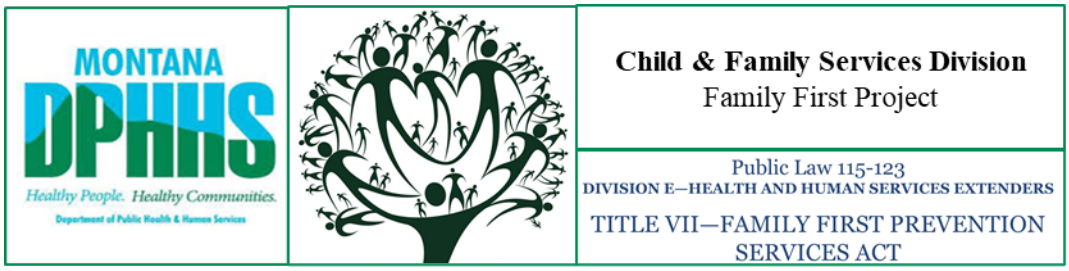

Montana 2021-2025
Title IV-E Prevention Plan

Montana Department of Public Health & Human Services

Child & Family Services Division

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Montana Department of Public Health & Human Services

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Introduction

The Department of Public Health and Human Services (DPHHS) Child and Family Services (CPS) is committed to prevention efforts across Montana. DPHHS has made significant efforts to identify, increase and implement evidence-based prevention models over the past three years. Previously, Child and Family Services Division (CFSD) and the Pew-MacArthur Foundation partnered to pursue the use of the Pew MacArthur "Results First" evidenced-based policy making initiative. Using innovative and customizable methods, this cross governmental team: 1) Created an inventory of Title IV-B funded in-home programs; 2) Reviewed all programs identified in the inventory process; and 3) Compared current programs against national clearinghouses of evidenced based practice.

The Results First partnership provided insights demonstrating strategies for improved data recording or tracking at the provider level. The partnership with PEW provided considerations, and technical assistance to develop strategies for successfully and appropriately embedding evidence and data requirements into service. Additionally, CFSD formally incorporated an evidenced-based focus in development of service delivery for the Title IV-B contracted services.

In 2017, a Child Abuse and Neglect Prevention Evaluation was completed by Bart Klika, MSW, PhD to develop recommendations to improve the prevention framework in Montana. From those recommendations, the First Years Initiative (FYI) Home Visiting initiative was developed. FYI was a large-scale effort to increase evidence-based home visiting services across the state, while utilizing funding streams between Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program and Child and Family Services Division (CFSD). In 2018, in preparation of the Title IV-E Prevention Plan, a large group of stakeholders came together to develop a strategic plan for preventing child abuse and neglect. Under the leadership of DPHHS Director Sheila Hogan, collaboration among all divisions and community stakeholders has created an opportunity and environment for improving primary, secondary and tertiary prevention services in Montana.

CFSD has increased focus on maintaining children in their home whenever possible, while still ensuring for their safety. Montana's removal rate peak in November 2017 at 11.1 (*per 1,000 children in the population (Reports Oriented Management (ROM))* but with recent efforts it has dropped to 8.6 in 2020. The Title IV-E Prevention Plan required under the Family First Prevention Services Act (FFPSA) (Public Law 115-123) will further support CFSD's mission of Keeping Children Safe and Families Strong. The Family First Prevention Services Act (FFPSA) authorizes new optional Title IV-E funding for time-limited prevention services for mental health and substance abuse prevention and treatment and for in-home parent skills-based programs. These evidence-based prevention services and programs may be provided for children who are candidates for foster care and their parents or kin caregivers.

DPHHS, CFSD is implementing the Title IV-E prevention program as authorized by FFPSA. As instructed in ACYF-CB-PI-18-09, the following is Montana's five-year prevention plan for calendar year 2021 through 2025. This plan builds upon Montana's existing Preventing Child Abuse and Neglect Strategic Plan, focusing on strengthening parents' capacity to safely care for their children and safely reducing the need for foster care. (Attach Link to Strategic Plan)

Montana's Title IV-E Prevention Plan will focus on utilizing well-support evidence-based models approved through the Title IV-E Prevention Services Clearinghouse. The prevention service array will be expanded through plan amendments as additional well-supported evidence-based services are approved through the Title IV-E prevention services clearinghouse, and the need and resource capacity of the specific services in Montana. Expansion includes extending prevention services to children at imminent risk of entering foster care and to their parents or kin caregivers.

CFSD began its planning for the Family First Prevention Services Act by educating DPHHS divisions, community services providers, tribal social service agencies and other stakeholders about the FFPSA requirements, potential opportunities to further the DPHHS service array, and funding structures. Several meetings were held with essential agency staff to assure readiness and understanding of the addition of Prevention Services. This team was instrumental in helping to determine the focus of the candidates for care and what internal processes are necessary for successful implementation. Montana DPHHS, CFSD has engaged several resources to coordinate its efforts to create an effective and sustainable Prevention Plan that addresses the critical needs of Montana's population of system-involved or at-risk families.

CFSD convened five meetings specific to the tribal social services agencies in Montana. Currently, each tribal social service agency has a pass-through Title IV-E agreement for IV-E allowable services. These agreements will be amended to include the approved services within the Title IV-E Prevention Plan. Tribes were giving the opportunity to provide feedback on candidacy definition, as well as discussion around the impacts of the QRTP requirements on funding for specific placement types. As Tribes develop prevention services and caseloads, CFSD will continue to diligently support efforts to access Title IV-E funding for prevention services.

Service Description and Oversight

Service Categories

Through the Title-IV Prevention Plan, Montana's Department of Public Health and Human Services, Child and Family Services Division will provide well-supported services or programs for a child and the parents or kin caregivers of the child when the child, parent, or kin caregiver's needs for the services or programs are directly related to preventing the child from entering foster care. Categories of prevention services and programs include:

Mental Health & Substance Abuse Prevention & Treatment Services

Approved, evidence-based mental health and substance abuse prevention and treatment services will be provided by a qualified clinician to a child or to the child's parent or kin caregiver for up to 12 months for each prevention period, beginning on the date the child was identified as a "child who is a candidate for foster care" in a prevention plan, also referred to as a prevention candidate. The child will be eligible for allowable child-specific administrative costs at the beginning of the month in which the child is identified as a candidate in a prevention plan.

In-Home Parent Skill-Based Programs

Approved, evidence-based in-home parent skill-based programs will be provided to a child and to the child's parent or kin caregiver for up to 12 months for each prevention period, beginning on the date the child was identified as a "child who is a candidate for foster care" in a prevention plan, also referred to as a prevention candidate. The child will be eligible for allowable child-specific administrative costs at the beginning of the month in which the child is identified as a candidate in a prevention plan.

Outcomes

Providing evidence-based prevention services and programs to families in Montana is expected to improve specific outcomes for children and families. The evidence-based services that Montana has included in this plan, in combination with services under review for future amendments to this plan, have been carefully mapped to the needs of children and families throughout the state. This assessment has included extensive stakeholder input with significant consideration for contextual factors, such as the presence and adequacy of services in other systems addressing these needs.

The evidence-based programs in the Montana plan are expected to improve outcomes for children and families in the following areas specific to our assessed needs:

- Improved parenting behaviors
- Improved parenting knowledge
- Improved emotional responsiveness
- Improved parent/caregiver collaboration
- Reduction in family conflict and improved skills in resolving family conflict
- Reduction in symptomatic problem behavior exhibited by children and adolescents
- Reduction in substance abuse
- Reduction in child maltreatment
- Reduction in other mental health symptoms, including trauma, anxiety, and depression

Overall, we expect that the outcomes provided by the evidence-based prevention services and programs will result in parents being better able to safely care for their children in their homes or with kin, thus preventing foster care placements where possible.

Evidence-Based Services and Programs

The evidence-based services and programs selected for Montana's five-year Title IV-E Prevention Plan are listed in the tables below. Each service has been identified well-supported by the Title IV-E Prevention Services Clearinghouse.

Service	**Parent Child Interaction Therapy (PCIT)**
Level of Evidence	Well Supported
Service Category	Mental Health Program and Services
Service Description	In Parent-Child Interaction Therapy (PCIT), parents are coached by a trained therapist in behavior-management and relationship skills. PCIT is a program for two- to seven-year-old children and their parents or caregivers that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship. During weekly sessions, therapists coach caregivers in skills such as child-centered play, communication, increasing child compliance, and problem-solving. Therapists provide live coaching to parents or caregivers. Most families can achieve mastery of the program content in 12 to 20 one-hour sessions. Master's level therapists who have received specialized training provide PCIT services to children and caregivers. (Title IV-E Clearinghouse)
Version of Book or Manual	Parent-Child Interaction Therapy Protocol Eyberg, S. & Funderburk, B. :2011. PCIT International, Inc PCIT will be implemented without adaption
Plan to Implement	CFSD will coordinate with DPHHS's Addictive and Mental Disorders Division to: • Identify providers currently providing PCIT • Crosswalk model components to current Medicaid billing codes • Identify additional providers interested in providing PCIT to fidelity • Provide training to interested providers • Assess rate in current model matrix

Service	**Parent Child Interaction Therapy (PCIT)**
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for PCIT, Montana expects to see the following outcomes: • Improved parenting knowledge • Increased positive parenting • Improved parent and child interactions • Decreased child behavior and attention problems • Improved parent/caregiver emotional health
Plan to Monitor Fidelity	Montana will utilize continuous quality improvement methods to conduct on-going monitoring to ensure PCIT's fidelity to the model and progress measures meet the standard established. In addition, providers of PCIT are required to implement fidelity monitoring and outcome measurement using PCIT tools.
How Selected	PCIT is typically appropriate for families with children who are between two and seven years old and experience emotional and behavioral problems that are frequent and intense. PCIT aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the quality of the parent-child relationship. In SFY20, 60% of children in foster care were under the age of seven. The utilization of a model that can improve parenting skills and decrease child behavior problems and is shown to be particularly effective with the age range of children who are at the greatest risk of entering foster care greatly increases the likelihood a child can be maintained in their home.
Target Population	Families with children who are between two and seven years old and experience emotional and behavioral problems that are frequent and intense
Assurance for Trauma Informed Service Delivery	See Attachment III: State Assurance of Trauma-Informed Service-Delivery
How Evaluated	Montana is requesting a waiver for evaluation of PCIT, which has currently been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported" .See Attachment II: States Request for Waiver of Evaluation Requirement for Well-Supported Practice Parent-Child Interaction Therapy is rated as a well-supported practice by the Title IV-E Prevention Services Clearinghouse because at least two studies with non-overlapping samples carried out in usual care or practice settings achieved a rating of moderate or high on design and execution and demonstrated favorable effects in a target outcome

Service	Parent Child Interaction Therapy (PCIT)
	domain. At least one of the studies demonstrated a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome.

Service	**Parents as Teachers**
Level of Evidence	Well Supported
Service Category	In-Home Parent Skill Based Programs and Services
Service Description	Parents as Teachers (PAT) is a home-visiting parent education program that teaches new and expectant parents skills intended to promote positive child development and prevent child maltreatment. PAT aims to increase parent knowledge of early childhood development, improve parenting practices, promote early detection of developmental delays and health issues, prevent child abuse and neglect, and increase school readiness and success. The PAT model includes four core components: personal home visits, supportive group connection events, child health and developmental screenings, and community resource networks.
Version of Book or Manual	PAT providers will utilize the curriculum as listed on the Title IV-E Clearinghouse: • Parents as Teachers National Center Inc (2016). Foundational Curriculum; and • Parents as Teachers National Center Inc. (2014). Foundational 2 Curriculum: 3 years through kindergarten It should be noted that there have been no adaptations to the original models, and both are presently being implemented in alignment with the versions reflected in the manuals on the Title IV-E Clearinghouse.
Plan to Implement	Montana has increased implementation of PAT over the past 3 years through the First Years Initiative. This initiative increased home-visitors through Public Health Departments and non-profit agencies. CFSD will: assess if there are additional communities across Montana that could utilize PAT and continue to build are the current efforts.
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive a positive effect through the independent review of the research conducted by the Title IV-E Prevention Clearinghouse for PAT, Montana expects to see the following outcomes: • Increased child safety • Improved child behavioral and emotional functioning • Increased positive parenting practices • Improved parent/caregiver mental or emotional health
Plan to Monitor Fidelity	Montana will utilize continuous quality improvement methods to conduct on-going monitoring of the use and implementation of PAT. CFSD will continue to partner with the Early Childhood Family Support Division (ECFSD) to utilize the fidelity review process under MIECHV funding requirements. Each site must meet yearly accreditation of their

Service	Parents as Teachers
	program and provide the certificate to the State Program Manager. Each site is required to do an Annual Performance Report and submit this to the States Program Manager. Each site is required to participate in monthly fidelity support calls
How Selected	In SFY20, 55% of children are in foster care were under the age of six (pre-school age). Montana has had success with PAT serving children who are risk of removal. CFSD will continue to build on that success.
Target Population	PAT offers services to new and expectant parents, starting prenatally and continuing until their child reaches kindergarten (Ages 0-5). PAT is a home visiting model that is designed to be used in any community and with any family during early childhood. However, many PAT programs target families in possible high-risk environments such as teen parents, low income, parental low educational attainment, history of substance abuse in the family, and chronic health conditions. Prenatal enrollment will only occur with pregnant or parenting youth in foster care
Assurance for Trauma Informed Service Delivery	See Attachment III: State Assurance of Trauma-Informed Service-Delivery
How Evaluated	Montana is requesting a waiver for evaluation of Parents as Teachers, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported." See Attachment II: States Request for Waiver of Evaluation Requirement for Well-Supported Practice. PAT is rated as a well-supported practice by the Title IV-E Prevention Services Clearinghouse because at least two studies with non-overlapping samples carried out in usual care or practice settings achieved a rating of moderate or high on design and execution and demonstrated favorable effects in a target outcome domain. At least one of the studies demonstrated a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome.

Service	**Healthy Families America**
Level of Evidence	Well Supported
Service Category	In-Home Parent Skill Based Programs and Services
Service Description	Healthy Families America (HFA) is a home visiting program for new and expectant families with children who are at-risk for maltreatment or adverse childhood experiences. HFA is a nationally accredited program that was developed by Prevent Child Abuse America. The overall goals of the program are to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term, and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed.
Version of Book or Manual	HFA providers will utilize the curriculums as listed on the Title IV-E Clearinghouse: • Healthy Families America. (2018) *Best practice standards*. Prevent Child Abuse America; and • Healthy Families America. (2018) *State/multi-site system central administration standards*. Prevent Child Abuse America. It should be noted that there have been no adaptations to the original models, and both are presently being implemented in alignment with the versions reflected in the manuals on the Title IV-E Clearinghouse.
Plan to Implement	HFA model is provided in one community in Montana. CFSD will: • Assess the outcomes and usage of the model in that community • Coordination with the Montana Chapter of Prevent Child Abuse America for interest in expansion of the HFA model • Identify additional providers interested in implementing the HFA model • Provide training to interested providers • Assess rate in current model matrix

Service	**Healthy Families America**
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse for HFA, Montana expects to see the following: • Reduced maltreatment • Improved parent-child interactions and children's social-emotional well-being • Increased school readiness • Promote child physical health and development • Promote positive parenting • Promote self-sufficiency • Increased access to primary care medical services and community services • Decrease child injuries and emergency department use
Plan to Monitor Fidelity	Montana will utilize continuous quality improvement methods to conduct on-going reviews to ensure fidelity to the model. Collect and analyze data for outcome and process measures. Evaluate outcome measure to assess strengths and weaknesses to model fidelity. Create technical assistance to address any issues. Sites must meet accreditation once every 3 years. It's a very rigorous and in-depth process with accountability to all 158+ best practice standards. Each sites supervisor is responsible to monitor home visiting staff for model fidelity. Each sites Program Manager is responsible to monitor the supervisor for model fidelity on a monthly and quarterly basis throughout the 3-year time frame. Program Managers at each site, also receive peer support calls regarding fidelity.
How Selected	In SFY20, 36% of children in foster care were under the age of two The removal rate in the county where FHA exist is one of the lowest in the state.
Target Population	Families are eligible to receive HFA services beginning prenatally or within three months of birth and can continue to support children through the age of 4 years old. Prenatal enrollment will only occur with pregnant or parenting youth in foster care. This program is designed to serve the families of children who have increased risk for maltreatment or other adverse childhood experiences. Each HFA site can determine which family and parent characteristics it targets. The HFA model offers support services for a minimum of three years regardless of the age of the child at intake, and was designed to serve **children through age five**, allowing families referred from child welfare to enroll in the program up until the child reaches 24 months of age. When referred from child welfare, may enroll up to two years of age.

Service	**Healthy Families America**
Assurance for Trauma Informed Service Delivery	See Attachment III: State Assurance of Trauma-Informed Service-Delivery
How Evaluated	Montana is requesting a waiver for evaluation of Healthy Families America, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported". See Attachment II: States Request for Waiver of Evaluation Requirement for Well-Supported Practice HFA is rated as a well-supported practice by the Title IV-E Prevention Services Clearinghouse because at least two studies with non-overlapping samples carried out in usual care or practice settings achieved a rating of moderate or high on design and execution and demonstrated favorable effects in a target outcome domain. At least one of the studies demonstrated a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome.

Service	**Nurse Family Partnership**
Level of Evidence	Well Supported
Service Category	In-Home Parent Skill Based Programs and Services
Service Description	Nurse Family Partnership (NFP) is a home-visiting program that is typically implemented by trained registered nurses. NFP serves young, first-time, low-income mothers beginning early in their pregnancy until the child turns two. The primary aims of NFP are to improve the health, relationships, and economic well-being of mothers and their children. Typically, nurses provide support related to individualized goal setting, preventative health practices, parenting skills, and educational and career planning. However, the content of the program can vary based on the needs and requests of the mother.
Version of Book or Manual	Providers will utilize the most up to date version of the manual. The current manuals being utilized in Montana is: Nurse Family Partnership. (2020). *Visit-to-visit guidelines.*
Plan to Implement	NFP is currently available in four communities through the County Public Health Departments. The Early Childhood Family Support Division (ECFSD) oversee the programs and funding. CFSD will coordination with ECFSD to: • Assess the success of the current programs • Assess the interest of additional program sites • Provide training to interested sites • Add service to current model matrix
Outcome Expected to Improve	Consistent with the outcomes identified as having a positive effect through the independent review of research conducted by the Title IV-E Prevention Services Clearinghouse, Montana expects to see the following: • Improved maternal health • Improved child health • Reduction in child maltreatment • Increased positive parenting practices • Improved family self-sufficiency

Service	**Nurse Family Partnership**
Plan to Monitor Fidelity	Montana will utilize continuous quality improvement methods to conduct on-going reviews to ensure fidelity to the model. NFP programs will utilize the web-based performance management system to collect and report characteristics, needs, services provided and progress towards goals. Each site must meet yearly accreditation of their program and provide the certificate to the State Program Manager. Each site is required to do an Annual Performance Report and submit this to the States Program Manager. Each site is required to participate in quarterly fidelity support calls
How Selected	In SFY20, 27% of children in foster care were under the age of two. In SFY20, 36% of children removed were under the age of two. NFP can provide primary prevention which is significantly important to maintain children in their homes safely.
Target Population	NFP is intended to serve first-time, low-income mothers from early pregnancy through their child's first two years. Though the program primarily focuses on mothers and children, NFP also encourages the participation of fathers and other family members. Prenatal enrollment will only occur with pregnant or parenting youth in foster care.
Assurance for Trauma Informed Service Delivery	See Attachment III: State Assurance of Trauma-Informed Service-Delivery
How Evaluated	Montana is requesting a waiver for evaluation of Nurse Family Partnership, which has been designated by the Title IV-E Prevention Services Clearinghouse as "Well-Supported". See Attachment II: States Request for Waiver of Evaluation Requirement for Well-Supported Practice. NFP is rated as a well-supported practice by the Title IV-E Prevention Services Clearinghouse because at least two studies with non-overlapping samples carried out in usual care or practice settings achieved a rating of moderate or high on design and execution and demonstrated favorable effects in a target outcome domain. At least one of the studies demonstrated a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome.

Evaluation Strategy and Waiver Request

Evaluation Strategy

Montana will request waivers to the evaluation requirements for the well-supported models of service within this plan, while implementing continuous quality improvement methods to support implementation of the models throughout Montana. The four models in Montana's Prevention Plan have all been determined to be well-supported by the Title IV-E Prevention Services Clearinghouse. A description of the Title IV-E Prevention Clearinghouse's rationale for rating these modes as "well-supported" has been provided in the "How Evaluated" section of the charts on the previous pages. CFSD is partnering with Montana State University Extension Office (MSU) to develop an evaluation of the impact of services implemented through the Title IV-E Prevention Plan. Together, CFSD and MSU will utilize the Evaluation Plan Development Tip Sheet identified in ACYF-CB-IM-19-04 and participate in the Evidence Building Academy hosted by the Urban Institute, OPRE and the Children's Bureau to inform development of the evaluation. The rigorous program evaluation is to ensure that services the state is investing in under the Title IV-E Prevention Plan are benefiting children and families.

Administrators, policymakers, service providers, and other stakeholders want to know what programs and services are accomplishing, what they cost, and how they should be operated to achieve the best possible outcomes. MSU, which is also conducting the Kinship Navigator Program evaluation, will conduct program evaluations of the above prevention services. The evaluation will occur in partnership with CFSD and service providers.

The evaluation type and design will be based on the desired purpose for the individual study, e.g., how to operate to achieve the best possible outcomes, determining cost effectiveness, or adding to the body of evidence to increase the evidence-level rating. The scope of CFSD's evaluation plan will consider existing evaluation activities or measures being completed by service or program developers.

The first two years of Montana's implementation of FFPSA will focus on formative evaluations to establish fidelity in service delivery. Starting in October 2021, the details for the evaluation plan will be confirmed, and formative evaluation readiness activities will begin, such as identifying contextual factors; developing theory of change and logic model; identifying operational factors such as organizational drivers, leadership support, and competency factors; determining availability and strength of a coaching or support system for providers; identifying data capacity and sources for collection; and conducting usability testing. The evaluation plan will include specific time frames, roles, and measures for ongoing evaluation. A baseline evaluation is anticipated to begin in October 2021. Later, reviews and studies for EBPs may transition to summative evaluations directed at analyzing client outcomes.

The following key components, in accordance with the Evaluation Plan Development Tip Sheet, will be considered in developing well-designed, rigorous evaluation plans for specific evidence-based programs or services.

Program or Service Background

- Provides context of the current situation to better understand the need for the intervention and its objective
- Describes the treatment or intervention, the target population, and the goal or desired outcome
- Articulates the theory of change
- Defines the key issues/problems the intervention seeks to address; and theoretical or causal links between intervention activities and expected changes
- States the key questions the research or study will address

Evaluation Design

- Communicates the framework or process to be followed
- Determines the type of evaluation (process, outcome, or cost)
- Lists relevant performance targets and associated indicators/measures
- Defines the sources and methodologies for measures
- Describes the research design (RCT, QED/propensity scoring, etc.), if applicable, and/or provide the evaluation criteria and procedures for review
- Maps the process using a logic model and specify short- and long-term outcomes

Data Collection

- Provides the raw material needed to calculate results and to assess program effectiveness
- Confirms that all indicators are noted on the logic model
- Ensures indicators are discrete and quantifiable
- Lists and explains tools, instruments, and/or other methods of data collection
- Determines frequency intervals for extraction
- Develops a sampling plan, if appropriate

Data Analysis

- Cleanses, transforms, and model data to confirm whether the intervention fulfills its purpose
- For quantitative data, describes specific statistical methods to be used to analyze data
- Identify statistical software applications and packages, and strategies to address anomalies
- Describes how results will be presented to mitigate bias and to ensure objectivity
- For qualitative data, describes analysis methods to be used to analyze qualitative data
- Indicates strategies to minimize personal bias of observers/data collectors
- Describes how results are validated using multiple data sources to corroborate accuracy
- Lists potential confounding factors and efforts to manage effects
- Articulates potential weaknesses or limitations in the selected research design and explain how these will be addressed or minimized

Distribution of Reports and Use of Findings

- Promotes transparency and make information about programs and services available to the public
- Identifies appropriate reports and level of detail for different audiences
- Indicates the frequency and format of methods for communicating evaluation findings
- Describes plans for disseminating evaluation findings
- Explains whether and how findings that emerge during the evaluation will inform intervention activities and program/organizational improvements (e.g., continuous quality improvement plan)

Logistics

- Coordinate staffing, timelines, budgets, and other infrastructures needed to perform program and service evaluations
- Determines the level of staffing resources needed
- Describes the evaluation roles and responsibilities of staff and others
- Lists relevant knowledge, skills, and experience of staff. Identify entities/organizations outside the core evaluation team that will be involved in the evaluation and specify their roles and responsibilities
- Provides a timeline that specifies the estimated start and end dates of all major evaluation activities, including initial planning and startup, staff recruitment and training, approval, instrument development, data collection, data analysis, submission of reports, and other dissemination activities
- Describes protocols for maintaining the security and confidentiality of electronic and hard- copy data sources
- Determines procedures for obtaining informed consent, as needed

Waiver Request

CFSD is submitting Attachment II, Request for Waiver of Evaluation Requirement for all the four models in the state's Prevention Plan. All four of the models have been vetted by the Title IV-E Prevention Services Clearinghouse and have been determined to be well-supported models as the evidence of the effectiveness of the practice is compelling. Documentation of that evidence is also attached and information on the reason for the well-supported rating has been provided in other sections of this Prevention Plan. The well-supported models in this plan are:

- Parent Child Interaction Therapy
-
- Health Families America
- Parents as Teachers
- Nurse Family Partnership

In addition, with each request for a waiver of an evaluation, DPHHS has provided documentation that the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(B)(iii)(II), including:

- How the State plans to implement the services or programs
- How implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved
- How information learned from the monitoring will be used to refine and improve practices

In general, Montana will mimic the CQI process from case reviews under the CFSR. For evaluation, Montana will collect verification of fidelity (accreditation) from those programs that are already required to have this as well as connect participation, accreditation, and outcomes such as child safety and child permanency with these programs both across the state and within specific subgroups (region, family demographics/risk factors, etc.) to understand current impacts. Montana will assess if there are trends in accredited program participation (looking statewide or by specific factor) meeting desired outcomes across the state. Considering any areas for improvement or areas of success that should be explore more deeply to understand lessons learned to improve impacts.

Montana will conduct targeted case studies to explore program outputs (fidelity/delivery of program) and outcomes (results of program) more deeply through select case studies. Utilizing the current case review process will allow for consistency and sustainability in reviewing cases within CFSD. Understanding what factors are unique for these providers and families that might be resulting in their outcomes will inform best practices within specific communities, families and Montana statewide. To track fidelity within programs that do not have accreditation like motivational interviewing. Montana will look at participation in relation to outcomes to identify the successful providers and conduct targeted case studies with those providers to understand what successful implementation looks like so we could provide "best practices" and recommendations for tracking fidelity in the future. Montana will continue to utilize research and data to improve outcomes for children and families.

Compelling Evidence of Effectiveness of Practice

Parent Child Interaction Therapy (PCIT)
The Title IV-E Prevention Services Clearinghouse shows that PCIT had favorable and statistically significant impacts on child behavioral and emotional functioning, positive parenting practices, and parent/caregiver mental or emotional health. There were no unfavorable effects.

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: Behavioral and emotional functioning	0.92 32	11 (46)	524	Favorable: 18 No Effect: 28 Unfavorable: 0
Child well-being: Social functioning	0.52 19	1 (2)	19	Favorable: 0 No Effect: 2 Unfavorable: 0
Adult well-being: Positive parenting practices	1.46 42	8 (25)	422	Favorable: 20 No Effect: 5 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.58 21	3 (6)	252	Favorable: 4 No Effect: 2 Unfavorable: 0
Adult well-being: Family functioning	0.29 11	5 (10)	177	Favorable: 0 No Effect: 10

Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group, and a negative number favors the comparison group. Effect sizes for some outcomes were not able to be calculated by the Prevention Services Clearinghouse. According to the Title IV-E Prevention Services Handbook of Standards and Procedures

Evidence Review for Parent-Child Interaction Therapy

There is substantial evidence in favor of the use of Parent-Child Interaction Therapy to increase positive parenting knowledge and practices, improve parent and child interactions and reduce child behavior and attention problems. The request for a waiver is supported by evidence demonstrating that:

- Parent-Child Interaction Therapy has been proven to have positive outcomes among various populations, which demonstrates its widespread effectiveness.
- Parent-Child Interaction Therapy has proven to have positive outcomes for populations that are similar to the target population identified in Montana's prevention plan.

Parent-Child Interaction Therapy has been evaluated and proven effective in many areas of the world and with many different populations. This treatment has proven effective for children with varying degrees of behavior challenges, including Oppositional Defiant Disorder and Attention Deficit Hyperactivity Disorder. A follow-up study of 23 of 50 original study participants was conducted and the reductions in behavior issues were demonstrated immediately after treatment and again 3 to 6 years after treatment (Hood & Eyberg, 2003). When compared to treatment as usual, Mexican American families who received Parent-Child Interaction Therapy reported greater reductions in behavior problems in children, and these reductions were also documented in observations (McCabe & Yeh, 2009). An online version of Parent-Child Interaction Therapy has also proven to have positive outcomes for rural families in Australia. The children who received PCIT with their mothers had identified conduct problems, and results demonstrate the treatment was effective in reducing these behavior problems and improving parenting practices (Fleming, Hohlhoff, Morgan, Turnell, Maiuolo, & Kimonis, 2021).

Because the Montana prevention plan aims to decrease the need for foster care placements, the target population includes families in need of intervention to decrease the risk of re-reports of child maltreatment. Parent-Child Interaction Therapy has been studied specifically with families in such situations. A randomized study of 110 parents with a known history of child abuse demonstrated that parents who received Parent-Child Interaction Therapy were less likely to have a re-report of abuse. The follow-up was conducted after roughly two years, and only 19% of abusive parents who received PCIT had a re-report, compared to 49% of parents who received standard parenting education. Parents who received PCIT also demonstrated greater improvement in parent-child interactions (Chaffin, Silovsky, Funderburk, Valle, Brestan, Balachova, Jackson, Lengsgraf, & Bonner, 2004).

Parents as Teachers (PAT)
The Title IV-E Prevention Services Clearinghouse shows that PAT had favorable impacts on child safety as well as child social and cognitive functions. The review showed that PAT produced very limited unfavorable impacts on outcomes.

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety	0.11 4	2 (6)	4825	Favorable: 2 No Effect: 3 Unfavorable: 0
Child permanency	0.16 6	1 (1)	4560	Favorable: 0 No Effect: 1 Unfavorable: 0
Child well-being: Social functioning	0.12 4	1 (6)	375	Favorable: 3 No Effect: 2 Unfavorable: 1
Child well-being: Cognitive functions and abilities	0.13 5	2 (12)	575	Favorable: 2 No Effect: 10 Unfavorable: 0
Child well-being: Physical development and health	0.08 3	1 (3)	375	Favorable: 0 No Effect: 3 Unfavorable: 0
Adult well-being: Positive parenting practices	0.27 10	1 (1)	203	Favorable: 0 No Effect: 1 Unfavorable: 0
Adult well-being: Family functioning	-0.07 -2	2 (11)	640	Favorable: 0 No Effect: 10 Unfavorable: 1
Adult well-being: Economic and housing stability	-0.09 -3	1 (10)	366	Favorable: 0 No Effect: 9 Unfavorable: 1

Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group, and a negative number favors the comparison group.

According to the Title IV-E Prevention Services Handbook of Standards and Procedures

Evidence Review for Parents as Teachers
There is substantial evidence in favor of the use of Parents as Teachers to improve parent/caregiver emotional health, increase positive parenting practices, improve child development, and increase child safety. The request for a waiver is supported by evidence demonstrating that:

- Parents as Teachers has been proven to have positive outcomes among various populations, which demonstrates its widespread effectiveness.
- Parents as Teachers has proven to have positive outcomes for the target population identified in Montana's prevention plan.

In Arizona, an assessment of over 500 parents and children who had participated in Parents as Teachers home visiting demonstrates that, when compared to peers who had not participated, greater improvements were made in parenting practices, children's academic performance, and children's in-school behavior as measured by school suspensions (Lahti, Evans, Goodman, Schmidt, LeCroy, 2019). In Missouri, a longitudinal study was conducted to examine the impacts of Parents as Teachers home visiting on school readiness, third-grade achievement, and parenting practices. Participants included 5,731 children of varying income levels and racial identities. Results indicate that Parents as Teachers is a promising prevention program in that participating parents were more likely to read to children and enroll them in preschool, which positively impacted school readiness and third-grade achievement (Zigler, Pfannenstiel, and Seitz, 2008).

The effectiveness of Parents as Teachers was examined in a comparison study in Montana, in which the study compared outcomes of a basic Parents As Teachers home visiting model and a more intense Parents As Teachers partnership model. The partnership was comprised of the local health department, a local family support non-profit, community mental health services, and public schools. While the partnership model demonstrated greater effectiveness in improving parents' emotional health, parenting practices, child development, and child safety, both models demonstrated positive outcomes (G. Haynes, Neuman III, Hook, D. Haynes Steeley, Kelley, Gatterdam, Nielson, & Paine, 2015).

Healthy Families America (HFA)
The Title IV-E Prevention Services Clearinghouse shows that HFA has favorable impacts on child safety, child well-being including cognitive functions and abilities, delinquent behavior and educational achievement and attainment, adult well-being including positive parenting practices, parent/caregiver mental or emotional health and family functioning.

Outcome		N of Studies (Findings)	N of Participants	Summary of Findings
Child safety	0.05 1	6 (105)	5702	Favorable: 4 No Effect: 101 Unfavorable: 0
Child permanency	-0.04 -1	4 (6)	4752	Favorable: 0 No Effect: 6 Unfavorable: 0
Child well-being: Behavioral and emotional functioning	0.10 3	2 (7)	1146	Favorable: 5 No Effect: 2 Unfavorable: 0
Child well-being: Social functioning	0.04 1	1 (2)	897	Favorable: 0 No Effect: 2 Unfavorable: 0
Child well-being: Cognitive functions and abilities	0.08 3	3 (9)	1555	Favorable: 2 No Effect: 6 Unfavorable: 1
Child well-being: Physical development and health	0.09 3	2 (6)	816	Favorable: 0 No Effect: 6 Unfavorable: 0
Child well-being: Delinquent behavior	0.64 23	1 (1)	793	Favorable: 1 No Effect: 0 Unfavorable: 0
Child well-being: Educational Achievement and Attainment	0.20 7	1 (3)	577	Favorable: 1 No Effect: 2 Unfavorable: 0
Adult well-being: Positive parenting practices	0.11 4	4 (27)	1518	Favorable: 3 No Effect: 24 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.10 3	4 (19)	2053	Favorable: 3 No Effect: 16 Unfavorable: 0

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Adult well-being: Parent/caregiver substance use	0.06 2	3 (15)	1876	Favorable: 0 No Effect: 15 Unfavorable: 0
Adult well-being: Family functioning	-0.02 0	4 (32)	2132	Favorable: 3 No Effect: 29 Unfavorable: 0
Adult well-being: Economic and housing stability	-0.08 -3	3 (6)	1876	Favorable: 0 No Effect: 6 Unfavorable: 0

Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group, and a negative number favors the comparison group. Effect sizes for some outcomes were not able to be calculated by the Prevention Services Clearinghouse.

According to the Title IV-E Prevention Services Handbook of Standards and Procedures

Evidence Review for Healthy Families America
There is substantial evidence in favor of the use of Healthy Families America to promote positive parenting, improve children's well-being and reduce child maltreatment. The request for a waiver is supported by evidence demonstrating that:

- Healthy Families America has been proven to have positive outcomes in a large number of states, which demonstrates its effectiveness among various populations and in various locations.
- Healthy Families America has proven to have positive outcomes for populations that are similar to the target population identified in Montana's prevention plan.

Thirty-three evaluations of Healthy Families America sites conducted in 22 states and the District of Columbia were reviewed and demonstrated positive impacts on reducing psychological aggression, neglect, minor physical aggression and severe physical abuse. Ten of the studies reviewed measured parenting attitudes and reported that parents who participated in the home-visiting program improved at a greater rate than parents in the control group (Harding, Galano, Martin, Huntington, & Schellenback, 2007). A study conducted in rural North Carolina evaluated the impact of Healthy Families American on parenting attitudes and practices and social/emotional competence of children. The results of this study indicate that parents who completed Healthy Families America home visiting exhibited positive changes to parenting attitudes and practices. The results also indicate that children in these families were less likely to exhibit social, emotional, and behavioral challenges (Cullen, Ownbey & Ownbey, 2010).

Healthy Families America has been authorized for expanded use with child welfare protocols.

This expanded use allows Home Visitors to enroll families who have been referred by child welfare agencies and who have a child who is up to 24 months in age**.** During the 2020 fiscal year, seventeen percent of Montana children removed from the home were between 3 and 24 months of age; and during the 2021 fiscal year, fourteen percent of Montana children removed from the home were between 3 and 24 months of age**.** The effectiveness of HFA for mothers who had previous substantiated reports of abuse or neglect is supported by findings from a randomized controlled trial of a subgroup of mothers receiving HFA home visiting in New York. The subgroup was comprised of 104 mothers who had at least one substantiated CPS report prior to enrolling in HFA home visiting services. The study found that the number of substantiated reports of child abuse or neglect was twice as high among mothers in a control group (not receiving HFA services) as for the mothers receiving HFA services (Lee, Kirkland, Miranda-Julian, & Greene, 2018).

The target population for Healthy Families America home visiting includes families with young children and families expecting the birth of a child, and the program has proven effective in attaining positive outcomes for this target population. The population served by Healthy Families America is the same target population identified in Montana's prevention plan, which indicates this program will be successful in helping Montana reach its objectives.

Nurse Family Partnership (NFP)
The Title IV-E Prevention Services Clearinghouse shows that NFP has favorable impacts on child safety, child well-being including physical development and health, and adult well-being including economic and housing stability.

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety	-0.10 -3	4 (14)	197308	Favorable: 1 No Effect: 7 Unfavorable: 6
Child well-being: Behavioral and emotional functioning	0.18 7	1 (7)	417	Favorable: 0 No Effect: 7 Unfavorable: 0
Child well-being: Cognitive functions and abilities	0.21 8	2 (13)	1353	Favorable: 1 No Effect: 12 Unfavorable: 0
Child well-being: Physical development and health	0.02 0	3 (16)	111412	Favorable: 5 No Effect: 11 Unfavorable: 0
Child well-being: Educational Achievement and Attainment	-0.09 -3	1 (5)	396	Favorable: 0 No Effect: 4 Unfavorable: 1
Adult well-being: Positive parenting practices	0.18 7	1 (1)	407	Favorable: 0 No Effect: 1 Unfavorable: 0
Adult well-being: Parent/caregiver mental or emotional health	0.06 2	1 (8)	1121	Favorable: 0 No Effect: 8 Unfavorable: 0
Adult well-being: Parent/caregiver substance use	0.00 0	2 (3)	1733	Favorable: 0 No Effect: 3 Unfavorable: 0
Adult well-being: Family functioning	0.03 1	2 (2)	1470	Favorable: 0 No Effect: 2 Unfavorable: 0

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Adult well-being: Parent/caregiver physical health	-0.01 0	2 (9)	2668	Favorable: 0 No Effect: 9 Unfavorable: 0
Adult well-being: Economic and housing stability	0.06 2	2 (13)	1577	Favorable: 1 No Effect: 12 Unfavorable: 0

Note: For the effect sizes and implied percentile effects reported in the table, a positive number favors the intervention group, and a negative number favors the comparison group. Effect sizes for some outcomes were not able to be calculated by the Prevention Services Clearinghouse.

According to the Title IV-E Prevention Services Handbook on Standards and Procedures

Evidence Review for Nurse Family Partnership

There is substantial evidence in favor of the use of Nurse Family Partnership to improve maternal and child health, increase positive parenting practices, and reduce child maltreatment. The request for a waiver is supported by evidence demonstrating that:

- Nurse Family Partnership has been proven to have positive outcomes among various populations living in different circumstances, which demonstrates its widespread effectiveness.
- Nurse Family Partnership has proven to have positive outcomes for populations that are like the target population identified in Montana's prevention plan.

A review of three separate large-scale, randomized controlled trials with diverse populations indicates program success in improving care provided by parents, decreasing injuries and ingestions, and improving the social, emotional, and language development of infants (Olds, 2006). The trials reviewed by Olds also demonstrate long-term positive impacts on family self-sufficiency, specifically as a result of fewer subsequent pregnancies, greater maternal participation in the work force, and decreased reliance on public safety net programs, such as food stamps.

A review of numerous Nurse Family Partnership program evaluations (six randomized trials and several additional analyses) aiming to project long-term outcomes, concluded that NFP has positive impacts on the health of participating mothers. NFP participants are less likely to smoke during pregnancy; are more likely to breast feed, which has positive health impacts for mothers and their infants; have fewer subsequent pre-term births; and are less likely to experience domestic partner violence (Miller, 2015).

A study was conducted to follow-up with parents and children who had participated in a previous study, which included follow-up with both those who received the service and control group participants. Child Protective Services records were used to examine maltreatment over a

fifteen-year period following the home visiting intervention. Results indicate that families who participated in Nurse Family Partnership home visiting had significantly fewer substantiated maltreatment reports than their control group counterparts (Eckenrode, Campa, Morris, Henderson, Bolger, Kitzman, & Olds, 2016).

Like Healthy Families America, the target population for Nurse Family Partnership participation matches the target population identified in the Montana prevention plan. The research discussed demonstrates that Nurse Family Partnership has proven positive outcomes for low-income, first time mothers, part of the target population identified in the Montana prevention plan.

CQI Strategy

DPHHS has provided documentation that the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(B)(iii)(II), including:

- How the State plans to implement the services or programs
- How implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved
- How information learned from the monitoring will be used to refine and improve practices

Montana will replicate the CQI process from case reviews under the CFSR. For evaluation,

1) Montana will collect verification of training (i.e., accreditation, completion of appropriate training) as a fidelity measure from Families First programs. These are already required to be documented by service organizations to ensure delivery of evidence-based Families First programs,
2) Further fidelity tracking data (observation or provider self-report of delivery process) will be collected from targeted case studies to understand program delivery and outputs more deeply.
3) Families First eligible families with outcomes data already available (i.e., child safety-reported, substantiated abuse and child permanency- placement stability) will be explored for trends predicted by service delivery factors (i.e. training status and region of delivery for statewide data and fidelity to delivery process for families receiving services from case-study providers), controlling for demographics.
4) Montana will assess if there are trends across the state in comparison to trends with case-study providers.

Comparisons will provide indication of strengths and areas for improvement that should be explored more deeply. These insights will also provide priority areas for professional development to improve outcomes in future delivery. Specifically, Montana will conduct targeted case studies (20 randomly selected case file reviews from across the state, semi-annually) to explore program output fidelity (training/delivery of program) and outcomes (results of program) more deeply through select case studies. Building on the current case review process as outlined above will allow for consistency and sustainability in reviewing cases within CFSD. Understanding what factors are unique for these providers and families that might be contributing to their outcomes will inform best practices within specific communities, families,

and Montana statewide. CQI evaluation will continue to utilize research and data to determine how to support evidence-based programming within Montana and improve outcomes for children and families.

Program Specific CQI Processes

Parent Child Interaction Therapy (PCIT)

A team led by Montana Department of Public Health and Human Services staff, representing the Child and Family Services Division and the Early Childhood and Family Support Division will partner with global PCIT trainers and a Montana State University (MSU) evaluation team to oversee the CQI of PCIT services in Montana.

1) Verification of PCIT provider training status will be compared to child safety- reported, substantiated abuse and child permanency- placement stability outcomes.
2) For PCIT providers within the case study, either global trainers (if provider is currently in their consultation phase of training) or MSU evaluators (if training was previous completed) will collect provider report of incorporated services according to the PCIT fidelity checklist for select sessions. PCIT will provide a deidentified ID for participants that can be matched to child safety- reported, substantiated abuse and child permanency- placement stability as well as Child behavior outcomes will be assessed through required PCIT Provider reports, which include whether Eyberg Child Behavior Inventory scores improved at the completion of therapy compared to service onset. Case studies will also explore casework's concerted effort to address caregiver, parent, and child wellbeing (meeting their needs, involvement in planning, frequency, and quality of visits) in addition to child safety and permanency measured above to determine associations. Additional supporting evidence artifacts such as case notes or participant goals will also be collected as available from providers to understand connections more deeply between delivery and outcomes.

Data sharing agreements will be established for the purpose of collecting fidelity measures and outcome data, and the evaluation team will collect progress report data from existing PCIT Providers and from global trainers for data collected from new PCIT Providers. Data related to PCIT-specific program outcomes will be gathered during targeted case studies and de-identified information will be shared with the MSU evaluation team following the file review process. The MSU evaluation team will provide semi-annual written reports outlining the results of the targeted case studies (file reviews) to the state leadership team led by the CFSD. The leadership team will collaborate with the evaluation team to make recommendations to improve service delivery if results indicate opportunities to improve outcomes.

Parents as Teachers (PAT)

Montana's Child and Family Services Division (CFSD) will partner with the Early Childhood Family Support Division (ECFSD) to collect the annual program fidelity measures, Performance Measures Reports, from each site offering Parents as Teachers home visiting. These sites are MIECHV funded and PAT affiliates. As PAT affiliates, sites are required to complete and submit annual fidelity measures to the PAT national organization; and to sustain MIECHV funding, sites are required to submit the certificate verifying fidelity from the national

organization to the Program Manager in ECFSD. The Performance Measures report captures:

- Staff training and qualifications
- Service delivery
- Program-specific outcomes:
    - Increase positive parenting
    - Increase child safety

The CQI of PAT will include:

1. Verification of PAT provider training status will be compared to child safety-reported, substantiated abuse and child permanency-placement stability outcomes across the state to determine if there are significant associations.

2. For PAT providers in the case study, Performance Measures Reports data will be collected for comparison between delivery and outcomes. Case studies will also explore casework's concerted effort to address caregiver, parent, and child wellbeing (meeting their needs, involvement in planning, frequency, and quality of visits) in addition to child safety and permanency measured above to determine associations. Changes in positive parenting as measured through HOME screener for parent child interaction. Additional supporting evidence artifacts such as case notes or participant goals will also be collected as available from providers to understand connections more deeply between delivery and outcomes.

ECFSD will share training status of all providers from the Performance Measures Reports as well as service delivery data for those providers in case studies with MSU evaluation team. This data will be linked to child safety and permanency data shared by CFSD with the MSU evaluation team. They will then provide semi-annual written reports outlining the results of the targeted case studies (file reviews) to the state leadership team led by the CFSD. The leadership team will collaborate with the evaluation team to make recommendations to improve service delivery if results indicate improvements are needed.

Healthy Families America (HFA)

Healthy Families America is currently being offered in one community in Montana, and the local HFA site is accredited, which requires the site to conduct monthly monitoring on multiple levels to ensure fidelity to the model. This site will partner with Montana's Child and Family Services Division (CFSD) to provide HFA home visiting services to families with a prevention plan; the site will provide verification of accreditation status; and the site will share data necessary to ensure the following outcomes are being achieved:

- Reduction in child maltreatment
- Increase in positive parenting

The CQI of HFA will include:

1. Verification of HFA provider training status will be compared to child safety- reported, substantiated abuse and child permanency- placement stability outcomes across the state to determine if there are significant associations.

2. For HFA providers in the case study, reports from monthly monitoring will be collected for comparison between delivery and outcomes. Case studies will also explore casework's concerted effort to address caregiver, parent, and child wellbeing (meeting their needs, involvement in planning, frequency, and quality of visits) in addition to child safety and permanency measured above to determine associations. Changes in positive parenting practices will be measured by Family Stress Inventory and Bonding Assessment Tool. Additional supporting evidence artifacts such as case notes or participant goals will also be collected as available from providers to understand connections more deeply between delivery and outcomes.

Data related to HFA-specific program outcomes will be gathered during targeted case studies and de-identified information will be shared with the MSU evaluation team following the file review process. This data will be linked to child safety and permanency data shared by CFSD with the MSU evaluation team. They will then provide semi-annual written reports outlining the results of the targeted case studies (file reviews) to the state leadership team led by the CFSD. The leadership team will collaborate with the evaluation team to make recommendations to improve service delivery if results indicate improvements are needed.

Nurse Family Partnership (NFP)

Montana's Child and Family Services Division (CFSD) will partner with the Early Childhood Family Support Division (ECFSD) to ensure that all sites offering Nurse Family Partnership home visiting are meeting accreditation requirements, which ensure fidelity. The sites are MIECHV funded and NFP affiliates. As NFP affiliates, sites are required to complete and submit annual fidelity measures; and to sustain MIECHV funding, sites are required to submit the Annual Performance Report to the to the State Program Manager in ECFSD. For quality improvement purposes, the outcomes being assessed include:

- Reduction in child maltreatment
- Increase in positive parenting practices

The CQI of NFP will include:

1. Verification of NFP provider training status will be compared to child safety- reported, substantiated abuse and child permanency- placement stability outcomes across the state to determine if there are significant associations.

2. For NFP providers in the case study, Annual Performance Reports will be collected for comparison between delivery and outcomes. Case studies will also explore casework's concerted effort to address caregiver, parent, and child wellbeing (meeting their needs, involvement in planning, frequency, and quality of visits) in addition to child safety and permanency measured above to determine associations. Changes in positive parenting practices will be measured through DANCE Screener (Dyadic Assessment of Naturalistic Caregiver-child Experiences). Additional supporting evidence artifacts such as case notes or participant goals will also be collected as available from providers to understand connections more deeply between delivery and outcomes.

Data related to NFP-specific program outcomes will be gathered during targeted case studies and de-identified information will be shared with the MSU evaluation team following the file review

process. This data will be linked to child safety and permanency data shared by CFSD with the MSU evaluation team. They will then provide semi-annual written reports outlining the results of the targeted case studies (file reviews) to the state leadership team led by the CFSD. The leadership team will collaborate with the evaluation team to make recommendations to improve service delivery if results indicate improvements are needed.

The table below illustrates CQI elements and sources for each evidence-based program.

Indicator	**PCIT**	**HFA**	**PAT**	**NFP**
Source	PCIT fidelity tool, Process report and Case study protocol	Monthly monitoring and Case study protocol	MIECHV Performance Measurement report and Case study protocol	MIECHV Performance Measurement report and Case study protocol
Fidelity Measures				
Training/current accreditation	Statewide and Case Study	Statewide and Case Study	Statewide and Case Study	Statewide and Case Study
Delivery Dosage (timing, frequency, frequency, and quality of visits)	Case Study only	Case Study only	Case Study only	Case Study only
Delivery of Program Content/Activities	Case Study only	Case Study only	Case Study only	Case Study only
Concerted effort to meet needs of all parties	Case Study only	Case Study only	Case Study only	Case Study only
Concerted effort to involve all parties in planning,	Case Study only	Case Study only	Case Study only	Case Study only
Outcome Measures				
Child Safety (reported, substantiated abuse)	Statewide and Case Study	Statewide and Case Study	Statewide and Case Study	Statewide and Case Study
Child permanency-placement stability outcomes	Statewide and Case Study	Statewide and Case Study	Statewide and Case Study	Statewide and Case Study
Program-specific outcomes	**Child behavior** – ECBI (Eyberg Child Behavior Inventory)	**Parent practices** – Family Stress Inventory and Bonding Assessment Tool	**Parent practices** – HOME (Home Observation for the Measurement of the Environment)	**Parenting practices**– DANCE Screener (Dyadic Assessment of Naturalistic Caregiver-child Experiences)

Monitoring Child Safety

CFSD will monitor and oversee the safety of children who receive prevention services under Montana's Title IV-E prevention plan. Children's safety is paramount and is central to child well- being. Children must be protected from the trauma of abuse and neglect. When safe to do so, children must also be protected from the trauma of separation from their families by effectively utilizing prevention services. Assessing safety and risk is an ongoing process throughout the entire in-home services case.

CFSD uses a comprehensive safety decision-making model, called Safety Assessment and Management System (SAMS). SAMS is used to assess and monitor the safety and risk of children and families, more specifically:

- Identify Immediate Danger
- Develop immediate safety plans (Protection Plan)
- Gather comprehensive information about the family's functioning
- Help determine which family situations qualify for in-home safety planning
- Identify services necessary to strengthen parents' protective capacities
- Assist with the development of on-going safety plans
- Identify the level of intensity needed for intervention with the family

SAMS Assessment

The SAMS Assessment is used to identify possible threats to a child's safety and what interventions are necessary to protect a child from threats to their safety. The outcome of the SAMS Assessment helps guide the decision about the need for ongoing intervention with the family. Interventions may include a safety plan that is implemented immediately to control or mitigate the identified threat. The caseworker will complete a safety plan for all children in the household when any threat to safety has been identified.

When a prevention plan is opened as a result of a child protective services (CPS) investigation, the caseworker will complete the initial SAMS Assessment prior to referring the case for in-home services. A Family Support Team will be assembled and launched to identify the services necessary to keep the child/ren in the home, while ensuring the voice of the parent is sought and considered within the development of the prevention plan.

If the prevention plan is not the result of an investigation, the caseworker will complete the Request for Services and identify if the family will participate in a prevention plan and what services they are requesting.

The Child and Family Services Division Title IV-E Unit will be responsible for determining and documenting if a child receiving the service meets the Prevention Candidate definition approved in this plan. The eligibility determination process does not utilize the SAM models reference above. SAMS is used to monitor child safety. It is not an eligibility tool.

Family Support Team

The Family Support Team (FST) allows children to remain in their own homes, while managing for safety threats. CFSD's mission is to keep children safe, while strengthening their family. When services are immediately put in place, the family will be more capable and willing to engage in services and be more transparent and open in partnering with CFSD to keep their children safe.

The FST meets weekly on cases where a Protection Plan or In-Home Safety Plan is being utilized. The FST's purpose is to ensure the services are provided to the family in a timely manner. The FST meeting, developing goals in real time, and completing referrals together, allow the FST providers to understand the need of the service, and the safety threat that is being managed through their service. By wrapping services around the family in a timely manner, child/ren will be able to remain in their homes, and with their families. The prevention plan will coordinate efforts to address the imminent risk of removal.

The overall purpose of FST is to assist in having children remain in their homes while promoting and ensuring the children's safety and reducing the risk and recurrence of maltreatment of children by their caregiver.

Child, Family and Service Provider Contacts

Child, family, and service provider contacts are used to help monitor safety and ongoing assessment of risk. Regular and purposeful visiting with the child and family enables the caseworker to assess how well the parents and other caregivers are meeting the children's needs for safety and well-being, as well as the family's progress towards case goal achievement. Private conversations with the children outside the presence of the caregiver are used as part of the ongoing monitoring of the child's safety. Communication with providers is essential to gain a full understanding of how the family is progressing in treatment services and maintaining any safety services required.

In-person contact by the Prevention Specialist will be required weekly through the first 30 days of the prevention plan. As the family stabilizes and service providers report improvements in the behaviors that impact imminent risk of removal, caseworker contact may gradually decrease to no less than once a month. The in-home safety plan, along with the prevention plan, is reviewed every 30 days with input from the child/ren, caregiver/s and providers. Based on this review, the intensity of the caseworker contact with the family will be determined.

Prevention Plan Review

Prevention plans are routinely reexamined and evaluated to monitor and track the child and parent or kin caregiver's progress during the provision of services. The written plan is developed with input from the child, family and Family Support Team and is tracked and adapted throughout the case. All parents and kin caregivers will have the opportunity to participate in the development and reexamination of the written plan. All children listed on the plan who are developmentally appropriate will have the opportunity to participate in the development of the plan. Updated assessments may be used to inform the plan review. The written plan will be reviewed as changes and improvement necessitate and updated at a minimum of every month. Any changes to the plan will be communicated to all parties involved in the prevention plan.

Consultation and Coordination

Consultation

Child and Family Services Division has consulted with other divisions within DPHHS responsible for administering mental health and substance abuse prevention and treatment services, as well as home visiting and in-home parent skill building. CFSD has collaborated with private and public services providers who deliver such services. Currently, CFSD and ECFSD work in close partnership to support and implement a coordinated intake and referral system for evidence-based home visiting services funded through MIECHV. All, local, MIECHV-funded home visiting programs receive referrals through their local CPS offices, however, 13 counties have one home visitor dedicated to receiving and following up on these referrals. This intentional partnership has led to a more robust coordinated intake and referral systems not only critical for the support of families but also a major function of MIECHV-funded services. Additionally, this partnership extends beyond the local communities to the state agencies overseeing the programs and has resulted in deeper communication, collaboration, and systems-level partnerships. CFSD developed a Road Map and Implementation Plan, with a specific sub-group for the Prevention Plan. The State Advisory Council will guide implementation of the provisions of the Family First Prevention Services Act. The State Advisory Council consists of current and retired legislators, service providers, law enforcement, tribal social services, youth, foster parent, country attorneys, Children's Trust Fund, Court Improvement Program director, judges, and the Child and Family Services Ombudsman.

CFSD held in-person meetings with community providers to gain feedback and collaborate. A statewide provider survey was conducted regarding the availability of current services and interest in being trained in approved EBPs. DPHHS has launched a new division, Early Childhood Family Support Division (ECFSD), focused on aligning and enhancing services for at risk families. CFSD has consulted, coordinated, and collaborated with ECFSD, Children's Mental Health Bureau (CMHB), and Addictive and Mental Disorders Division (AMDD) on FFPSA related issues.

Consultation efforts helped guide selection of the service array for the Montana's Title IV-E Prevention Plan and will continue to guide development of a continuum of mental health and substance abuse prevention and treatment services, and in-home parent skill-based programs, to be added through future plan amendments.

Coordination

Montana CFSD will continue to utilize its model matrix to contract with private providers to provide evidence-based services (EBS) identified by the California Clearinghouse and non-EBS services that promote and support maintaining children in their home. These services are provided under Title IV-B Parts 1 and 2 of the Social Security Act. Title IV-B Part 1 funds are primarily used for child welfare caseworker costs. In this capacity, these funds support critical activities essential to caseworker activities with children and families.

The service model matrix contracts require all providers to have the ability to provide at least one, if not all three, of the following service categories: family support, preservation, and family reunification. The actual services provided are dependent upon the individual needs of the family referred for services, and CFSD and providers used family engagement to create focused and individualized treatment planning. A family must have been referred to one of these providers by the Department for the family to be served using title IV-B, subpart 2 funding. Safety factors, measured goals, defined expected outcomes, and family involvement in case planning was required to be reported by these service providers.

Below is a description of the flexible services provided using title IV-B, subpart 2 funding. These services were made available as necessary to non-family and kinship foster care providers and focus on in-home services and a strength-based approach to building on a family's focused goals and abilities designed to ensure the safety of children. Montana's robust array of family support and family preservation services provided through the Department includes, but is not limited to, the following:

- Child and family assessment
- Family Support Teams (FST)
- Home visiting
- Parenting skill building (appropriate discipline, role modeling, age-appropriate expectations, bonding)
- Educational classes (GED, occupational, parenting)
- Family Engagement Meetings (FEM)
- Organizational skills (budgeting, housekeeping, shopping, meal preparation)
- Family behavior skills (anger management, communication, role modeling)
- Mental health therapy for individuals and families and other mental health services
- Preventive health services
- Resource linkage for housing, job services, basic needs, substance abuse, and other mental health issues
- Transportation for access to services or activities provided by the Department
- Accessing and providing hard services
- Mentoring for birth parents and children
- Inpatient, residential or outpatient substance abuse treatment services
- Assistance to address domestic violence
- Services and activities designed to facilitate access to and visitation of children by parents and siblings

- Family Visitation
- Services designed to provide temporary childcare and therapeutic services for families including crisis nurseries; and
- Well supported, supported, promising, and general practice models as appropriate (i.e., evidence-based, trauma focused, or evidence-informed practices, models, and programs).

Family reunification services include, but are not limited to, the same robust array of services listed above. These services were provided by contractors and the CFSD staff in specific service areas of the state where contract providers were limited, or not available. Contract compliance procedures and protocols, as described earlier for family support and family preservation services, also apply to family reunification services.

Throughout all the title IV-B, subpart 2 services, the level of intensity, and the length of each family is provided services changes greatly between prevention, preservation, crisis intervention, family support, and reunification services. There were no limits on how many times a child and family could receive services. CFSD continues to make these services available, as applicable and necessary, to non-family and kinship foster care providers.

Montana's allocation of title IV-B, subpart 2 funds is approximately $710,000.00, per fiscal year. The Department continues matching general funds to federal funds at above the required 20% federal match rate to provide for a continuum of services. CFSD's allocation of title IV-B, subpart 2 funds will be utilized for services to address prevention of child abuse and neglect, intervention and protection, treatment services, foster care support, family preservation services, family support services, reunification services, adoption, and kinship care.

CFSD continues to ensure that final expenditures in each service category (family support, family preservation, family reunification, and adoption promotion) are reached with a minimum of 20% of the total title IV-B, subpart 2 allocation. The required state match provides a balance of flexible service provisions. CFSD will continue to:

- Combine its report on the family support and family preservation services and report separately on the family reunification and adoption promotion and support services; and,
- Analyze the services provided with these funds to ensure that the allocation of the funds maximized the benefits that can be derived from this funding.

In SFY20 approximately 2,000 children and 1,400 families were provided prevention, family support and family preservation and reunification services:

- Family Support and Family Preservation services: Approximately 900 children / 630 families
- Reunification services: Approximately 1100 children / 775 families

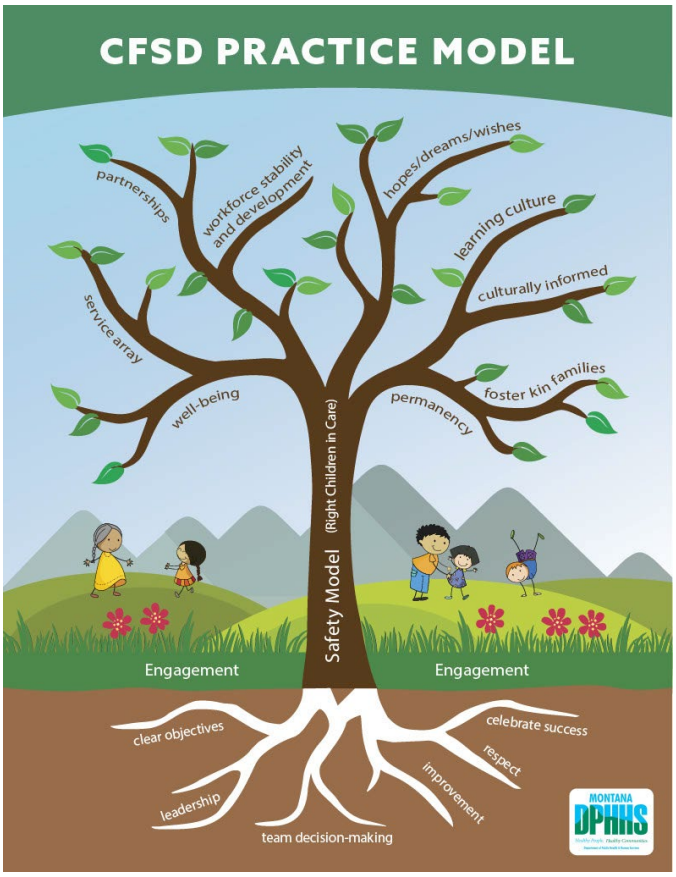
The Department provides title IV-B, subpart 2 flexible and comprehensive services to as many of the fifty-six counties through fee for service rate matrix contracts. If the need arises in a rural county where there are limited-service providers, or a specific service is not available but needed, the Department will work with the providers in contracted counties to provide flexible service provisions listed prior.

Child Welfare Workforce Support

Ongoing Support

In Montana, child welfare services are state administered and supervised. DPHHS and CFSD are committed to supporting and enhancing a competent, skilled, and professional workforce. This highlighted area of development within the Montana Program Improvement Plan (approved February 2020) will be a focus over the next 2 years.

In 2018, the CFSD management team established Leadership Guiding Principles to provide direction to leadership across CFSD for supporting frontline caseworkers, as well as creating expectations for improved service delivery to families. In 2020, management launched an overarching practice model to support frontline caseworkers in understanding their roles and responsibilities to families. A supervisor training is in development to increase supervisors' ability to support, educate, and counsel frontline caseworkers. CFSD, in coordination with the University of Montana, Center for Children, Families and Workforce Development have developed training teams to support development of competency and skills of the workforce in delivering quality casework and trauma-informed and evidence-based services.



The Practice Model builds from the Leadership Guiding Principles and highlights engagement as the foundation for success with families. Caseworkers and supervisors were trained in Motivational Interviewing in 2019 to increase engagement skills with families. This practice model provides caseworkers with a structure for approaching their work with children and families.

A focus on engagement skill building will enhance implementation of the Title IV-E Prevention Plan, by ensuring that the workforce is qualified, and that caseworkers develop appropriate prevention plans and conduct ongoing assessments to ensure ongoing child safety.

Child Welfare Workforce Training

CFSD is committed to having a prepared, well-trained workforce. The agency provides training and support for caseworkers in assessing what children and their families need, connecting to families served, knowing how to access and deliver needed trauma-informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of services.

In CFSD, casework for prevention services aligns with the practice model, which focuses on the skills of engaging, assessing, teaming, planning, and intervening. As such, CFSD training for caseworkers for prevention services will serve as a reinforcement of training for overall good case practice.

Caseworker training addresses engaging families in a trauma-informed way to conduct safety and risk assessments using SAMS and to assess overall family strengths and needs. For prevention training, additional emphasis will be given to incorporating those assessed needs into the written prevention plan in a way that identifies the strategy to allow the child to remain safely at home or with a kin caregiver, and connecting to appropriate evidence-based trauma-informed services and programs. The training will reinforce the importance of preserving the parent-child relationship, maintaining children safely in their home with in-home services when possible, and the importance and priority of kinship placement in the event a child cannot safely remain at home.

Training will be provided to existing caseworkers, supervisors, and administrators at the local level. The prevention services concepts will also be incorporated into new employee Practice Model training, which will include in-class training, simulation training, and field experience.

Targeted training will take place with designated Prevention Services Specialists. Staff will be trained on how to conduct a comprehensive family assessment and the provision of prevention services that includes building knowledge, skills, and abilities in accordance with CFSD core competencies. Training will address the areas of:

- Family centered practice
- Cultural humility
- Family engagement
- Importance of early intervention
- Family needs assessment
- In-Home safety planning
- Collaboration; partnership with Tribes and service providers
- Trauma informed care
- Protective factors framework
- Positive youth development
- Intimate partner violence
- Mental health
- Substance use disorders

- Family Engagement meetings
- Evidence based prevention service provision
- Kinship care
- Ongoing safety management
- Continuous quality improvement; and
- Documentation

Additional resources will also be provided to caseworkers for each of the specific evidence-based mental health, substance abuse, and in-home parent skills services included in Montana's Title IV-E Prevention Plan. The training will coach workers to understand the target population best served by the approved models, the specific needs the models have been determined to effectively address, the anticipated outcome of the model and the providers, and their locations, where the well-supported services are available. Supervisors will coach and mentor CPS staff in identifying the well-supported models that are most likely to successfully address the specific issues bringing the family to the agency's attention and the process for referring families to the services.
CFSD core trainings provided to all Child Protection Specialist workers will also address and reinforce requirements for prevention services.

Training will address assessment of youth and family strengths and needs while also addressing identified risk and protective factors using the Family Functioning Assessment. Training will also be provided on case planning, which focuses on skills needed to engage with a youth and family, reducing risk through building skills and assisting the youth to remain or transition back into their community. Casework skills will be further strengthened with training on Motivational Interviewing and wrap around services approaches. Supervisors will provide feedback of critical child protection specialist processes. Supervisors will observe and provide coaching on the worker's use of motivational interviewing skills with youth and families, information gathering for the FFA, coordination of child and family team meetings, and development of the Prevention Plans.

An initial statewide training was held in June 2021 regarding how to utilize the safety model's safety plan determination assessment to identify if a prevention plan is appropriate for the family. The procedure and the prevention plan template were updated to align with the safety model. Fidelity reviews will be occurring to ensure correct implementation of prevention plans. Updates have been made to Montana's new worker training, so all new employees understand the use of prevention plans.

Our Prevention and Support Services Program Manager meets routinely with providers and local offices to identify appropriate prevention services and improve coordination between CFSD and community providers. Family Support Teams are one venue where communication and identification of appropriate prevention services for families occurs.

Prevention Caseloads

CFSD has established processes to determine, manage, and oversee caseload size and type for

prevention caseworkers. Prevention cases will be managed by Prevention Services Specialists. Prevention services are a component of in-home services. Whenever possible within existing region and office staff resources, specialization is encouraged. For example, in larger offices, some teams will specialize in managing in-home cases. Some smaller offices will have individual workers that specialize in managing in-home cases. In more rural, smaller offices, ongoing workers that manage combined in-home and foster care cases will be assigned prevention cases. The target caseload standard for caseworkers managing prevention cases is a ratio of 1:12 for CFSD.

Prevention Cases will be identified through Family Support Team (FST) meetings. The FST consists of the Family Support Team Coordinator, Child Protection Specialist, Prevention Services Specialist, family, natural supports, and community providers.

Overseeing caseload size and type is essential. Manageable caseloads and workloads can make a significant difference in a caseworker's ability to spend adequate time with children and families and on completing critical case activities, and ultimately having a positive impact on outcomes for children and families. Successfully managing caseworkers' workload can help caseworkers better serve the children and families on their caseload.

Regional Administrators will provide oversight to the caseload size and case type for caseworkers. The Fiscal Bureau Chief provides monthly data reports to Management Team. Reports include information about caseloads, such as number of youths in care and reports in each county. CFSD will enhance the report to include prevention cases. Each of the state's six regions has a Regional Administrator that monitors the region and team specific caseload data, including overall number of cases and the different case types.

Assurance on Prevention Program Reporting

The Montana Department of Public Health and Human Services provides an assurance in Attachment I that DPHHS will report to the Secretary required information and data with respect to the provision of services and programs included in Montana's Title IV-E Prevention Plan. This will include data necessary to determine performance measures for the state and compliance. Data will be reported as specified in Technical Bulletin #1, Title IV-E Prevention Data Elements, dated August 19, 2019. (See Attachment I)

Child and Family Eligibility for the Title IV-E Prevention Program

Child and family eligibility for the Title IV-E Prevention Program is based on a child being at imminent risk of entry into foster care, but able to safely remain at home or in a kinship placement with receipt of approved evidence-based services under the child's prevention plan.

Prevention Candidate Definition

For the purposes of the Title IV-E Prevention Program, a child under age 18 is a prevention candidate when at serious risk of entering or reentering foster care, but able to remain safely in the home or with a relative as long as mental health, substance use disorder, or in-home parenting skill-based programs or services for the child, parent or kin caregiver are provided. To

be eligible for Title IV-E Prevention Services, the child's prevention candidate status must be designated in the child's prevention plan prior to provision of services. Pregnant and/or parenting foster youth are also eligible for prevention services when services are designated in the child's foster care plan prior to provision of services.

A child may be at serious risk of entering foster care based on circumstances and characteristics of the family as a whole and/or circumstances and characteristics of individual parents, children, or kinship caregiver that may affect the parents' ability to safely care for their children.

The CFSD Title IV-E Eligibility Unit is responsible to determine and document if a child meets the Prevention Candidate definition. This unit will determine the Prevention Candidate eligibility for all children whether the children are under State of Montana or tribal jurisdiction.

Each of the four factors below must be met in order to establish candidacy

First:
The child, parent/s or caregiver/s have come to the attention of CFSD or tribal agencies through a report to Centralized Intake.

Second:
(a) the allegation of abuse or neglect did not meet the statutory definition of abuse or neglect, but the family needs services to prevent imminent risk of entering foster care; or
(b) the report requires an investigation, and the child(ren) can remain in the parent's home safely with appropriate prevention services

Third:
One of the following the circumstances or characteristics is present:

- Children who have exited foster care through reunification (within the last 12 months), guardianship or adoption
- Children who have had a previous removal or report to Centralized Intake
- Children with in-home and out-of-home protection plans
- Children with in-home safety plans and no legal involvement
- Children born with positive toxicology results
- Children born to mothers with a positive toxicology result
- Pregnant adolescents and young adults (ages 18-23) or parenting youth (to age 18)
- Children of parents who have been in foster care
- Children who live in a household where substance abuse, domestic violence or mental health impacts the daily functioning of the caregivers and/or children
- Children with siblings in foster care

Fourth,
The parent/s or caregiver/s must agree to engage in the prevention plan. For the purpose of this plan, caregivers include individuals that are related by birth, marriage or unrelated but have an emotionally significant relationship with the child that takes on the characteristics of a family relationship.

Also, for Indian children, the definition of kin caregiver under ICWA (25 U.S.C. Sec. 1903) will be utilized, which includes:

- An "extended family member" as defined by the law or custom of the Indian child's tribe; or,
- In the absence of such law or custom, a person who has reached the age of 18 and who is the Indian child's grandparent, aunt or uncle, brother or sister, brother-in-law or sister-in-law, niece or nephew, first or second cousin, or stepparent;or
- An Indian custodian, as defined by ICWA case law.

Children who are under the placement and care responsibility of the state are, by definition, in foster care and are not prevention candidates when placed with a kin caregiver

Prevention Candidate Determination

Child and family eligibility for the Title IV-E Prevention Program is determined through assessments conducted by caseworkers for the Division of Child and Family Services (CFSD) utilizing designated assessment tools. These assessments (of children identified in a prevention plan) determine if the child is at substantial risk of entering foster, but can remain safely in the home or in a kinship placement as long as the title IV-E prevention services that are necessary to prevent the entry of the child into foster care are provided.

CFSD caseworkers assess children and families utilizing the immediate danger assessment and family functional assessment (FFA), which together identify a child's risk of entry into foster care and the child and family's needs related to protective capacities and vulnerabilities impacted by mental health, substance abuse, and/or parenting skills.

A comprehensive decision-making assessment is utilized during a child protective services investigation and identify if a child can remain safely at home with a safety plan, and if families have needs related to substance use, mental health, and/or parenting skills. Montana's Safety Assessment and Management System utilizes a functional assessment (Family Functional Assessment) completed with the family throughout the investigation time period and determines if there is impending danger. In addition, the Safety Plan Determination (SPD) assessment outlines if the child(ren) can be maintained in their home safely while the parents' protective capacities are strengthened to remedy the impending danger.

The Family Functional Assessment (FFA) is used to create a shared understanding of the reasons for agency involvement and to create plans and strategies to address the concerns assessed. The FFA focuses on the unique dynamics of each family and the role each individual play in this dynamic. The purposed of the FFA is to organize information for decision-making, analyze case data, identify the presences or indicators of threats to child safety and determine which families CFSD will serve. There are six assessment areas: maltreatment, nature, parenting—discipline, parenting—general, adult general functioning and child functioning.

When completion of the FFA indicates impending danger and the SPD indicates an in-home safety plan is enough to manage safety of the children while treatment services can be provided, a prevention plan will be utilized.

The investigating Child Protection Specialist will complete an eligibility form that identifies under which criteria that child or family meet the prevention candidacy definition. The family's individualized prevention plan will outline the evidence-based models that will be used to increase the parents' protective capacities and skills to safely care for their children. The prevention case will be transfer to a Prevention Child Protection Specialist. The Prevention Specialist will continually assess for safety and ensure the appropriate services are being implemented to support the family's needs.

A child may be reassessed for prevention candidate status at the end of each 12-month prevention episode utilizing the processes described above, based on continuing serious risk for

entry into foster care and continuing need for evidence-based prevention services to safely prevent the entry of the child into foster care. Candidate status is confirmed through a new prevention plan.

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Attachments

Attachment I: State Title IV-E Prevention Program Reporting Assurance
Attachment II: State Request for Waiver of Evaluation Requirement for a Well-Supported:
- Practice for Parents as Teachers
- Nurse Family Partnership
- Health Families America
- Parent Child Interaction Therapy

Attachment III: State Assurance of Trauma-Informed Service Delivery
Attachment IV: State Annual Maintenance of Effort (MOE) Report