Montana Department of Justice
Office of the Child and Family Ombudsman

Contact the Ombudsman:

1-844-25CHILD

1-844-252-4453

DOJOMBUDSMAN@mt.gov

10th Anniversary Edition

Contents

Letter from the Ombudsman

Dear friends and community partners,

I am honored to present the Office of Child and Family Ombudsman (OCFO) Tenth Anniversary Annual Report. The Montana legislature created OCFO to provide a unique service to the citizens of Montana. OCFO is an impartial, neutral, and free resource for children, families and professionals involved with the child protection system. The office was developed in 2013 and opened to the public in March 2014. I am pleased to share some of the successes of our office.

As the office grew and took on additional responsibilities, we have maintained our duty to the citizens of Montana. This annual report includes aggregate data and stories about OCFO's impact over the past 10 years.

I would like to extend a sincere thank you to the Ombudsman who have come before:

Traci Shinabarger (2013 – 2020)

Gala Goodwin (2016 – 2022)

Marci Buckles (2020 – 2023)

They have worked to maintain the office with a high level of professionalism and integrity.

I also extend a thanks to Attorney General Austin Knudsen, Division of Criminal Investigation Administrator Bryan Lockerby, and Department of Justice staff for their unwavering support and commitment to improving Montana's child protection and child welfare systems to build a better future for us all. It is important to acknowledge Special Services Bureau Chief, Dana Toole, for her leadership throughout the ten years. She has continued to guide the office towards efficiency and value. Dana continues to be a champion for Montana's children and families in child welfare.

OCFO's success is due in part to the partnerships within state government and the general public. As we reflect upon the past ten years, we also look forward to work ahead.

Sincerely,

Kaci Gaub-Bruno

Kaci L. Gaub-Bruno, M.A.

Mission

The Office of the Child and Family Ombudsman responds to citizen requests to protect the rights of children and families by improving case outcomes and strengthening Montana's child welfare system.

To support its mission, OCFO follows four principles consistent with the standards of the United States Ombudsman Association (USOA).

Principles

1. OCFO is independent of the Montana Department of Public Health and Human Services (DPHHS), meaning it is separate and free from influence of the individuals whose actions OCFO reviews. It is part of the Montana Department of Justice's Division of Criminal Investigation and managed by the Special Services Bureau (SSB).

2. OCFO is impartial. OCFO treats citizens equitably and works collaboratively with all parties to improve services for the children of Montana. It may advocate certain recommendations, which benefit the individual who requested assistance; however, advocacy is always directed at improving services offered by DPHHS and should not be construed as supporting one individual over another.

3. OCFO is confidential. It adheres to Montana law.

4. OCFO provides a credible review process to each citizen contacting the Ombudsmen. OCFO keeps each requestor apprised of each step of the process and takes actions that improve transparency of the child welfare system.

To request assistance, contact our office in one of the following ways:

Telephone: 1-844-25CHILD (1-844-252-4453)

Fax: 406-444-2759

Email: DOJOMBUDSMAN@mt.gov

Highlights 2013 – 2023:

- OCFO was accessible and responsive to citizens with a total of 2,664 contacts.
- OCFO has assisted 1,009 families involved in the child welfare system.
- OCFO submitted 91 *Findings Reports* and one Out of Home Placement Briefing to the Director of DPHHS.
- OCFO has submitted three systemic reports to the Attorney General and Legislature.

Case studies from the past 10 years:

The following stories illustrate a small portion of the impact OCFO has had on the child welfare landscape in Montana. All identifying information has been omitted for confidentiality purposes.

A child is returned to the care of his parent:

A mother named Julie submitted a request to OCFO to review her case as she felt that she completed all the requirements to have her child returned to her care. Her child, Aaron, had been out of the home for 16 months. Julie had been living at a sober living facility and had recently moved out of the facility to a two-bedroom apartment. She had maintained her sobriety for the last 14 months. Julie was also under the supervision of a probation officer who gave CPS glowing reports. Julie had maintained a part time job for the last seven months and she regularly had Aaron unsupervised over the weekends with no issue or concerns voiced by her CPS worker. Julie wanted Aaron to live with her. Julie wanted to prove to her team, her son and herself that she could be a good parent.

OCFO completed an initial review of the case and found a court document for a guardianship placement for Aaron with a non-relative. The court document was dated with the court nearly a month before OCFO was contacted. The Child and Family Service Division (CFSD) plan was to give guardianship of Aaron to his current foster parent, Regina. CPS stated in the guardianship affidavit that Julie couldn't provide a supplemental diet drink to Aaron that had been "prescribed" by his pediatrician. Julie informed OCFO that a family meeting was upcoming and that she wanted the Ombudsman to attend. Prior to the meeting, the Ombudsman emailed the Regional Administrator regarding requirements for the child to go home, current active safety threats and to obtain the doctor's written order for the supplemental diet drink.

At the family meeting, Julie, Regina, the Ombudsman, the facilitator, and the CPS met and discussed how the case had been and how Aaron had been doing. The guardianship court hearing was less than a month away and Julie shared with the group all the tasks she had completed towards having Aaron with her. Regina expressed her concern that having Aaron back may overwhelm Julie and cause her to relapse. Midway through the family meeting, a CPS supervisor entered the meeting and stated that Julie had completed what she needed to, and that Aaron would be placed back in Julie's home by the end of the week.

Following the family meeting, the Regional Administrator emailed the Ombudsman that Julie did not have any active safety threats and that Aaron would be returned home to Julie with a safety plan. The Regional Administrator did supply OCFO with the

pediatrician's note listing several types of high fat food that would help support Aaron's growth, not medically ordering the expensive supplemental diet drink.

OCFO concluded that prior to the family meeting CFSD had not followed law, policy, and procedure, and submitted a *Findings Report* to the Director of DPHHS.

Since the family meeting, Julie and Aaron have had their legal case dismissed and have had no other additional reports or investigations with CPS.

Diligent Search finds a family home:

A father, Jerry, submitted a *Request for Assistance* form to OCFO. He had his child, Lucy, removed from his home over a year prior. The mother had passed away before the removal from his home. At the time the review was requested, Jerry was living out of state and had not completed his court ordered treatment plan. Jerry recognized that he could not safely parent Lucy and that he would ultimately have his parental rights terminated.

In his request form, Jerry wanted the Ombudsman to review Lucy's placement. During the review the Ombudsman did not locate the required forms for 42 U.S.C. §§ 671(a)(29) which requires Child and Family Services to exercise due diligence to identify and provide notice to the relatives of the child. The procedure of searching for relatives is called a Diligent Search. During the case review, the Ombudsman found that no search had been done for potential maternal or paternal family placements.

The Ombudsman wrote a *Findings Report* recommending that Diligent Search letters be sent to maternal and paternal family members immediately. These letters did go out to relatives and several responded that they would willingly be a placement for Lucy. This action by the Ombudsman resulted in Lucy being placed with a safe family member in Montana. Although Jerry did eventually have his parental rights terminated, the safe family member has since adopted Lucy. Lucy has not had any other additional reports or investigations with CPS since her adoption.

In the first six years of OCFO operations, the concern of identifying and providing notice to relatives of the children in foster care was significant. However, since the recommendation from Lucy's *Findings Report* citizen's concerns over sending letters to family members for potential placement has decreased. In fact, locating family members has not been named to OCFO as a concern by citizens in over four years.

ICWA safeguards a parent's right to parent:

A mother submitted a late-night *Request for Assistance* form through OCFO's online intake form. Sarah was in the hospital after recently giving birth to her first child, a baby girl named Amber. Sarah had not had any interactions with CFSD as an adult or as a child. Sarah had lost her housing midway through her pregnancy and had been living at the local homeless shelter. Sarah left the shelter to go to the hospital to deliver Amber.

Although the birth was difficult, both Sarah and Amber were healthy and happy. Shortly after the delivery a CPS worker arrived to remove Amber from Sarah's care. The reason for the removal was that Sarah did not have adequate housing for herself and the baby. Sarah stated that she could return to the shelter once she and her baby were medically cleared to leave the hospital. However, the CPS worker disagreed and told Sarah she needed more stable housing to care for a newborn. Sarah identified to CPS that the potential father of her child was an enrolled member of a tribe. The Indian Child Welfare Act (ICWA) may apply to Amber. This would be a higher standard of social work and practice, along with ensuring all prevention measures had been completed before the removal of Amber.

Once the Ombudsman began their review of the case, questions were emailed to the Regional Administrator regarding the safety threat at removal and the "active efforts" that had been completed to prevent the removal. The Ombudsman referenced the safety management documentation that stated the only concern was the "lack of housing." There was no documentation as to whether the CPS had confirmed with the shelter if Sarah and Amber could return. There was also no documentation of CPS offering housing resources or vouchers to local hotels. The safety management documentation did not follow up with Sarah to see where she was living after she had been discharged from the hospital. Amber was living in a state licensed foster care home that was not considered ICWA compliant.

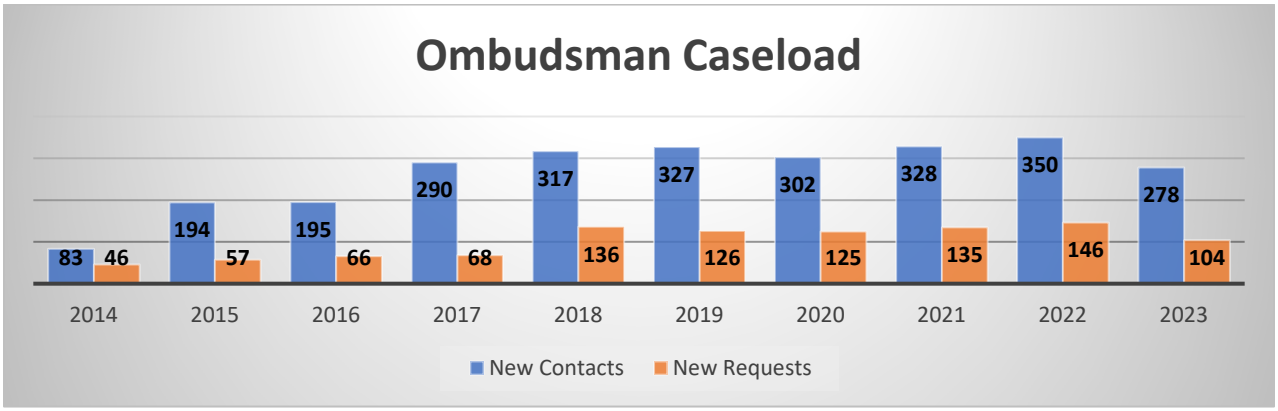
The Ombudsman wrote a *Findings Report* that detailed the lack of active efforts made in the case as well as the lack of documented active safety threats to Amber. The lack of overall documentation was also a concern identified in the *Findings Report*. Following the issuing of the report, Amber was promptly returned to Sarah's care and ultimately a judge granted Temporary Investigative Authority (TIA) to CPS. Subsequently, Sarah and a representative from the shelter were able to secure stable housing for Sarah and Amber. The shelter was also able to provide the family with other necessities.

Annual Report Data 2013 – 2023:

Duty: Respond to Citizens' Requests

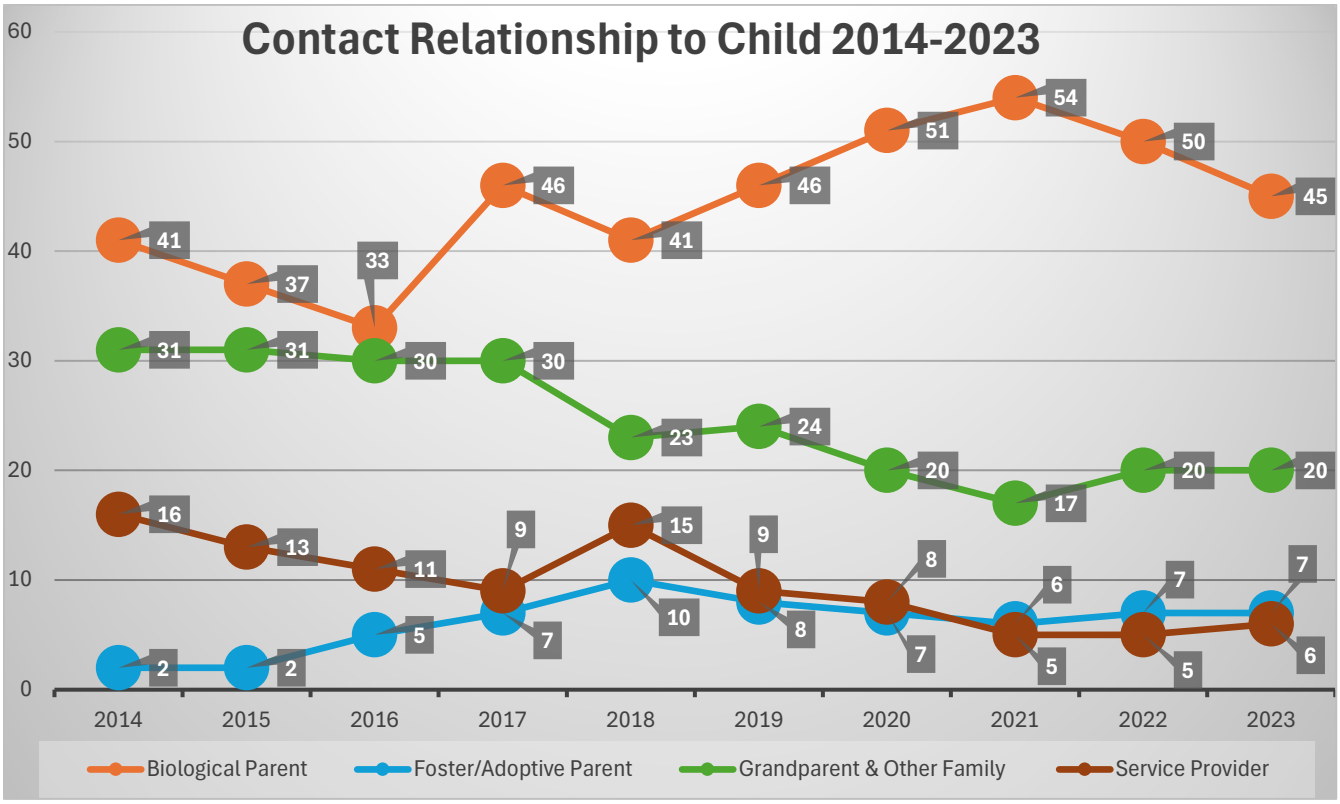
When a citizen calls, emails, or writes OCFO, they begin the Intake process as a *Contact*. If the Contact submits a Request for Assistance (RFA) form, they are then called a *Requestor*. OCFO reaches out to Contacts at least three times to assist in completing the RFA form.

Graph 1: Ombudsman Caseload over 10 years



Graph 2: Contacts by Relationship to the Child

OCFO tracks the relationship between the Contact and the child, or children, identified in the concern about CFSD action. Biological Parents were the largest category of contacts to OCFO followed by Grandparents and Other Family.



Duty: Investigate Findings

Outcomes

Review Process

An OCFO case review is an investigation of all the CFSD actions or omissions for a specific case. Each CFSD case may include records located in three different electronic databases:

- Child and Adult Protective Services or *CAPS*
- Montana Family Safety Information Systems or *MFSIS*
- Document Generator or *Doc Gen*

Additional case specific records may also be maintained in a hard file at the CFSD local office. The range of intervention provided by OCFO includes referral to services; mediating concerns directly with the requestor and CFSD; addressing concerns directly with legally mandated stakeholders; and in some cases, preparing a Findings Report which is submitted to DPHHS and to the citizen requestor's who fit within MCA 41-3-205 Confidentiality - disclosure exceptions. OCFO conducts an accurate and comprehensive case review for each citizen requestor. The Ombudsmen frequently provide resources to citizens even when the case is not appropriate for OCFO services or must be declined.
Table 1 describes in more detail the outcomes of individual contacts.

Table 1: Status of all contacts to OCFO for 2020—2023.

Outcome Measures	2020 Outcomes	2021 Outcomes	2022 Outcomes	2023 Outcomes
Closed, no further contact.	28%	30%	30%	21%
Declined to intervene.	1%	2%	5%	4%
Referred and closed.	14%	13%	12%	14%

No citizen response after review opened*	N/A	N/A	1%	21%
Closed – Concerns fully resolved*	7%	3%	4%	4%
Closed – Plan established*	10%	11%	3%	4%
Closed – Questions answered*	20%	19%	25%	12%
Findings Report to DPHHS Director*	2%	3%	3%	2%
Open from previous year's contacts*	7%**	17%**	9%**	10%**
Pending review at end of year*	12%	3%	8%	6%

*A *Request for Assistance* was received from a citizen.

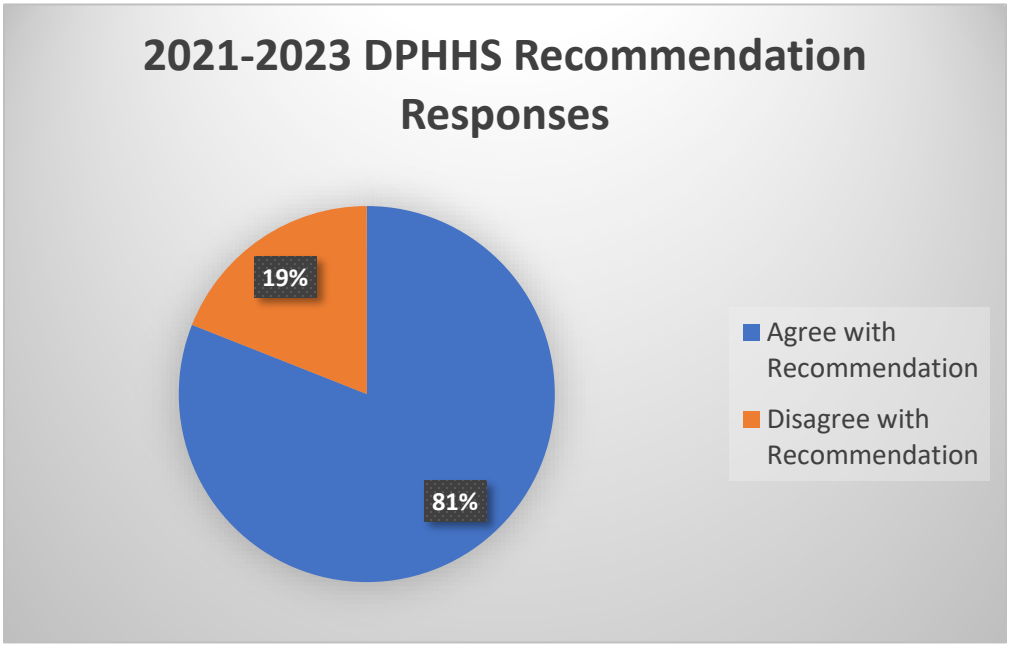
**This data factors into the previous calendar year's overall contact numbers.

Duty: Share Findings

Findings Reports and Recommendations

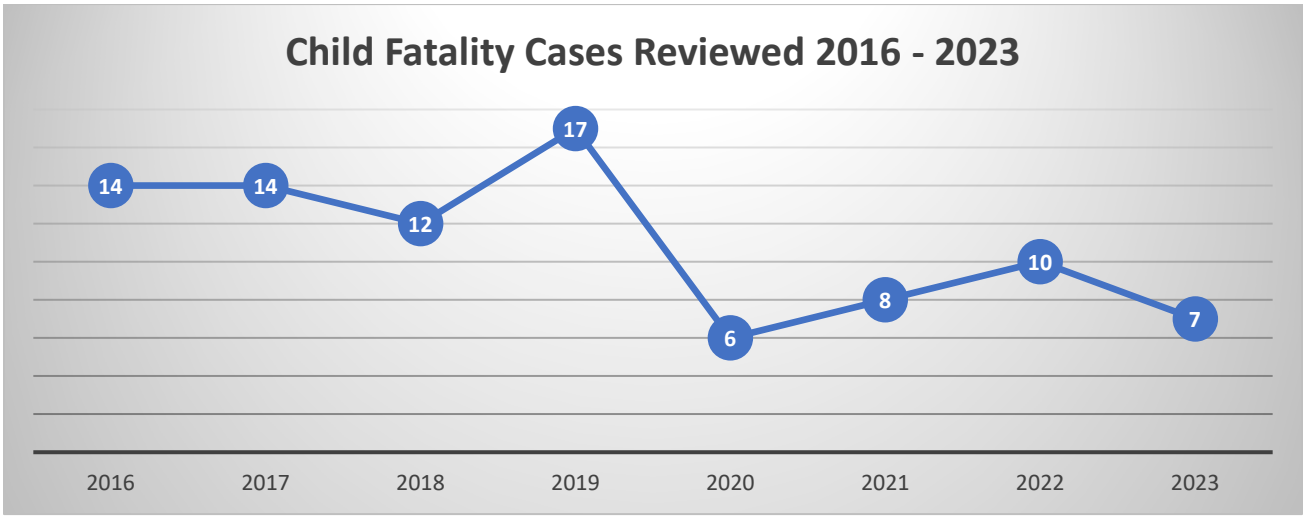
Following the 2021 Legislature, DPHHS has been required to respond to recommendations made by OCFO. Since this began, DPHHS has responded to each OCFO recommendation from 2021-23 within the required statutory 60-day timeline. Below is a graph with the three-year average of recommendations made to DPHHS.

Graph 3: Recommendations to DPHHS



Child Fatalities: 2016-2023

Montana Code Annotated MCA 41-3-209 requires the DPHHS CFSD to provide critical incident notifications to OCFO, including child fatalities. OCFO conducts an accurate and comprehensive case review for each child fatality, however OCFO's authority is limited to review only CFSD records and does not include all medical, law enforcement, criminal history, educational, mental health, medical examiner or coroner findings, or other sources of documentation about the deceased child or his/her family. To provide a comprehensive, neutral review, the child fatality review team includes the Special Services Bureau (SSB) staff from other related programs. OCFO reviews are initiated separate from a criminal investigation. The following sections summarize the SSB Child Fatality Review Team's findings.

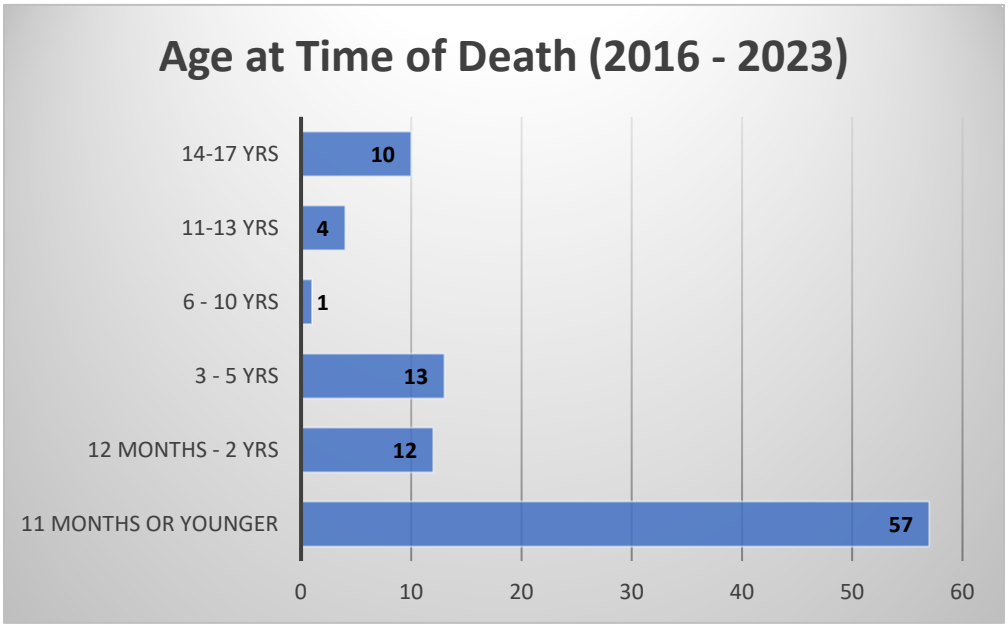


Child fatality cases have been reviewed by OCFO since July 1, 2015. The 2016 OCFO Child Fatality Report reviewed 14 fatalities dated between July 1, 2015, and December 15, 2016, an eighteen-month date range.

Child Fatality Review Findings:

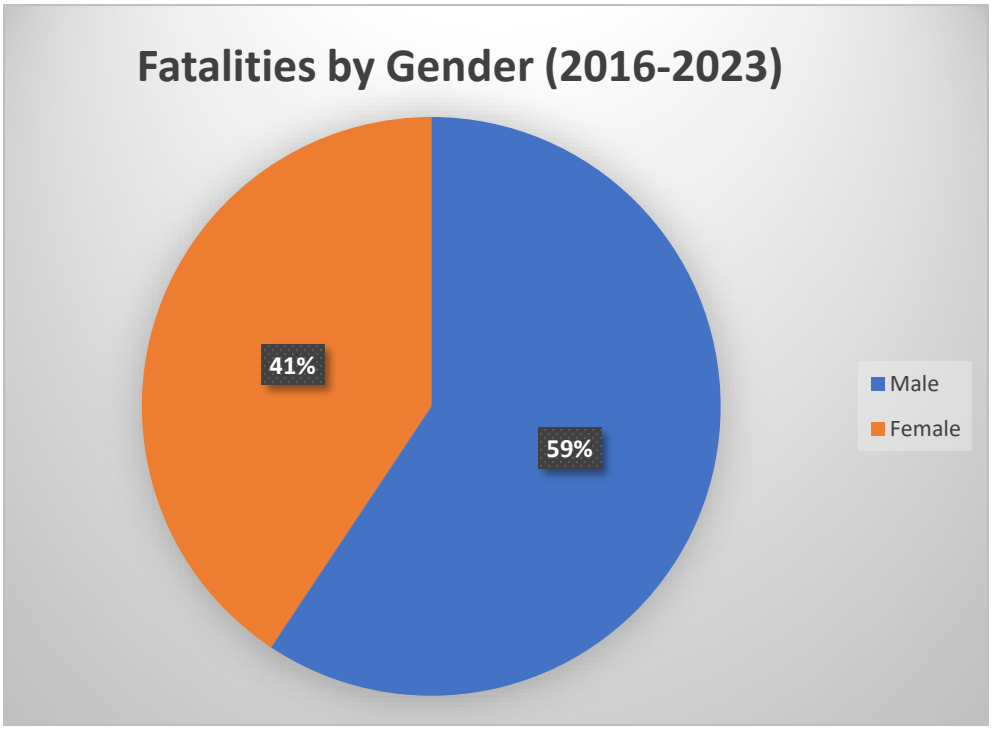
Finding 1: Age at Time of Death

There were more fatalities involving children under the age of one.

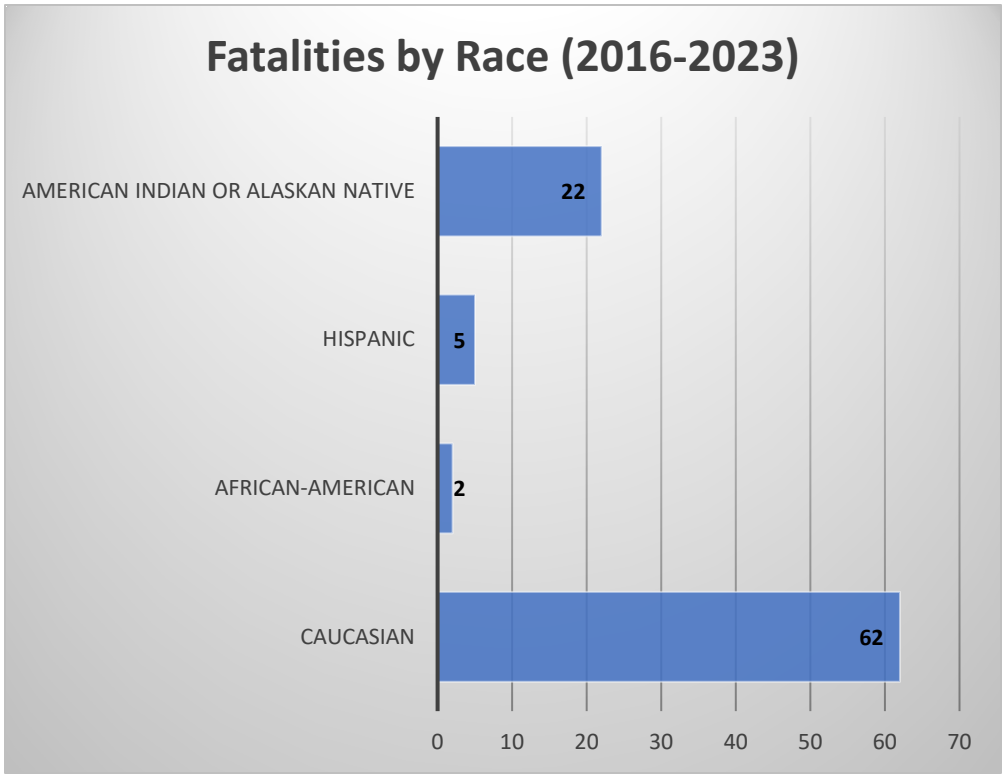


Finding 2: Gender

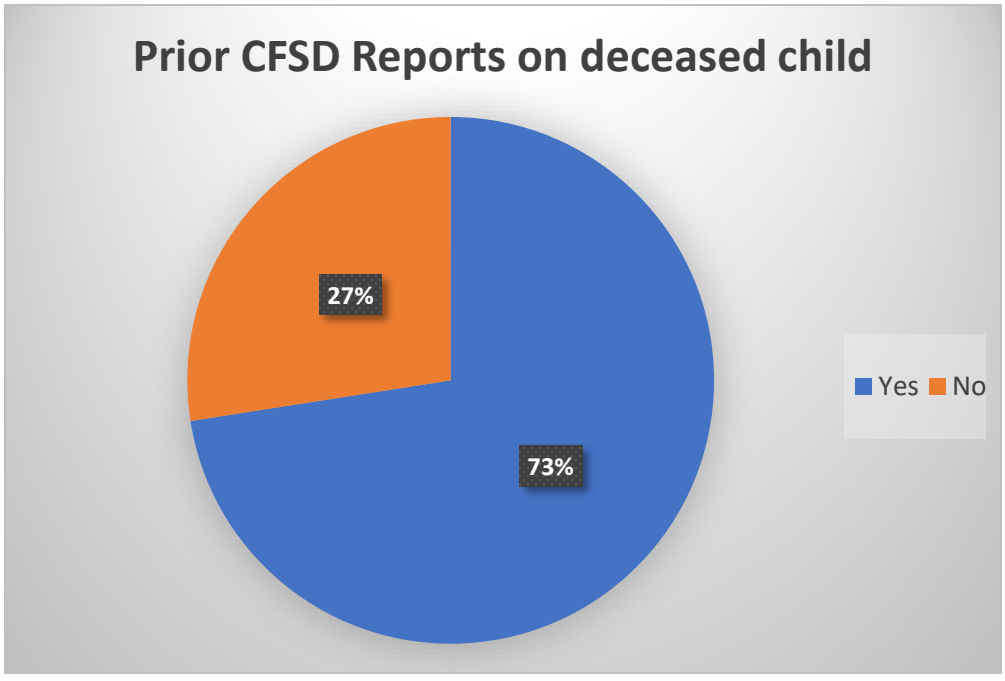
59% of the fatalities were male children.



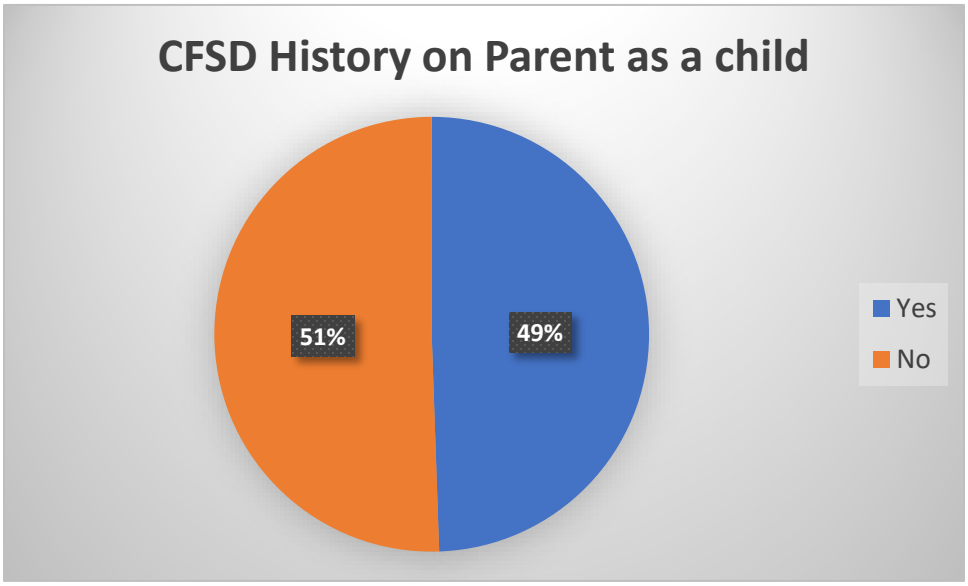
Finding 3: Race
DPHHS CFSD identified the race of each child.



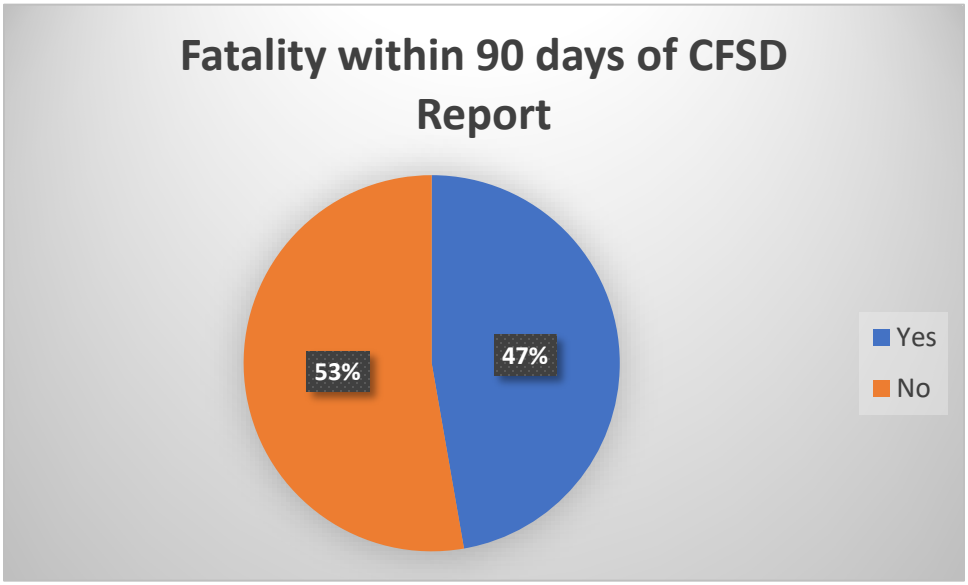
Finding 4: Prior CFSD Reports



Finding 5: The Parent had history with CFSD as a child.



Finding 6: Fatality occurred within 90 days of a report to CFSD.



2023 Recommendation:

OCFO extends one recommendation to DPHHS.

Recommendation 1: DPHHS instruct CFSD Centralized Intake (CI) staff to enhance training regarding risk assessments of newborns and/or infants.

Rationale 1: OCFO has been reviewing child fatalities in accordance with MCA 41-3-209 since July 2015. Since then, there have been a total of 91 fatalities. Of these, 57 were under the age of 12 months. CI staff are the frontline in decision making at CFSD. Their role in transferring reports of alleged abuse and/or neglect into the field is paramount. An enhanced, more comprehensive review of the child and family's CPS history, along with the current circumstances, will support the report as it goes out to the field.

Conclusion:

The DOJ Special Services Bureau and OCFO recognize the impact case reviews and child fatalities have on citizens, communities, and professional stakeholders. Child abuse is a community problem; preventing and responding to child abuse requires strong collaboration among multiple agencies. We sincerely thank the Department of Public Health and Human Services for sharing information and considering recommendations for future system improvements.

Appendix I: 2023 Recommendations from OCFO to DPHHS

OCFO's statutory authority includes making case specific findings as well as recommendations to strengthen the system. Often the cases reviewed, and the findings determined, relate to specific actions of a worker and or higher-level administrator. While there is value in reporting back to the agency the areas of practice that were assessed during case reviews, it is the recommendations for overall case practice that stand to benefit the citizens of Montana. OCFO recommendations have directed the agency to clarify their policy and procedures for ease of use by field staff once they are working in the field.

Recommendations from the eight 2023 *Findings Reports* are listed in the order they were issued as written, apart from identifying information as to protect citizen confidentiality. Responses from DPHHS/CFSD are below each recommendation in blue.

There was a total of 34 formal recommendations to DPHHS. DPHHS agreed with 73.5% of the recommendations and disagreed with 26.5%. The responses which differ from the OCFO recommendation are in orange font.

2023 Recommendations from OCFO to DPHHS	
Report 1:	1) CFSD direct Region 3 Administrator to instruct regional CPS and CPSS to obtain independent, corroborative, and attributable information regarding an anonymous report before assessing the allegation and making case decisions.
DPHHS Response:	When CFSD has EPS or TLC of a child, CFSD is tasked with always ensuring the physical safety of that child. The assessment of child safety in Dependency and Neglect cases is a continual and dynamic process and there are circumstances when safety determinations must be made immediately and in real time to ensure child safety. These decisions are legally sanctioned by the Court's provision of EPS and TLC authority to the Department. When CFSD received information on February 10, 2023, the District Court had already adjudicated the child a YINC, as defined in MCA 41-3-102(35). The District Court had ordered CFSD to effectuate any other temporary disposition that may be required in the best interests of the child, including approving, arranging, and supervising visitation between the parent and the child. Based on the totality of information possessed by CFSD, the determination was made to end the visit early to protect the child's safety. This decision is within the legal authority granted to CFSD by the District Court.
	2) CFSD direct the Region 3 Administrator to train regional CPSS and CPS to document monthly a parent(s) successes and accomplishments in ACTD [*Activity Detail screen]*, as well as services and referrals made for the parent(s) by the assigned CPS worker.
DPHHS Response:	Region 3 will train the Case Management procedure to regional CPS and CPSS on September 12, 2023, with a focus on documenting parent successes and accomplishments as well as services and referrals made for the parent(s). Thorough and quality documentation were also a training topic at the regional all-staff meeting on August 2, 2023.
	3) CFSD direct Region 3 Administrator to train regional CPSS and CPS on In-Home Criteria and Conditions for Return (CFR) in blue field guide, along with documenting how the impending dangers with the family are out of control, observable, imminent, severe, and impactful.
DPHHS Response:	Region 3 trained regional CPS and CPSS on the updated Safety Management Plan (SMP) document, In-Home Criteria and the Conditions for Return, and the descriptive documentation of impending dangers on May 16, 2023, as well as July 11, 2023. Region 3 will additionally train regional CPSS on Safety Plan Determination/Conditions for Return (SPD/CFR) documentation on August 23, 2023.
	4) CFS direct Region 3 Administrator to train regional CPSS and CPS on guidelines for working with families who experience poverty.
DPHHS Response:	CFSD regularly interacts with individuals of varying backgrounds, including socioeconomically disadvantaged families. CFSD Practice Principles and values encourage family-centered practice that recognizes individuals are the experts on their own family, support skill-building, growth, and strengthening a family's support network, and approaches

	work with families in an engaging and empowering manner. In this case, CFSD offered extensive support to this family in the pursuit of reunification. The mother chose not to accept many of those offers of support. CFSD disagrees with this recommendation that training is necessary for regional staff on working with families that experience poverty. CFSD believes that the statement contained in the guardianship affidavit did not fully reflect the case circumstances, including the efforts by CFSD to offer the birth mother support and the mother's refusal to accept those offers of support. CFSD will continue to enhance staff training on thorough affidavit writing to help ensure all relevant case circumstances are included.
Report 2: **DPHHS Response:** **DPHHS Response:**	1) CFSD direct Region 4 Administrator to instruct regional CPS and/or CPSS to submit an affidavit to the appropriate jurisdiction for dismissal for the identified children #604724. The birth mother in this case had met the safety management thresholds in large part due to support from Family Drug Court and Florence Crittenton Home. The birth mother was unsuccessfully discharged from Family Drug Court on July 18, 2023, due to non-compliance with the rules and expectations of Family Drug Court. The dismissal order states the reasons for dismissal include the mother's choice to stop submitting to urinalysis testing in May 2023, submitting a positive test on June 29, 2023, taking an unauthorized trip to Bozeman on July 4, 2023, and at least three previous sanctions for non-compliance during the life of the Family Drug Court case. The birth mother has a meeting scheduled with Florence Crittenton on September 12, 2023, that will determine whether she will be unsuccessfully discharged from the program due to non-compliance with program rules and expectations. The mother was non-compliant with the program requirements to regularly submit to urinalysis testing and maintain employment. The mother has not been regularly submitting to UAs since May 2023 and was terminated from her employment. CFSD is actively assessing the sustainability of the in-home safety plan and the safety of the children. 2) CFSD direct the Region 4 Administrator to train regional CPSS and CPS to document monthly parent(s) success, accomplishments and all THV transition plans in ACTD, as well as services and referrals made for the parent(s) by the assigned CPS worker. On April 5, 2023, Region 4 CPS and CPSS received training on the Case Management Procedure with a specific focus on documenting monthly parent successes and accomplishments, trial home visit transition plans, and services and referrals made for the parents by CFSD. 3) CFSD direct Region 4 Administrator to train regional CPSS and CPS on the Case Management Procedure: THV section, emphasizing the need to update a monthly IHSP, identify a transition plan, complete a Case Closure form, and submit an affidavit for dismissal when the family does not have

DPHHS Response:	any confirmed reports of child abuse and neglect during the first 6 months of the THV. On April 5, 2023, Region 4 CPS and CPSS received training on the Case Management Procedure with a specific focus on updating the in-home safety plan monthly, documenting transition plans, and using the Case Closure Assessment Form as a dynamic, working document to determine if the safety concerns have been sufficiently mitigated for the case to be dismissed. Given the dynamics of Family Drug Court, additional training on the submission of affidavits for dismissal is not necessary, due to the court's expressed desire to maintain oversight of the case. 4) CFSD direct Region 4 Administrator to review and train regional CPSS and CPS on Permanency and Safety Policy as pillars of the work and the mission of CFSD. Specifically, how safety and permanency of children in their homes, and how it is assessed, is integral to determining the level of involvement CFSD has with families.
DPHHS Response:	Region 4 CPSs and CPSSs were trained on CFSD policies on Permanency and Safety on April 5, 2023, and on July 12, 2023.
Report 3:	1) CFSD direct Region 6 Administrator to instruct regional CPSS and CPS to report all critical incidents, specifically when neglect or abuse occurs with a substitute care provider, to OCFO within 5 business days.
DPHHS Response:	The Region 6 Administrator will review the critical incident criteria as defined by OCFO and will train CPS and CPSS to notify the Child Welfare Manager (CWM) and Regional Administrator (RA) within one business day when these incidents are discovered, so that timely notification can be made to OCFO. 2) CFSD direct the assigned Region 6 CPSS or CPS to send the hardcopy letter of determination to the parent in R/R 547835.
DPHHS Response:	CFSD provided the hard copy letter of determination to the parent on August 16, 2023. 3) CFSD direct Region 6 Administrator to instruct regional CPS and CPSS to send hardcopy letters of final investigation determinations to all parents, and/or legal guardians, or custodians within 30 days of the closure of the report.
DPHHS Response:	The Region 6 administrator trained regional CPSS on procedures specific to sending determination letters upon the closure of reports on August 28, 2023. Regional CPS received training on these procedures at a regional all-staff meeting on August 29, 2023. 4) DPHHS direct CFSD to implement a procedure regarding the request for the disclosure of information from citizens to provide and maintain transparency.
DPHHS Response:	ARM 37.47.608, "Protective Services: Procedures," states CFSD "shall respond to a request for disclosure within 30 calendar days of the request," and contemplates that it may not be possible to fulfill disclosure requests within such period. Senate Bill 181, passed during the 2023 legislative session, requires CFSD to inform parents of "the process for reviewing the department's records of the investigation." CFSD is in the final stages of

	updating its Family Guide to the Montana Child Welfare System that will be provided to every family that is the focus of a child abuse or neglect investigation. The Family Guide to the Montana Child Welfare System informs parents how to request records from CFSD – providing transparency into the process for parents. CFSD does not believe an additional procedure on processing requests for disclosure of information is necessary because the procedures are already defined and outlined in the above-referenced ARM and fully explained in the Family Guide to the Montana Child Welfare System.
Report 4:	1) CFSD direct Region 3 Administrator to review and train regional CPSS and CPS on Permanency and Safety Policy as pillars of the work and the mission of CFSD. Specifically, how safety and permanency of children in their homes, and how it is assessed, is integral to determining the level of involvement CFSD has with families.
DPHHS Response:	Region 3 will train regional CPS and CPSS on the Permanency Policy and the Safety Policy on October 4, 2023.
	2) CFSD direct Region 3 Regional Administrator to complete a fair and reasonable safety assessment of the birthfather. Adhere to established policy and procedure if the identified child can be safely placed with the noncustodial, nonoffending parent.
DPHHS Response:	CFSD was on the precipice of placing the identified child with the father when a concern was noted about possible substance use. As part of the investigation and assessment of safety that CFSD is required by statute and policy to complete, the father was asked to submit to a single urinalysis test on March 24, 27, and 28, 2023. The father chose not to submit to a urinalysis test on any of those dates. CFSD referred the father to an alternate testing provider and offered a drug patch as an alternative method of testing, but the father failed to present at the provider's location for application of the patch. On April 5, 2023, the District Court judge ordered the father to submit to a single urinalysis test before the child would be allowed to be placed in his home. It has been over five months since the District Court judge ordered the father to submit to this test, but the father has still not submitted a single urinalysis test. On August 25, 2023, circumstances required that child #677459 be moved from the child's foster placement. CFSD made multiple attempts to contact the father to inform him that, if he were to submit to a urinalysis test pursuant to the verbal order by the District Court and the results did not reveal safety or risk concern for the child, the child would be placed with him. The father has continued to refuse to submit to any urinalysis test. As a result, the child was moved to a different foster placement.
	3) CFSD direct Region 3 Administrator to train regional CPSS and CPS on the relevant law, and policy on the rights of noncustodial parents and established placement procedures.
DPHHS Response:	Region 3 will train regional CPS and CPSS on the Placement Procedure, including a focus on placement with noncustodial parents, on December 6, 2023.

	4) CFSD direct Region 3 Administrator to train regional CPSS and CPS on the Case Management Procedure: Contact with Parents section, emphasizing the need to meet both parents face-to-face on a monthly basis.
DPHHS Response:	Region 3 will train regional CPS and CPSS on the Case Management Procedure, including a focus on the Contact with Parents section, on December 6, 2023.
	5) CFSD direct Region 3 Administrator to train regional CPSS and CPS to document of a nonoffending, noncustodial parent's treatment goals or objectives for each condition or requirement established in the plan.
DPHHS Response:	The documentation of a parent's treatment goals or objectives for each condition or requirement established in the court-ordered treatment plan will be covered in the training of the Case Management Procedure.
	6) CFSD direct Region 3 Administrator to train regional CPSS and CPS on the DPHHS-CFSD Client Drug Testing Guidelines, specifically as it relates to how drug use impacts a child's safety and obtaining documentation and recommendations from a substance use treatment provider.
DPHHS Response:	CFSD asserts that in this case the CFSD Client Drug Testing Guidelines were adhered to and that the CPS utilized the least restrictive intervention possible to assess safety and risk as it relates to any potential substance use concerns. The guidelines state that when drug or alcohol use is alleged or identified, a drug test of the caregiver will be requested. If the drug use has impacted the child safety, the CPS is directed to refer the individual to a substance use disorder (SUD) professional for further assessment. In this case, CFSD has made repeated requests to the father to submit to an initial urinalysis test to inform the safety assessment process and any next steps in that process. Despite verbally agreeing to submit to a urinalysis test on multiple occasions, both when requested by CFSD and when ordered to do so by the District Court, the father has never done so. CFSD offered a drug patch as an alternative to a urinalysis test, to which the father also agreed, but failed to show up at the provider's office for the application of the patch. CFSD has not referred the father to a SUD professional for further assessment because the father's continued refusal to submit to any testing has resulted in an inability to complete an informed safety assessment. Referring the father to a SUD professional for further assessment without information on whether the father has a substance use disorder and how that use (if any) impacts child safety would constitute a more restrictive intervention. CFSD always strives for a culture of learning and continuous improvement. In the interest of maintaining this agency culture, Region 3 trained regional CPSS on the CFSD Client Drug Testing Guidelines on September 13, 2023, and regional CPSS will be reviewing the guidelines with staff in their respective unit meetings.

Report 5:	**1)** DPHHS direct CFSD direct Region 6 Administrator to train regional CPSS and CPS on completing investigations only during the statutory and procedural required 60 days.
DPHHS Response:	CFSD completed the formal investigation within the timeframes required by statute, procedure, and ARM. The additional actions taken to gather information occurred based on OLA's recommendation during the informal review process that was prompted by the submission of additional information by the subject of the investigation in the letter requesting the initiation of the fair hearing process. The additional investigation was limited to the evidence provided by the subject of the investigation. CFSD is always striving to be a culture of learning and continuous improvement. In the interest of maintaining this agency culture, the Region 6 administrator will train regional CPS and CPSS on the investigative procedure in November 2023.
	2) DPHHS direct CFSD to limit informal reviews to the records and documentation in the case record and any written material provided by the subject of the substantiated abuse and/or neglect per ARMS 37.47.610.
DPHHS Response:	In this case, the additional investigation was limited to the evidence provided by the subject of the investigation. ARM 37.47.610 requires CFSD to consider such information during the information review process, prior to a fair hearing. As explained in the response to #1 above, when the subject of a substantiated investigation requests a fair hearing and submits additional information, OLA may advise that CFSD conduct an additional investigation with respect to such additional information. This investigation can be related to the written materials provided by the subject to determine if the substantiated finding should be amended, or if a request should be made to schedule a fair hearing. CFSD's actions comported with the spirit and letter of ARM 37.47.610 during this informal review.
	3) DPHHS direct CFSD to develop the "Substantiation Determination Procedure" within 60 days of receipt of this report.
DPHHS Response:	CFSD is working on the development of a Substantiation Determination Procedure, in collaboration with OLA. The development of procedures that are thorough, comprehensive, and not cumbersome to interpret is a process that requires extensive consideration, deliberation, and collaboration within CFSD and between CFSD and OLA. The application of an arbitrary 60-day timeframe could force the premature publication of a procedure that is not ready for publication and, thus, not in the best interest of the public or CFSD.
	4) DPHHS direct CFSD to provide the "Substantiation Determination Procedure" on the public facing policy and procedure website.
DPHHS Response:	When the Substantiation Determination Procedure is finalized and approved it will be placed on CFSD's public facing policy and procedure website.

DPHHS Response:	5) CFSD direct Region 6 Regional Administrator to complete a fair and reasonable safety assessment of the alleged perpetrator(s) in R/R 568040. Adhere to established policy and procedure regarding safety determinations and investigation outcomes. CFSD believes the Out of Home Assessment was completed in a fair and reasonable manner and the determination to substantiate the allegations is consistent with policy, procedure, and ARM. When the subject of the investigation requested a fair hearing and submitted additional written information, CFSD completed an informal review inclusive of, and limited to, that the existing record and such additional information (and any elaboration of that additional information), consistent with the process contemplated by ARM 37.47.610. At the conclusion of the informal review, CFSD determined that no evidence warranted amending the substantiated findings and decided to move forward with the fair hearings process outlined in ARM 37.47.610.
Report 6: **DPHHS Response:** **DPHHS Response:**	1) CFSD direct Region 3 Administrator to train regional CPSS and CPS on the Case Management Procedure: THV section; specifically focused training on the need to update a monthly IHSP, identify a transition plan, complete a Case Closure form with the parent, and submit an affidavit for dismissal if the family does not have any confirmed reports of child abuse and neglect during the first 6 months of the THV. On October 17, 2023, regional CPS and CPSS in Region 3 were trained in the case management procedure, including a focus on the monthly IHSP, transition planning, Case Closure forms, and dismissal requirements. On December 6, 2023, regional CPS and CPSS in Region 3 will be trained on the Case Management Procedure and Placement Procedure with a specific focus on THVs. 2) CFSD direct the Region 3 Administrator to train CPSS to develop plans for children in out-of-home placement to be seen by the assigned worker in 48 hours when the children have not been seen in 30 days. CFSD makes active efforts to ensure each child in care is seen monthly. For example, during the first two weeks of every month, CFSD generates lists for Home Visit with Child (HVC)/Visit with Child (VWC) that identifies, for divisional and regional leadership, children who have and have not had an HVC/VWC during the previous month. The Region 3 RA reviews this list when it is generated, highlights the children about whom she has concerns or who have not been seen, and forwards the list on to regional CPSS. The Region 3 RA staffs with each CPSS twice monthly, and one of those staffings is exclusively focused on HVC/VWC. At this staffing, the CPSS must provide a written plan to the RA that explains how the HVC/VWC will be completed or entered into the electronic case management system. The Region 3 RA also uses these regularly scheduled HVC/VWC staffings to analyze any patterns with specific cases or specific workers for recurring issues with completing or entering the HVC/VWC monthly.

DPHHS Response: **DPHHS Response:**	3) CFSD direct Region 4 Administrator to instruct the assigned CPS to complete and close R/R 576239 within 7 days of the receipt of this report. R/R 576239 was closed on October 24, 2023. 4) CFSD direct Region 4 Administrator to train regional intake and ongoing CPSS and CPS on completing investigations during the statutorily required 60 days. Region 4 CPS and CPSS were trained on investigative timelines on September 17, 2023.
<u>Report 7:</u> **DPHHS Response:** **DPHHS Response:**	1) DPHHS direct CFSD to obtain the outcome and determinations of the State of Tennessee's Special Investigations Unit and Licensing investigation. On October 5, 2023, CFSD requested that Tennessee's Department of Mental Health and Substance Abuse Services provide CFSD with a copy of the outcome and determinations of its investigation. CFSD has had follow-up conversations via email with the Director of Licensure over the Division of Administrative and Regulatory Services on October 13, 16, 23, and 24, 2023. The outcome and determinations of this investigation were received on November 17, 2023. Admission were placed on hold throughout the investigation. Licensing violations were substantiated as that term is defined under Tennessee Law. The facility addressed the violations and has been given approval to resume admissions. 2) DPHHS direct CFSD to cease placing foster youth from the State of Montana at Bledsoe Academy. When a child's mental and behavioral health needs require a higher level of care, CFSD first seeks placement at one of the two Medicaid providers enrolled with the State of Montana Children's Mental Health Bureau (CMHB) as Psychiatric Residential Treatment Facilities (PRTF), Shodair Children's Hospital and the Yellowstone Boys and Girls Ranch (YBGR). If Shodair and YBGR are unable to provide care for the youth and deny placement, CFSD extends the search to out-of-state providers that are enrolled as providers with Montana Medicaid through CMHB. CFSD does not extend the search for placement outside of this enrolled network of providers unless a denial has been received from every provider facility that is enrolled as a provider with Montana Medicaid. If denials are received from all such enrolled provider facilities, CFSD then expands the search for higher level of care. Children remain in higher level of care placements only for as long as is necessary for them to build the therapeutic skills to be successfully discharged from the program and safely maintained in a lower level of care. Bledsoe Academy is an out-of-state facility that is not enrolled as a provider in the Montana Medicaid network. CFSD is committed to ensuring that the least restrictive intervention possible is used to ensure the safety of children. This commitment is reflected in the CFSD Safety Policy and is used as a foundational principle of the CFSD procedures manual. Placement decisions in each child's case are individualized to that child's unique needs. A child is considered for a higher level of care only when it

DPHHS Response:	is not possible to adequately treat the child's unique mental and behavioral health needs, while safely maintaining that child, in a lower level of care. Prior to any child being placed with an out-of-state provider that is not enrolled with Montana Medicaid through CMHB, CFSD obtains a copy of the facility's operating license. This is to ensure the facility is licensed and approved as a mental and behavioral health provider in the state in which it operates. When a provider facility is licensed, it indicates they have met initial and ongoing requirements imposed by that state's oversight body. In the pursuit of obtaining the appropriate and necessary mental and behavioral health interventions for Montana children in need of such care, CFSD will consider all licensed facilities on a case-by-case basis and determine if the placement is appropriate for that child. 3) DPHHS direct CFSD to engage in monthly in-person visits to all children in out-of-state placements. These visits must include a private, confidential interview with the children/youth to inquire about care received. Prior to an out-of-state placement, and quarterly thereafter, CFSD shall perform a tour of the entire facility, have a meeting with leadership about program culture and therapeutic programming. CFSD has been completing monthly in-person visits to all children in out-of-state placements since 2019. All these visits include a private, confidential interview with the child, and CFSD has developed guiding questions to ensure each of these in-person visits addresses physical safety, emotional safety, and any unaddressed needs or concerns the child has with facility culture or therapeutic programming. Licensed facilities are required to hold regularly occurring clinical treatment team meetings that include discussions about therapeutic programming. The CFSD Case Management Procedure also requires the ongoing assessment of any recommendations by licensed mental health professionals and monthly contact with service providers to discuss the treatment progress in the therapeutic program. Finally, the licensing and oversight body of the state where the facility operates completes assessments of its licensed facilities program culture and therapeutic programming. The response to the second recommendation outlines the steps CFSD takes prior to placing a child in an out-of-state residential treatment facility.
Report 8: **DPHHS Response:**	1) CFSD direct Region 4 Administrator to review and train regional CPSS and CPS on returning the child to the parent/guardian following the end of the voluntary 30-day placement unless an abuse and/or neglect petition has been filed on CFSD's behalf. Region 4 Lewis & Clark County reviewed and trained the FFA procedure with regional CPS and CPSS on January 8, 2024. The FFA procedure includes a focus on voluntary Out-of-Home Protection Plans lasting for no more than thirty days unless a petition is filed in District Court requesting legal intervention. 2) CFSD direct Region 4 Administrator to review and train regional CPSS and CPS on the relevant law and policy on ICWA voluntary placement procedures.

DPHHS Response:	Region 4 Lewis & Clark County reviewed and trained regional CPS and CPSS on the relevant law and policy on ICWA voluntary placement procedures on January 8, 2024.
	3) CFSD direct Region 4 Administrator to review and train regional CPSS and CPS on completing Family Functioning Assessments within 30 days if the child(ren) are placed out of the home.
DPHHS Response:	Region 4 Lewis & Clark County reviewed and trained the FFA procedure with regional CPS and CPSS on January 8, 2024.
	4) CFSD direct Region 4 Administrator to review and train regional CPSS and CPS on offering placement stabilization plans.
DPHHS Response:	Region 4 Lewis & Clark County completes ongoing, dynamic assessments of placement stability during each monthly visit with resource parents. If it is determined that additional supports and interventions can improve the stability of the placement, a Placement Stabilization Plan is offered to the resource parent. The implementation of a Placement Stabilization Plan requires the ability to manage for the safety of all children in the home. In this situation, CFSD determined that there was no intervention that could manage for the safety of the children in the home, which is a prerequisite to implementing a Placement Stabilization Plan. CFSD always strives for a culture of learning and continuous improvement. In the interest of maintaining this agency culture, Region 4 Lewis & Clark County trained regional CPS and CPSS on the Case Management Procedure, specifically offering Placement Stabilization Plans, on January 8, 2024.