight Role and Significance of Child Abuse and Neglect Hotline 1-866-820-5437

- Develop and implement a strategy to educate the general public and mandatory reporters about the Hotline
- Ensure the Hotline number is widely known and available to those who interact with, support and/or provide care for youth
- Educate the public and service providers regarding the process of reporting suspected abuse and neglect and how using their voice can support Montana's children and families

Promote Awareness, Resources and Support for Safe Sleep Practice

- Reinforce the importance of practicing safe sleep practices for infants with parents and care providers, including having a safe sleep place, keeping soft items out of the sleep area and placing babies to sleep on their back

- Educate home-based service providers on safe sleep practices and how to support and ensure that care providers have a safe sleep environment
- Identify families who do not have a safe sleep space and create a plan as a community to ensure a safe sleep space is provided

Increase Access to Home Visiting Services

- Develop a strong community and statewide service array for home visiting resources
- Develop a partnership within all communities to ensure home visiting nurses are working with all infants in Department care
- Explore options to support and improve access to all home visiting services to best support children and families within their own home environments

Conclusion

The Commission recognizes and gives thanks to the many community members, caregivers, medical professionals, law enforcement, teachers, social workers, and providers who care deeply about keeping children safe and who are committed to leading grassroots community change. Each perspective adds value to the Commission's work, and the team will work to include representatives from every critical sector in the future.

The COVID-19 pandemic that hit Montana in March of 2020 has affected each one of our lives in myriad ways, including the ability to come together in person to carry out our individual and collective contributions to this work. We are grateful for the dedication and flexibility of those serving children and families across the state, despite the additional challenges and risks of working in the time of COVID. The impact will likely be felt for some time to come, but we will continue to work toward our goals and wrap around families hardest-hit by this unprecedented public health emergency.

The Commission's findings indicate, once again, that collaboration, effective communication, and active teamwork across entities that serve children and families are the core characteristics of meaningful, long-term health and safety of Montana kids.

- We must ensure that parents have access to behavioral health care, parenting resources, and community support.
- We must ensure that foster families who open their homes to kids in need have the resources and respite to serve children in times of crisis.
- We must promote social norms that prioritize parenting and give children and families tools to be as resilient as possible in order to thrive in spite of adversity.

The goal of this report is to carry forward and facilitate the implementation of the lessons of these fatalities to prevent them in the future to the greatest extent possible. We at the Commission continue to build and support our community partnerships as we all work to prevent child abuse and neglect in our communities. In Appendix C, you will find a summary of programs that align with many of the Commission's recommendations.

Thank you for taking the time to read this report and for your care and passion for the next generation of Montanans.

Appendix A

Statewide Team

Commission members during the July 2018 – June 2020 reporting period:

Name	Title	City
Georgia Cady	Program Director, Tumbleweed	Billings
Katherine Curtis	Retired Judge, 11 th Judicial District	Kalispell
Abigail Eyre	Therapist	Polson
Nichole Griffith	Executive Director, Victim-Witness Assistance Services	Great Falls
Mary Pat Hansen	Clinical Supervisor, First Step Resource Center	Missoula
Shonna Larkey	Licensed Foster Parent	Great Falls
Dan Mayland	Detective, Gallatin County Sheriff's Office	Bozeman
Eric Moore	Senator, Montana Legislature	Miles City
Sasha Neulinger	Survivor of Multi-Generational Child Sexual Abuse	Bozeman
Scott Pederson	Deputy Chief, Yellowstone County Attorney	Billings
Traci Shinabarger	Child & Family Ombudsman, Dept. of Justice	Helena
Laura Weiss Smith	Deputy Director, Dept. of Public Health & Human Services	Helena
Arlene Templer	Tribal Member, Confederated Salish & Kootenai Tribes	Ronan
Jenn Wihlborg	Service Director, AWARE Mental Health Residential	Missoula

APPENDIX B

Appendix B

Individual Cases

This Appendix contains a description of the fatality and near fatality cases compiled by the Department of Health and Human Services Child and Family Services Division.

The information is included in this report to satisfy federal reporting requirements, and to provide readers with an overview of fatalities and near fatalities attributable to abuse and neglect during the reporting period of **July 1, 2018 to June 30, 2020**.

The case descriptions have been edited for brevity and confidentiality.

Fatalities and Near Fatalities

2018 Fatalities

Age and Gender	2-year-old female
Fatality or Near Fatality	Fatality
Cause and Circumstance	Severe head trauma
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable

Age and Gender	8-month-old female
Fatality or Near Fatality	Fatality
Cause and Circumstance	Concerns regarding sleep conditions, bottle propping
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable

Age and Gender	1-month-old male
Fatality or Near Fatality	Fatality
Cause and Circumstance	Concerns regarding sleep conditions
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There was an open investigation at the time of the fatality regarding concerns of domestic violence.
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	CFSD staff had initiated an investigation.

2018 Near Fatalities

Age and Gender	3-month-old male
Fatality or Near Fatality	Near Fatality
Cause and Circumstance	Severe head trauma
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable

Age and Gender	2-month-old female
Fatality or Near Fatality	Near Fatality
Cause and Circumstance	Multiple injuries from physical abuse
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable

2019 Fatalities

Age and Gender	6-month-old male
Fatality or Near Fatality	Fatality
Cause and Circumstance	Autopsy states cause of death is inconclusive; child was found not breathing at daycare
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable

Age and Gender	18-month-old female
Fatality or Near Fatality	Fatality
Cause and Circumstance	Unsafe sleep, parental drug use and chronic neglect
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable

Age and Gender	3-month-old female
Fatality or Near Fatality	Fatality
Cause and Circumstance	Multiple injuries from physical abuse
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None

Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable
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Age and Gender	11-year-old male
Fatality or Near Fatality	Fatality
Cause and Circumstance	Firearm fatality and parental drug use
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There had been previous investigations regarding parental drug use.
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable

Age and Gender	7-month-old male
Fatality or Near Fatality	Fatality
Cause and Circumstance	Unsafe sleep and parental drug use
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There was a previous investigation regarding physical abuse.
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Department had an in-home safety plan and a court ordered treatment plan.

Age and Gender	11-month-old female
Fatality or Near Fatality	Fatality
Cause and Circumstance	Drowning and parental drug use
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There were previous reports regarding concerns of domestic violence and parental drug use.
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Department had an in-home safety plan and in-home visiting providers were involved.

Age and Gender	5-month-old female
Fatality or Near Fatality	Fatality
Cause and Circumstance	Unsafe sleep and parental drug use
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There were previous reports regarding parental drug use.
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There was an open investigation at the time of the fatality regarding parental drug use.

Age and Gender	5-year-old male
Fatality or Near Fatality	Fatality
Cause and Circumstance	Multiple injuries due to physical abuse, including head trauma

Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There were previous reports with concerns of physical abuse.
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable

Age and Gender	5-year-old male
Fatality or Near Fatality	Fatality
Cause and Circumstance	Multiple injuries sustained from a motor vehicle accident due to lack of restraint, and parental substance use
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There were previous reports regarding parental substance use.
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There was an open case at the time of the fatality regarding parental substance use.

2019 Near Fatalities

Age and Gender	6-month-old male
Fatality or Near Fatality	Near Fatality
Cause and Circumstance	Shaken Baby Syndrome
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable

Age and Gender	4-month-old male
Fatality or Near Fatality	Near Fatality
Cause and Circumstance	Severe head trauma
Previous Reports Pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Previous investigation concerning parental drug use.
Department Services Provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There was a voluntary protective service agreement and in-home safety plan in place.

Age and Gender	9-month-old male
Fatality or Near Fatality	Near Fatality
Cause and Circumstance	Severe head trauma
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable

Age and Gender	6-year-old female
Fatality or Near Fatality	Near Fatality
Cause and Circumstance	Multiple injuries sustained from a motor vehicle accident due to lack of restraint, and parental substance use
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There were previous reports regarding parental substance use.
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	There was an open case at the time of the fatality regarding parental substance use.

2020 Fatalities

Age and Gender	2-month-old female
Fatality or Near Fatality	Fatality
Cause and Circumstance	Multiple physical injuries and starvation
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable

Age and Gender	12-year-old male
Fatality or Near Fatality	Fatality
Cause and Circumstance	Multiple injuries due to physical abuse and neglect
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable

2020 Near Fatalities

Age and Gender	1-month-old male
Fatality or Near Fatality	Near Fatality
Cause and Circumstance	Severe head trauma and parental drug use
Previous reports pertinent to Abuse or Neglect that led to Fatality or Near Fatality	None
Department services provided on behalf of the child that are pertinent to Abuse or Neglect that led to Fatality or Near Fatality	Not applicable

Summary of Programs that Align with Commission Recommendations

Numerous statewide, regional, and local programs support the Commission recommendations. This list is not all-inclusive, but does highlight some new and ongoing DPHHS programs, involving a variety of partners, that align with the recommendations in Section III.

CORE Trainings

The Collaborative Resources (CORE) Training teaches community partners about the safety model that Child and Family Services uses to ensure children are safe. This training breaks down the different components of the safety model to teach partners about how decisions about child safety are made.

Child welfare is complex, and the only way we will move forward in addressing the needs of the families, and children in Montana is to work together. We all play a role in making sure children are given the opportunity they need to grow and develop in a safe, healthy family and community. We envision a system where all community partners are working together collaboratively for a common purpose with shared responsibilities to keep children safe and families strong.

To further achieve this goal, these trainings have created the opportunity to hear from our community stakeholders regarding strengths and areas for growth in each community. We conducted listening sessions following the trainings to offer an opportunity for questions and feedback to help improve the child welfare system. CORE Trainings were conducted across the state starting in the spring of 2019 and continue to be offered in individual communities. To date CFSD has conducted over 12 trainings statewide.

First Years Initiative

The First Years Initiative is specifically aimed at preventing child abuse, neglect, and fatalities of children zero to three, recognizing the increased rate of vulnerability and instances of abuse and neglect in this age range. This partnership among public health departments, nonprofit organizations, and CFSD provides targeted resources, education, and services during the early critical period in the lives of children and their parents—pregnancy, the weeks and months after birth, and extending through the first years of a child's life.

Three major parts of the initiative are in full swing:

1. Home visitors solely committed to families in need who are known to CFSD,
2. Extensive planning and collaboration to roll out a safe sleep campaign, and
3. A private-public partnership with the Montana Healthcare Foundation for the Perinatal Behavioral Health Initiative in sites across Montana to serve women with wraparound health and behavioral health services during the critical prenatal window.

Safe Sleep

Unsafe sleep in children under the age of one has consistently been a top cause of child fatalities in Montana since at least 2017. Recognizing the vulnerability of young children, DPHHS launched the First Years Initiative in 2018, with a focus on providing targeted resources, education and support for young children and their families.

Since its inception, the initiative has distributed more than 1,500 cribs for safe sleeping across Montana with Healthy Mothers Healthy Babies (HMHB) and launched a targeted home visiting program for at risk families. We continue this collaborative, innovative work in 2020 with the HMHB media campaign to promote safe sleep for all Montana babies.

Perinatal Health

This initiative is a new public-private partnership with the Montana Healthcare Foundation that focuses on prenatal and postpartum care for women with substance use disorders. This partnership will increase timely access to care and improve outcomes for pregnant and postpartum women experiencing behavioral health challenges, such as mental health disorders and substance use disorder. Participating practices will use screening, brief intervention, and referral to treatment as core elements of their practice model.

Perinatal Behavioral Health Initiative will establish integrated care teams that will screen and assess, provide effective outpatient interventions, coordinate services such as transportation and housing to address social factors, and establish referral networks for women who need more care.

The Meadowlark Initiative

The Meadowlark Initiative brings together clinical and community teams to provide the right care at the right time for patients and their families; improve maternal outcomes, reduce newborn drug exposure, neonatal abstinence syndrome, and perinatal complications; and keep families together and children out of foster care.

Based on research and examples from other states, implementing a supportive, team-based approach to prenatal and postpartum care along with better coordination between health care providers and social service agencies offers a powerful way to improve these outcomes.

The Meadowlark Initiative provides funding and technical assistance to allow medical practices that provide prenatal and postpartum care to implement a coordinated, team-based approach that improves outcomes for women with SUDs and mental illness. The initiative will support at least one prenatal practice in each Montana community that has a hospital that delivers babies. The Meadowlark Initiative is funded and supported through a partnership between the Montana Healthcare Foundation and the Montana Department of Public Health and Human Services.

The Meadowlark Initiative brings a new standard of pregnancy care to Montana by offering routine screening and treatment for substance use disorders and mental illness as a part of prenatal and postpartum care. The initiative supports recovery while keeping families together and children out of foster care. In partnership with the State of Montana, we developed the initiative to respond to the high rates of foster care placement reported by the Child and Family Services Division and the research which showed a lack of treatment available for pregnant women with substance use disorders.

<https://mthcf.org/the-meadowlark-initiative/>

Home Visiting

DPHHS works with established home visiting sites in public health departments and nonprofit organizations to hire additional home visitors to work alongside child protection workers located in 13 communities across the state. These additional home visitors are exclusively dedicated to CFSD cases and are housed within the current infrastructure of the statewide, federally funded home visiting program.

Each home visitor carries a caseload of 18-25 families who are referred to home visiting by the local CPS offices. They provide families with targeted resources, education, and services during the early critical period in the lives of children and their parents—from pregnancy through the first years of a child’s life.

MAPP-NET

The State of Montana received a federal HRSA grant in September 2018 to expand access to pediatric psychiatry. The Montana Access to Pediatric Psychiatry Network (MAPP-Net) grant strives to support primary care providers and behavioral health specialists in serving children and youth in their communities with mental healthcare needs through education and consultation. Two activities will help us meet this goal: Project ECHO and the toll-free Access Line.

Project ECHO

Project ECHO is a hub-and-spoke model out of the University of New Mexico. Billings Clinic is the contracted “hub” for this program and began Project ECHO Pediatric Mental Health sessions in March 2019. An expert hub team consisting of a Child and Adolescent Psychiatrist, Psychiatric Pharmacist, Psychotherapist and Resource Specialist meet twice per month with primary care providers across the state utilizing the online platform Zoom. A member of the hub team delivers a 25-minute didactic. Then, participants can present de-identified cases to review.

The hub panel and spoke sites offer feedback and suggestions on the presented cases. This collaboration among peers helps to support the presenter’s care for their pediatric patients with mental health care needs and provides an opportunity for increased knowledge for everyone listening. ECHO clinics are grant-funded and there is no cost participate.

Access Line

1-844-922-MAPP (1-844-922-6277)

A toll-free access line was established in 2019 for primary care providers to call and consult with a Child and Adolescent Psychiatrist during daytime business hours. Consultations are with Billings Clinic Child and Adolescent Psychiatrists. This is a provider-to-provider call, and patients do not participate. There is no cost for primary care providers to participate in this service.

PAX Good Behavior Game

In May 2019, Montana received \$2.1 million in federal grant dollars to support the PAX Good Behavior Game in schools across the state.

The PAX Good Behavior Game, designed for K-5 classrooms, provides teachers with research-based strategies focused on creating a classroom climate that facilitates productivity, teamwork, and encourages development of resiliency that will continue over the course of a student’s lifetime.

Through HB 118 funding from the 2017 Legislature and various other funding sources, hundreds of teachers and thousands of students in 47 Montana schools have already been trained on the Good Behavior Game over the past several years.

Funds are being used for training school personnel delivered by the PAXIS Institute, the organization that developed the program. PAXIS will also offer community strategic planning and development training to educate communities about the program and assist with sustainability plans. School personnel will receive in-

person training as well as additional resources including stipends for classroom supplies and ongoing personal support, mentoring, and coaching. Grant funding will also pay for continued program evaluation performed by the University of Montana.

The Center for Children, Families, and Workforce Development (Center) at the University of Montana is evaluating schools already using the program with suicide prevention funding allocated during the 2017 legislative session. The Center will continue follow-up research to determine effectiveness of the program as more schools are funded. Part of the evaluation plan is collecting student behavioral data as well as pre-and post-test surveys where teachers measure behavioral, skill, and attitude gains from the beginning of the school year to the end.

Child Abuse and Neglect Hotline Media Campaign

Montana saw a decrease in calls to the Abuse and Neglect Hotline in March with the onset of the Covid-19 emergency. Calls dropped from an average of 765 a week to just 425 the week of March 15. As of June 2020, calls were steadily increasing due in part to a rigorous public awareness campaign about reporting abuse and neglect.

Montanans should know that simply making a call to the Hotline will not immediately result in the removal of a child from his or her home. Child welfare workers investigate each case and talk to multiple individuals to understand the safety concerns and threats to a child.

Many systems are involved in keeping kids safe and removals, if necessary, including social workers, judges, and attorneys. Your call to the Hotline, however, could literally save a life in cases where abuse and neglect are found.

ParentingMontana.org

In January 2019, Governor Bullock launched a new comprehensive set of resources to better equip anyone in a parenting role, youth, prevention specialists, counselors, and others with easy-to-use tools to support the success of Montana's children from kindergarten through the teen years.

When both youth and parents have strong social and emotional skills, better academic and workplace outcomes can be achieved. Parents can develop the social and emotional skills of their children at any age while addressing common parenting challenges like establishing routines and making sure homework is completed.

The website features practical tools for parents who want to know more about issues such as anger, bullying, chores, confidence, conflict, discipline, friends, homework, listening, lying, peer pressure, reading, routines and stress, and underage drinking. The tools use a socially- and emotionally-informed process that is developmentally appropriate. The website is organized by age-appropriate topics for age five all the way up to 19-year-olds.

The Media section can be used to help share these resources with others, including video, radio, and print materials. These can be shared on social media, in newsletters, or through traditional channels such as television, radio, and direct mail. All the tools and information on the website can be easily viewed, downloaded, or shared electronically. The website also has a link of how Montanans can connect with a Prevention Coordinator in their area.

The Center for Health and Safety Culture will continue to develop additional tools and resources over the next several years.

Support and funding for the website comes from Montana Department of Public Health and Human Services (Addictive and Mental Disorders Division, Early Childhood and Family Support Division and Children's Trust Fund) and Montana State University's Center for Health and Safety Culture.

Montana Children's Trust Fund

The Legislature created the Children's Trust Fund in 1985 to serve as the lead agency in reducing and ultimately ending maltreatment of Montana children. The trust fund provides financial support to local programs across the state to prevent child abuse and neglect and strengthen families.

The trust fund is administratively attached to the Department of Public Health and Human Services and is administered by a seven-member volunteer board appointed by the Governor. Board members represent the geographic and cultural diversity of the state. Each member serves a three-year term and represents a profession involved in preventing child abuse and neglect.

Top priorities for Montana Children's Trust Fund are:

- Funding effective, primary prevention programs in local communities throughout Montana and enhancing communities' capacity to prevent child abuse and neglect by allocating CTF funds annually for primary and secondary child abuse and neglect prevention programs to community-based organizations;
- Supporting public education (such as conferences, workshops, and seminars) that increase participants' knowledge and understanding of child abuse and neglect prevention, and strengthening families and communities; and
- Increasing positive parenting skills that ensure the health, safety and well-being of children.
- The Montana Children's Trust Fund's priorities are fulfilled by increasing the number of parents and caregivers who are educated in healthy, positive, and protective child-raising skills. When families are supported, children are less likely to be at risk for child maltreatment and more likely to grow up happier and healthier.

