CHAPIN HALL

Final Report

Maryland Social Services Administration Placement Needs Assessment

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January 2025

Recommended Citation

Small, L., Brunsink, A. M., Heisler, K., Lardner, M., Naqvi, S. & Olson, S. (2024). *Maryland Social Services Administration Placement Needs Assessment: Final Report*. Chicago, IL: Chapin Hall at the University of Chicago

Acknowledgements

We would like to thank the Maryland Department of Human Services and Social Services Administration Executive Teams for the opportunity to dive deeply into the needs of youth in and expected to enter out-of-home care in Maryland. Invaluable to this project was the support and responsiveness of DHS Principal Deputy Secretary for Programs Carnitra White, DHS Senior Advisory to the Secretary Stephen Ligget-Creel, SSA Executive Director Dr. Alger Studstill, SSA Executive Consultant Julie Farber, SSA Principal Deputy Executive Director Tenille Thomas, SSA Deputy Executive Director Hilary Laskey, Director of Baltimore City Department of Social Services Brandi Stocksdale, and SSA staff DebraLynn Pierson, Keisha Peterson, Charles Wood, and Shana Proctor.

We would especially like to thank the volunteer case reviewers, without whom the case review portion of this project would not have been possible: Christine Abbatiello, Enimien-Omon Ayewoh, Lisa Beeman, Debbe Fairbank, Yvonne Fox, Lori Engle, Jennifer Evans, Debbe Fairbank, Elizabeth Orff, Everly Owens, Renee Pierson, Terry Prochnow, Denise Plater, Theresa Kleppinger, Rachel Maconachy, Debbie Marini, Robin McGuckian, Faith Murphy, Claudia Nelson, Stephanie Thomas, Prisca Tuyishime, Carrie Vincent, Sara Savanuck, Jennifer Wright, Susan Loysen, Mary Jackson, Jody Simmons, Sarah Shrewsbury, Hayley Landes, Tina Linkous, and Larissa Royal. All views and insights were taken into consideration when forming recommendations.

Disclaimer

The points of view, analyses, interpretations, and opinions expressed here are solely those of the authors and do not necessarily reflect the position of Maryland's Social Services Administration.

In addition, this final report of Maryland Social Services Administration's placement needs assessment does not include the executive summary, which is a separate but complementary document.

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INTRODUCTION AND BACKGROUND

Research suggests that an individualized approach to the selection of placements for children in out-of-home care based on each child's unique needs, preferences, and background leads to improved placement and well-being outcomes (Konijn, Baart, van Rooij, Collonessi, Lindauer, & Assink, 2019). Matching children with appropriate placements based on needs can decrease the likelihood of disruptions and placement changes, which in turn can increase successful reunification, adoption, and other forms of permanency and contribute to positive mental health outcomes, better academic performance, and healthier overall development (Konijn et al., 2019; Rubin, O'Reilly, Luan, & Localio, 2007; Mabille Skoglund, Thørnblad, & Holtan, 2021; Clemens, Helm, Myers, Thomas, & Tis, 2017).

As states face growing pressure to minimize both the entry of children into foster care and the frequency of placement changes unrelated to reunification, kinship care, or adoption, placement-matching and proactively projecting placement needs based on historical trends have become growing strategies to address the challenge of multiple placement disruptions and anticipate needed system capacity. Selection of placement based on needs may also contribute to the overall effectiveness of child welfare services, allowing resources to be allocated more efficiently and improving agency-wide permanency outcomes. Several states have included placement-related priorities in recent reform initiatives (Oregon Department of Human Services, 2019; Texas Department of Family and Protective Services, 2017).

The Department of Human Services in Maryland has collaborated with Chapin Hall at the University of Chicago to conduct a comprehensive statewide assessment of the placement needs of youth currently in and anticipated to enter out-of-home care in Maryland. This assessment examines those needs.

Maryland Department of Human Services (DHS), Social Services Administration (SSA)

The Maryland Department of Human Services (DHS) administers the Social Services Block Grant (Title XX), Title IV-B, and Title IV-E Programs. DHS oversees services provided by the 24 Local Departments of Social Services (LDSS) and those purchased through community service providers. The DHS/Social Services Administration (SSA) under the Executive Director is responsible for the social service components of the Title IV-E plan and programs. The offices or units within SSA provide the infrastructure to support the overall child welfare mission. Direct services to children and families are

provided through Maryland's 24 LDSS. Each LDSS Director reports to the DHS Deputy Secretary for Programs and is responsible for ensuring that child welfare services are delivered to children and families in accordance with the vision of the Secretary and policies set forth by SSA.

CJAMS (Child, Juvenile, and Adult Management System)

CJAMS, or the Child, Juvenile, and Adult Management System, is Maryland's Comprehensive Child Welfare Information System (CCWIS). CJAMS is the statewide case management system used by workers and supervisors providing support for child protective services, family preservation, foster care, and adult protection.

LITERATURE REVIEW

Child Welfare Reform: Strengthening System Capacity and Supports

Out-of-home care capacity and placement needs assessments are instrumental in ensuring that child welfare systems are responsive, collaborative, and equipped to meet the diverse needs of youth in their care. Capacity and placement needs assessments serve as a foundation for data-driven decision-making, strategic planning, and ongoing improvements to enhance the overall effectiveness of the child welfare system and its ability to meet the needs of the youth in its care. This literature review focuses on the approaches and methodologies used by Oregon, Texas, Illinois, and Washington, D.C. in assessing the needs of youth in their care and their foster care system capacity. These states have systematically evaluated their placement arrays, utilizing quantitative and qualitative methods to enhance overall capacity and quality. Their approaches and methodologies served as informative benchmarks for shaping our approach and methods for this current placement needs assessment.

Assessing Out-of-Home Placement Capacity: Approaches and Methods

States have adopted various approaches to conducting placement needs assessments to better understand and predict the needs of children served within the out-of-home foster care system. Oregon, Texas, Illinois, and Washington, D.C. relied on their child welfare information systems as primary data sources, and all but one incorporated information extracted from completed Child and Adolescent Needs and Strengths (CANS) assessments into their analyses. The CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Texas and Oregon also used historical placement data to identify trends and project the demand for their continuum of out-of-home placement types based on the youth's physical, behavioral, or mental health needs.

Uniquely, Oregon used a five-step process in its assessment: randomized sampling for system-wide representation, case reviews, panel reviews, system inventory, and matching (Oregon Department of Human Services (ODHS), 2019). Researchers used historical placement data to pull a random sample of 1,000 removals from its child welfare information system, spanning three years, representing the overall child welfare system's characteristics and diverse representation based on geography, age,

and other factors (ODHS, 2019). The state developed an assessment tool for case reviews, systematically documenting various child and family characteristics, vetted by a team of experts to ensure accuracy and comprehensiveness. These case reviews examined individual removals within a six-month post-removal window, considering both electronic and hard-file case documentation. They made assumptions about future placements' stability and foster care providers' capability (ODHS, 2019). Cases were grouped based on potential placement issues, and an expert panel organized out-of-care options by intensity levels. Experts subsequently reviewed case information to determine suitable placements, removing personal identifiers like race and location to prevent biases (ODHS, 2019). The final steps included capturing the current system inventory through contracting records, making assumptions to estimate the family foster care system's inventory, and identifying "identical twins" data for a statistically identical control group in impact analysis (ODHS, 2019). The sampled population and placements were then scaled to system size to establish the estimated number of placement beds, informing the required buffer size (ODHS, 2019). The difference between the estimated number of placement beds (with buffer) and the current inventory determined the system capacity gap.

Similarly, in its annual foster care capacity needs assessments, Texas utilizes historical placement data pulled from its child welfare information system to project future foster care capacity needs that vary by county and/or catchment areas (Texas Department of Family and Protective Services (TDFPS), 2017). To aid their analyses, researchers developed a range of maps and tables designed to collectively offer insights into capacity needs within a county or regional catchment (TDFPS, 2017). The visual tools are used to address several key questions, including the distribution of foster care demand across the state, identifying areas with surplus or insufficient supply to meet placement demand, understanding the types of placements lacking in each area, examining collaborative efforts among counties to share foster care resources, and determining strategic targets for resource development by the Texas Department of Family and Protective Services (TDFPS, 2017). Texas' forecasting methodology integrated past trends with projected changes in removals and expected duration of youth stays (TDFPS, 2018). This approach also included estimates for placements categorized by service level within each catchment area per age group and gender (TDFPS, 2023). Texas made three modifications to secure forecasted data, as noted in its 2017 assessment report: eliminating a point-in-time approach and using a child’s complete placement flow; considering resource sharing among neighboring counties; and analyzing future placements by type, age, and assigned level of care (TDFPS, 2017). In analyzing a child's complete placement flow within a fiscal year, placement needs were defined and based on the volume of children navigating the system (TDFPS, 2017). By examining placement flow, Texas could inform foster care providers about the expected volume of new placement requests for children from their area. Moreover, this analysis provided insights into the anticipated ages and service levels required (TDFPS, 2017).

Like Texas and Oregon, Illinois adopted a comprehensive strategy utilizing both quantitative and qualitative methods. However, Illinois distinguished itself by concentrating specifically on its behavioral health system. Researchers engaged in comprehensive data collection efforts to examine the needs of youth in Illinois requiring residential treatment programs using data from their child and youth-centered information system and its child welfare information system (Chapin Hall at the University of Chicago, 2023). Researchers created business process maps to visualize the paths to critical services, highlighting entry points, eligibility criteria, and institutional factors influencing service provision (Chapin Hall at the University of Chicago, 2023). Researchers also used two Latent Class Analyses (LCA) to understand better the distinct needs and subgroups within the residential treatment population (Chapin Hall at the University of Chicago, 2023). The first LCA focused on DCFS youth who required residential placement; The second LCA analyzed a sample of Illinois K–12 students with Individualized Education Programs (IEP) eligible for, but not necessarily placed in, residential placement (Chapin Hall at the University of Chicago, 2023). To conduct the LCA, the following dimensions were selected for the model: gender, age, placement instability, hospitalization history, detention history, developmental disability, emotional/behavioral issues, risk behaviors, danger to others, and danger to self (Chapin Hall at the University of Chicago, 2023). Additionally, data from CANS assessments was utilized to formulate dimensions related to developmental disability, emotional/behavioral issues, risk behaviors, danger to others, and danger to self. This method helped researchers gain a deep understanding of the important factors that affect the residential service requirements of young people in Illinois (Chapin Hall at the University of Chicago, 2023).

Washington D.C.'s (the District) 2021 needs assessment examined administrative and program data within each section to identify resource gaps in its current child welfare system (District of Columbia Child and Family Services Agency (DCCFSA), 2021). The assessment also examined trends in youth entering foster care and evaluated changes in entry rates. Like Oregon, Texas, and Illinois, the District's methodology utilized various quantitative and qualitative data sources, such as its child welfare information system, manual databases, data from Healthy Families Thriving Communities Collaboratives, surveys, focus groups, interviews, qualitative case reviews, and quantitative analysis (DCCFSA, 2021). Researchers gathered data from multiple perspectives, including youth, birth parents, resource parents, and child welfare professionals. Surveys and focus groups provided valuable insights; however, the District acknowledged that data limitations due to the absence of required fields in specific data systems limited their ability to generalize about populations, services, and outcomes (DCCFSA, 2021). It is important to note that these data limitations experienced by the District are not unique. All states deal with similar limitations to different extents.

Placement Needs Assessments Driving System Improvements

Despite these data challenges, Oregon, Texas, Illinois, and Washington, D.C. are all leveraging placement needs assessment findings to identify systemic issues and drive improvement initiatives across their out-of-home care continuums. Notably, Oregon developed an assessment tool to match youth with suitable placements based on needs, uncovering systemic gaps that led to recommendations for improving capacity building in step-down care. Through its adoption of annual assessments, Texas leveraged findings to discern strengths and gaps in its continuum of care, paving the way for expansion in the levels of care based on youth needs. The state further streamlined placement information by introducing the General Placement Search system in 2021, offering caseworkers real-time data on placement availability and vacancies (TDFPS, 2023). Washington, D.C.'s 2021 needs assessment revealed a decline in children served in foster care, underscoring the importance of prevention programs. Annual assessments continue to provide the District insights for enhancing placement stability, addressing placement trends, and guiding strategic interventions (DCCFSA, 2022). Meanwhile, assessment findings pinpointed system obstacles and disparities in Illinois, culminating in statewide recommendations for improved data tracking, increased capacity, and enhanced coordination across systems (Chapin Hall at the University of Chicago, 2023).

The transformative impact of comprehensive, statewide capacity and placement needs assessments is evident in the advancements made by these states. In the next section, we detail the methods used to conduct this assessment of the placement needs of youth currently in and anticipated to enter out-of-home care in Maryland.

METHODOLOGY

Research Objectives and Methods

The assessment approach and methodology utilized in this assessment are informed by the insights gleaned from the above-noted literature review of foster care capacity and placement needs assessments conducted in other states. This assessment was guided by the three research objectives and methods shown in Table 1.

Table 1. Placement needs assessment objectives and methods

Research Objective	Method
1. **Describe the placement needs of children historically served by Maryland's foster care system**, with a specific focus on children who were determined to be medically fragile or had developmental disabilities, pregnant or parenting, placed out of state, or experienced hospital overstays or stays in hotels and offices. This objective also provides details about the demographics, characteristics, trends, and placement patterns of these youth.	Descriptive analysis of CJAMS[1] and other administrative data SSA has collected for these populations. Case review of child placement information and placement referral forms for a sample of children with hospital overstays, hotel stays, or office stays.
2. **Forecast the number of placements into each placement setting Maryland should anticipate** in the next state fiscal year.	Grouped hierarchical forecasting based on historical entry and placement patterns. This technique forecasts the number of placements anticipated by region and placement setting. The forecast is based solely on historical patterns and assumes no

[1]CJAMS, or the Child, Juvenile, and Adult Management System, is Maryland's Comprehensive Child Welfare Information System (CCWIS). CJAMS is the state-wide case management system used by workers and supervisors providing support for child protective services, family preservation, foster care, and adult protection.

Research Objective	Method
	significant changes in policy, practice, or the child welfare population.
3. **Develop needs profiles** based on children historically served by Maryland's child welfare foster care system.	Latent Class Analysis of CANS assessment results to identify distinct profiles of children based on similar needs and strengths, and to examine the relationship between these profiles and placement decisions.

In addition to the specific methods described above, the assessment team also met with key SSA staff, the Staff Attorney for the Director's L.J. Legal Counsel, the Program Manager for Court Processes for Baltimore City Department of Social Services, the SSA Child Welfare Medical Director, the SSA hospital liaison, and researchers at the University of Maryland School of Social Work who work closely with and provide CJAMS analytical files to SSA and its partners.

Terms and Definitions

Hospital Overstays, Hotel Stays, and Office Stays

A hospital overstay was defined as children who experienced a hospital admission where the *actual* length of stay in the hospital (*Date of Discharge* minus *Date of Admission*) exceeded their *expected* length of stay by 10 or more days.[2] A hotel stay was considered any period of hotel start dates (i.e., entries) and end dates (i.e., exits) that occurred within six consecutive days of each other; entries occurring more than six days since the previous exit constituted a new hotel stay. Finally, office stays were calculated in hours by children who spent more than four hours in the SSA office building[3] within six consecutive days of each other; entries and exits that occurred more than six days since the previous exit and were greater than four or more hours constituted a new office stay.

[2]"Ten or more" days was used to identify children who had experienced a prolonged hospital overstay that was more likely due to challenges in finding an appropriate placement for the child vs. factors unrelated to placement availability.

[3]If the exit date was missing, the child was assumed to still be in the office. In these cases, the length of stay was as of January 12, 2024 (i.e., the censor date). "More than four hours" was used because this is the consent decree requirement.

Placement Settings and Types

For this assessment, specific placement settings were grouped into five broad placement types shown in Table 2. The definitions provided are based on the Code of Maryland Regulations (COMAR).[4] For most analyses, the Foster Care placement type is separated into Foster Care (Non-relative) and Foster Care (Relative/Kin).

Table 2. Placement types and definitions

Placement Type	Definition
Foster Care	Continuous 24-hour care and support services provided for a minor child by an individual, or individuals certified by a licensed child placement agency as foster parents[5]. (Sec. 07.05.02.02)
Group Homes (Non-therapeutic)	A facility owned, leased, or operated by a licensee that provides: (a) Residential services for youths such as care, diagnosis, training, education, and rehabilitation; and (b) A group living experience. (Sec. 14.31.05).
Group Homes (Therapeutic)	Therapeutic living services for at least four, but not more than eight, children by providing access to a combination of developmental, diagnostic, and therapeutic mental health services in a home-like environment. (Sec 10.21.07.08)
Residential Treatment Center	A program of care provided in a residential setting by a provider on a 24-hour basis for longer than 24 hours to a child or children unless otherwise provided by state law. (Sec. 14.31.02.03)
Treatment Foster Care	A 24-hour substitute care program, operated by a licensed child placement agency or local department of social services, for children with a serious emotional, behavioral,

[4]The Code of Maryland Regulations can be found and searched online at https://dsd.maryland.gov/Pages/COMARSearch.aspx.

[5]Certain settings classified under Foster Care may not align with the regulatory definition outlined in COMAR, such as informal relative and kin settings (e.g. 'Biological Parent').

Placement Type	Definition
	medical, or psychological condition as described in Sec. 07.02.21. (Sec.07.05.02.02)

Table 3 shows how each specific placement setting observed in CJAMS was mapped to the five placement types.

Table 3. Placement settings mapped to the five broad placement types

Foster Care	Group Homes (Non-therapeutic)	Group Homes (Therapeutic)	Residential Treatment Center	Treatment Foster Care
Non-Relative Regular Foster Care Respite Care Emergency Foster Home Care Intermediate Foster Care Foster Care - Home Foster Care - Non-Foster Home Setting Adoption Pre-finalized Adoptive Homes Independent Living Residential Program SILA Home/Apartment Own Home/Apartment **Relative/Kin** Formal Kinship Care Relative/Fictive Kin Home Restricted (Relative) Foster Care	Alternative Living Units Emergency Group Shelter Care Mother/Baby Program Residential Group Home Teen Mother Programs	Therapeutic Group Homes	DJS Funded Facility/not detention Residential Treatment Centers	Treatment Foster Care (Private) TFC, Level 1 TFC, Level 2 TFC, Level 3 TFC, Level 4 Treatment Foster Care

Foster Care	Group Homes (Non-therapeutic)	Group Homes (Therapeutic)	Residential Treatment Center	Treatment Foster Care
Biological Parent Father & Stepmother/Paramour Home Father's Home Mother and Father's Home Mother and Stepfather/Paramour Mother's Home				

There are ten additional settings or living arrangements workers can select in CJAMS which were not mapped to any of the five placement types: Trial Home Visit, College, Halfway House, Homeless Shelter, Job Corps, Summer Camp, Adult Correctional Institution, Secure Juvenile Detention, Homeless, and Runaway. These settings were excluded in many analyses involving placement settings, such as first placements upon entry and placement moves. Many of these settings represent a temporary absence from the child's ongoing foster care placement and are generally not considered a formal placement. Excluding such placements is consistent with the Children's Bureau's guidance on what constitutes an official placement, at least as far as reporting to The Adoption and Foster Care Analysis and Reporting System (AFCARS) is concerned.[6]

Regions

Maryland is comprised of 24 jurisdictions: 23 counties and Baltimore City. When reporting results by jurisdiction, some smaller jurisdictions were grouped into regions and others were kept separate, per the map shown in Figure 1 and Table 4. These regions were developed specifically for this placement needs assessment in collaboration with SSA.

[6] Children's Bureau (March 5, 2024). Child Welfare Policy Manual: 1.2B.7 - AFCARS, Data Elements and Definitions, Foster Care Specific Elements, Placements (https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=150)

Figure 1. Maryland regions used for the placement needs assessment

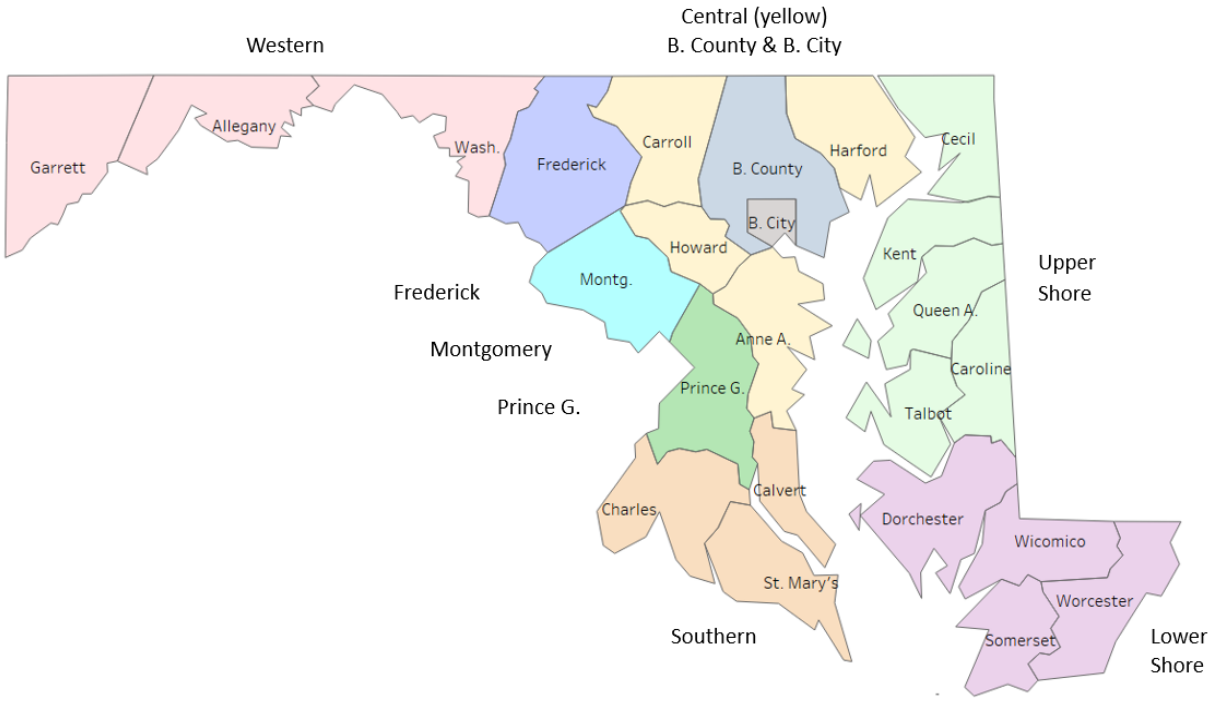


Table 4. Regions developed for this placement needs assessment

Region	Counties
Western	Garrett, Allegany, Washington
Central	Howard, Anne Arundel, Harford, Carroll
Upper Shore	Cecil, Kent, Queen Anne's, Caroline, Talbot
Lower Shore	Dorchester, Wicomico, Worcester, Somerset
Southern	Charles, Calvert, St. Mary's
No region assigned	Baltimore, Baltimore City, Frederick, Montgomery, & Prince George's

Placement Needs

Placement needs were defined in various ways depending on the availability of data and the population of interest. Generally, the administrative, quantitative data in CJAMS is limited when it comes to *direct* measures or mentions of child behavioral and/or mental health needs . For example, there are many children placed in settings (like a facility approved or licensed by the Developmental Disabilities Administration) or whom have characteristics (like prescribed medications) which would require a diagnosis, but the diagnosis information in CJAMS is blank. Other examples include female youth placed in Teen Mother Programs who have no documented history in CJAMS of being pregnant or parenting. These and other examples are described in more detail in each section of this report. More direct indicators of need are likely available in reports that workers can upload into CJAMS, such as results of mental health and physical evaluations, but reviewing this kind of documentation was beyond the scope of this assessment. Consequently, many of the findings in this assessment are based on the assessment team's analysis of children's *inferred* needs based on the administrative data. As an organizing framework and informed by the scope of work and available data, inferred needs were grouped into the following categories. These categories organize the forthcoming results.

- Children entering care in a state agency with an historically low entry rate
- Age at entry
- Race and ethnicity
- Circumstances of removal
- Past and current placements
- Placement instability (e.g. number of placement changes/moves within a year)
- Pregnant and parenting status
- Placement in certain settings (e.g. Developmental Disabilities Administration (DDA)-approved or licensed providers)
- Children placed out of state
- Presence of an Individualized Education Program (IEP)

To address the limited needs data in CJAMS, the team conducted a limited case review for a sample of children with hospital overstays, hotel stays, and office stays. Information on needs was extracted from several placement referral forms used by Maryland's caseworkers: the Child Placement Information Form, Placement Referral Form, Form 818, and Form 872. These forms and the case review process will be described later.

It is important to note that the needs of the child are often intertwined with the capacities and needs of the foster care provider, as well as the child's family and kin network, with some of whom the child may be reunified. Assessing the needs of providers, the child's family, and the child's community – other than what could be inferred from the administrative data – was beyond the scope of this assessment, but such an assessment is critical for understanding the placement needs of children and the supports and services needed while they are in care.

FINDINGS

Research Objective 1 - Describe the placement needs of children historically served by Maryland's child welfare foster care system.

Introduction

This objective involved analyzing historical data on children who entered Maryland's foster care system over the past five state fiscal years (SFY 2020 to 2024). This analysis included, to the extent possible based on available data, specific information on children who were determined to be medically fragile or had developmental disabilities, were pregnant or parenting, were placed out of state, or who experienced hospital overstays or stays in hotels and/or offices. For children in hospital overstays, hotels, and offices, some of the children may have entered care before SFY 2020 but were still included in the analysis.

Analysis for this objective consisted of descriptive statistics by various groupings of interest, including year of entry, region, age, race and ethnicity, circumstances of removal, and placement settings. All data cleaning and analyses were performed in R (version 4.3.3) and R Studio (version 2024.04.1). Tables and figures were done in R and Tableau (version 2024).

The source, type, and amount of data differed for certain populations of children. For example, at the time of this assessment, SSA had been using tracking sheets outside of CJAMS to track children in hospital overstays, hotels, and offices.[7] The hospital overstay and hotel data can include children from any jurisdiction, while office data is limited to Baltimore City.[8] Because the methods, analytic approach, and findings varied for certain populations, the results below are organized according to these four populations:

- **Population 1** – Children historically served by Maryland's foster care system with placements in foster care, group homes, residential treatment centers (RTCs), and treatment foster care. This

[7]In November 2023, SSA transitioned away from using a separate tracking system for hospital overstay children. Workers now enter this information in a new area of CJAMS.

[8]The Modified Consent Decree in *L.J., et al. v. Ruth Massinga, et al.* requires Baltimore City Department of Social Services (BCDSS) to track and report on children in BCDSS custody who experience office stays lasting longer than 4 hours.

population will also include children with hospital overstays, hotel stays, and office stays, but we dedicate separate sections to these three populations to examine them in greater detail.

- **Population 2** – Children historically served by Maryland's foster care system with one or more hospital overstays.
- **Population 3** – Children historically served by Maryland's child welfare system with one or more hotel stays.
- **Population 4** – Children historically served by Maryland's child welfare system with one or more office stays.

Population 1 – Children historically served by Maryland's foster care system with placements in foster care, group homes, residential treatment centers, and treatment foster care.

Data

Data for this population included all children who entered Maryland's foster care system between SFY 2020 and SFY 2024 (the reporting period; 7,796 removal episodes after data cleaning). We refer to this as the "served file". Data was provided to the assessment team by the University of Maryland, which created the served file based on CJAMS data as of July 12, 2024. By grouping children according to when they entered care, we can observe and describe the full experience and trajectory of each child, starting with a common timeframe shared by each cohort. For example, children entering care in 2020 may have entered a slightly different foster care system – with different policies, practices, workers, and conditions – than children who entered in 2024. Analysis of entry cohorts allows one to detect differences and track changes in placement patterns that could be due to new programs, policies, practices, or historical events.

The served file included demographic, case, and placement data for children who entered care at any point during the reporting period. The file included one record per child, per removal episode, per placement. Children who entered care at age 18 or older were excluded. The University of Maryland provided three additional datasets for children served during the reporting period (also derived from CJAMS) which the assessment team merged into the served file, matching on the child's unique identifier (CJAMS Person ID, referred to hereafter as the CJAMSPID). These files contained data on 1) physical and mental health diagnoses and prescribed medications, 2) whether the child was ever documented as pregnant, parenting, or both, and 3) a list of youth in care who were identified as having a relationship of "biological mother" or "biological father" to another known individual with an age that is appropriately younger than the youth. Significant efforts were made to address data quality concerns evident in the served file. These efforts involved removing records due to data quality issues or imputing data, such as missing placement end dates, based on values in related

records. Appendix A summarizes some of the data quality challenges encountered during analyses and how they were addressed.

Results

Rate of entry

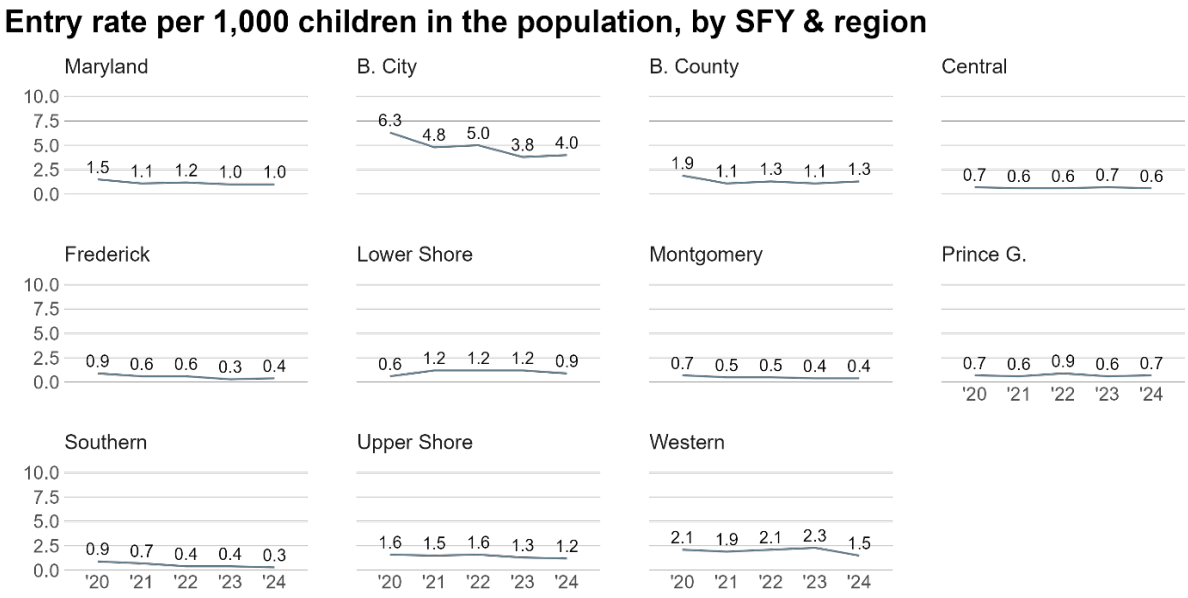
According to the latest data from the Children's Bureau (as of February 2024), Maryland has the second lowest entry rate in the country, with 0.91 entries per 1,000 children.[9] A low entry rate is not unusual for Maryland, which has maintained a low entry rate relative to other states for many years. States with low entry rates tend to bring in children with more difficult and complex needs than other states, and for whom outcomes like placement stability and timely permanency may be more difficult to achieve. The impact of low entry rates, and the assumed higher needs of children who come into care in these states, is so significant that the Children's Bureau includes a state's entry rate as a risk-adjuster when calculating a state's risk standardized performance (RSP) for permanency in 12 months for children entering care.[10] Figure 2 shows the entry rate per 1,000 children for Maryland and each region, by SFY (See Appendix B for entry rates by jurisdiction).[11]

[9]Children's Bureau (February 2024). National – Supplemental Context Data (a supplement to Maryland's Child and Family Services Review Round 4 Data Profile). A state's foster care entry rate is the number of children who enter care in a 12-month period divided by the state's census child population as of July 1st of each year. The entry rate per 1,000 creates a standard reference point (in this case, every 1,000 children in a state's child population) which facilitates comparisons across states whose population sizes might differ.

[10]As part of the Child and Family Services Reviews (CFSR), Round 4, states are required to meet or exceed a certain level performance, known as a national standard, on seven CFSR statewide data indicators. If they do not meet the national standard, they must include the indicator in a Performance Improvement Plan (PIP). Risk-adjustment is an effort to compare states more equitably with each other when determining their performance, based on characteristics like the state's entry rate and the age-mix and size of its child welfare population.

[11] Maryland's entry rate shown in Figure 2 (1.0 in the most recent [SFY]] is based on analysis from the University of Maryland, whereas the .091 entry rate reported earlier is based on analysis from the Children's Bureau using data from a slightly different timeframe.

Figure 2. Entry rate per 1,000 children in the population, by SFY and region



Central = Anne Arundel, Carroll, Harford, & Howard | Lower Shore = Dorchester, Somerset, Wicomico, Worcester
Upper Shore = Caroline, Cecil, Kent, Queen Anne's & Talbot | Southern = Calvert, Charles, St. Mary's
Western = Allegany, Garrett, Washington

Census data is from the National Center for Health Statistics (2020 Vintage Bridged-Race Postcensal Population Estimates).

While all regions show low entry rates and mostly steady declines over the past five years, Baltimore City's entry rate has been noticeably higher than all others', every year. In other words, as a proportion of the child population, children in Baltimore City are more frequently removed from home than children in any other region.

Table 5 shows the number and percentage of children who entered care in Maryland by SFY and region. (See Appendix C for this data by jurisdiction). Maryland experienced a decrease in foster care entries over the observed period, with entries falling from 1,956 in 2020 to 1,352 in 2024. While the absolute numbers have decreased, the proportional distribution of entries across the regions has remained relatively stable. Baltimore City consistently had the highest percentage of foster care entries, followed by Baltimore County and the Central region. The Southern region, Upper Shore, and Western region consistently had lower percentages of all state entries, reflecting their smaller populations.

Table 5. Number and percentage of children entering care, by SFY, and region

Region	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Maryland	1,955	1,501	1,620	1,368	1,352	100%	100%	100%	100%	100%
B. City	750	566	592	451	467	38%	38%	37%	33%	35%
B. County	333	205	241	194	231	17%	14%	15%	14%	17%
Central	200	172	185	207	190	10%	11%	11%	15%	14%
Frederick	56	39	37	21	22	3%	3%	2%	2%	2%
Lower S.	27	51	50	50	40	1%	3%	3%	4%	3%
Montg.	168	115	109	106	105	9%	8%	7%	8%	8%
Prince G.	150	115	177	122	136	8%	8%	11%	9%	10%
Southern	79	63	39	38	26	4%	4%	2%	3%	2%
Upper S.	84	79	84	66	60	4%	5%	5%	5%	4%
Western	108	96	106	113	75	6%	6%	7%	8%	6%

A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

Central = Anne Arundel, Carroll, Harford, & Howard
Lower Shore = Dorchester, Wicomico, Somerset, Worcester
Upper Shore = Caroline, Cecil, Kent, Queen Anne's, Talbot
Southern = Calvert, Charles, St. Mary's
Western = Allegany, Garrett, Washington

Age at entry

Some placement needs of children can be inferred based on the age they enter care, e.g. infants who enter care have very different needs than youth who enter in their late teens. Age alone, of course, is insufficient to determine where a child should be placed, but age is a contributing factor for most placements. Table 6 shows the number and percentage of children who entered care in Maryland by age and region for the most recent SFY (2024).[12] (See Appendix D for this data by jurisdiction). The percentages are unique to each region (i.e. they show the percentage of children by age group for that region's total entries), thus reflecting their unique case mix. An upcoming section on circumstances of removal shows how several circumstances of removal vary by age at entry.

[12]When data are reported for one year, SFY 2024 is used because it is the most recent year for which a full year of data was available.

Table 6. Number and percentage of children entering care, by age group and region (SFY 2024)

Region	Total	Total	< 1	1 - 4	5 - 10	11 - 13	14 - 17	< 1	1 - 4	5 - 10	11 - 13	14 - 17
Maryland	1,352	100%	273	256	325	190	308	20%	19%	24%	14%	23%
B. City	467	100%	112	88	107	63	97	24%	19%	23%	13%	21%
B. County	231	100%	44	32	59	32	64	19%	14%	26%	14%	28%
Central	190	100%	29	32	51	34	44	15%	17%	27%	18%	23%
Frederick	22	100%	7	4	5	2	4	32%	18%	23%	9%	18%
Lower S.	40	100%	4	10	11	7	8	10%	25%	28%	18%	20%
Montg.	105	100%	25	22	25	8	25	24%	21%	24%	8%	24%
Prince G.	136	100%	20	30	27	21	38	15%	22%	20%	15%	28%
Southern	26	100%	8	5	4	3	6	31%	19%	15%	12%	23%
Upper S.	60	100%	11	14	14	8	13	18%	23%	23%	13%	22%
Western	75	100%	13	19	22	12	9	17%	25%	29%	16%	12%

A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

Central = Anne Arundel, Carroll, Harford, & Howard
Lower Shore = Dorchester, Wicomico, Somerset, Worcester
Upper Shore = Caroline, Cecil, Kent, Queen Anne's, Talbot
Southern = Calvert, Charles, St. Mary's
Western = Allegany, Garrett, Washington

In SFY 2024, about 39% of children entering care were younger than five years of age, 38% were ages 5 to 13, and 23% were 14 - 17. Frederick and the Southern region had the highest percentage of young children (< 1) entering care (32% and 31%, respectively),[13] followed by Baltimore City and Montgomery (24%) and Baltimore County (19%).

Race and ethnicity

The unique placement needs of children from different racial and ethnic groups has been well-established in the literature. Table 7 shows the number and percentage of children who entered care in Maryland by race, ethnicity, and region for the most recent SFY (2024). (See Appendix E for this data by jurisdiction). As with the age percentages, these percentages reflect each region's unique case mix.

[13]The number of entries in these areas is very low, so small changes for any age group can manifest as large percentages.

Table 7. Number and percentage of children entering care by race and ethnicity and region (SFY 2024)

Region	Total	Total	Black	Hisp.	White	Two or More	Other	UTD	Black	Hisp.	White	Two or More	Other	UTD
Maryland	1,352	100%	658	108	310	94	4	178	49%	8%	23%	7%	0%	13%
B. City	467	100%	356	27	49	15		20	76%	6%	10%	3%		4%
B. County	231	100%	78	13	75	11	1	53	34%	6%	32%	5%	0%	23%
Central	190	100%	67	10	72	22	2	17	35%	5%	38%	12%	1%	9%
Frederick	22	100%	7	3	8	4			32%	14%	36%	18%		
Lower S.	40	100%	16		18	3		3	40%		45%	8%		8%
Montg.	105	100%	31	31	10	13		20	30%	30%	10%	12%		19%
Prince G.	136	100%	72	16	1	1		46	53%	12%	1%	1%		34%
Southern	26	100%	12		4	5		5	46%		15%	19%		19%
Upper S.	60	100%	4	5	38	3		10	7%	8%	63%	5%		17%
Western	75	100%	15	3	35	17	1	4	20%	4%	47%	23%	1%	5%

A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

Central = Anne Arundel, Carroll, Harford, & Howard
Lower Shore = Dorchester, Wicomico, Somerset, Worcester
Upper Shore = Caroline, Cecil, Kent, Queen Anne's, Talbot
Southern = Calvert, Charles, St. Mary's
Western = Allegany, Garrett, Washington

Hispanic can be of any race. Other includes American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, and Other. UTD = Unable to determine, which includes Declined, Missing, and Unknown.

In SFY 2024, 49% of children entering care in Maryland were Black or African American (non-Hispanic), 23% were White (non-Hispanic), and 8% were Hispanic (can be any race). Baltimore City (76%) and Prince George (53%) had the highest percentage of Black or African American children among their entries, while regions like Lower Shore, Upper Shore, and Western had higher proportions of White children. Montgomery County had equal proportions of Black and Hispanic children.

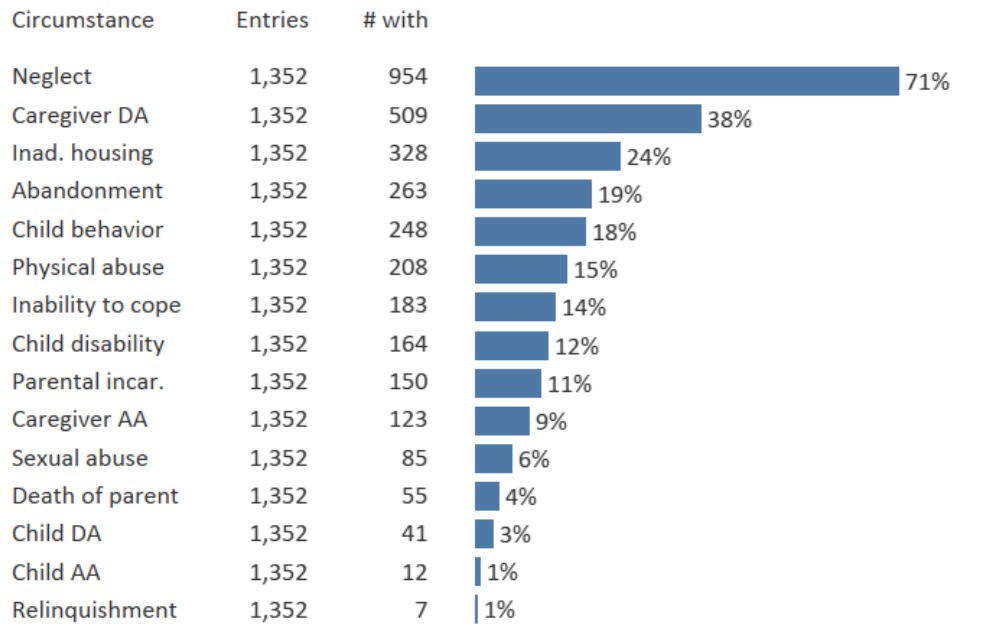
Circumstances of removal

In CJAMS, workers can document multiple circumstances of removal, which reflect factors present around the time of the child's removal (but not necessarily *reasons* for the removal) from home. Historically, these circumstances have been mapped to 15 circumstances of removal the Children's

Bureau requires states to include in their AFCARS[14] submissions. A child can have one or more of these circumstances. Although some of these circumstances may not inform the kind of placement setting the child needs, they do inform the kinds of support the child needs to maintain a stable placement, enhance well-being, and achieve timely permanency. These circumstances also inform the kinds of support the originating family needs to increase the chance for reunification and later, reduce re-entry.

Figure 3 shows the number and percentage of children who entered care in Maryland by circumstances of removal for the most recent SFY (2024). The most frequent circumstances of removal are Neglect (71%) and Caregiver Drug Abuse (38%).

Figure 3. Circumstances of removal for children entering care (SFY 2024)



A child can have one or more circumstances of removal. Therefore, the counts of circumstances will exceed the number of children entering care.

AA = Alcohol abuse, DA = Drug abuse

Circumstances of removal vary significantly by age at entry (Table 8). Children under one year of age who enter care have much higher rates of caregiver drug abuse (35%) as a circumstance of

[14] Adoption and Foster Care Analysis and Reporting System. Recent legislation increased the number of circumstances of removal to document from 15 to 34. For these 34 circumstances, see elements 72 – 105 in https://www.acf.hhs.gov/sites/default/files/documents/cb/afcars-tb-20.pdf.

removal than children in other age groups. Older youth (age 14-17), on the other hand, are more likely to come in with circumstances of child drug abuse (71%), child behavior problems (61%), child alcohol abuse (50%), abandonment (41%), and child disability (37%).

Table 8. Number and percentage of circumstances of removal for children entering care, by age at entry (SFY 2024)

Counts

Circumstance	Total	< 1	1 - 4	5 - 10	11 - 13	14 - 17
Neglect	954	175	211	260	131	177
Caregiver DA	509	177	112	130	52	38
Inad. housing	328	85	73	92	32	46
Abandonment	263	36	31	48	41	107
Child behavior	248	2	3	21	70	152
Physical abuse	208	27	44	63	28	46
Inability to cope	183	50	41	42	24	26
Child disability	164	24	18	26	36	60
Parental incar.	150	28	36	49	16	21
Caregiver AA	123	23	32	37	15	16
Sexual abuse	85	4	6	29	16	30
Death of parent	55	5	11	13	10	16
Child DA	41	5	1	2	4	29
Child AA	12	2	1	1	2	6
Relinquishment	7	4	0	2	0	1

Percentages

Circumstance	< 1	1 - 4	5 - 10	11 - 13	14 - 17
Neglect	18%	22%	27%	14%	19%
Caregiver DA	35%	22%	26%	10%	7%
Inad. housing	26%	22%	28%	10%	14%
Abandonment	14%	12%	18%	16%	41%
Child behavior	1%	1%	8%	28%	61%
Physical abuse	13%	21%	30%	13%	22%
Inability to cope	27%	22%	23%	13%	14%
Child disability	15%	11%	16%	22%	37%
Parental incar.	19%	24%	33%	11%	14%
Caregiver AA	19%	26%	30%	12%	13%
Sexual abuse	5%	7%	34%	19%	35%
Death of parent	9%	20%	24%	18%	29%
Child DA	12%	2%	5%	10%	71%
Child AA	17%	8%	8%	17%	50%
Relinquishment	57%	0%	29%	0%	14%

A child can have one or more circumstances of removal. Therefore, the counts of circumstances will exceed the number of children entering care.

AA = Alcohol abuse, DA = Drug abuse

Figure 4 shows how the circumstances of removal vary by region, for children entering care in SFY 2023. Although neglect is common across all regions, it is highest in Frederick (82%), Montgomery (81%), and Baltimore City (80%). Caregiver drug abuse is also prevalent in every region, and is highest in Lower Shore (53%), Upper Shore (52%), and Frederick (45%).

Figure 4. Circumstances of removal for children entering care, by region (SFY 2024)

Percentages

Circumstance	MD	B. City	B. County	Central	Frederick	L. Shore	Montg.	Prince G.	Southern	U. Shore	Western
Neglect	71%	80%	59%	67%	82%	70%	81%	60%	69%	58%	65%
Caregiver DA	38%	35%	38%	41%	45%	53%	41%	27%	31%	52%	40%
Abandonment	19%	24%	15%	19%	9%	5%	14%	27%	31%	8%	15%
Physical abuse	15%	20%	11%	12%	9%	8%	10%	15%	19%	17%	20%
Child behavior	18%	17%	16%	19%	14%	25%	10%	20%	27%	30%	25%
Inad. housing	24%	29%	27%	19%	18%	23%	16%	18%	15%	28%	21%
Inability to cope	14%	17%	7%	17%	14%		15%	18%	4%	7%	7%
Parental incar.	11%	10%	8%	13%	36%	8%	15%	3%	8%	5%	31%
Caregiver AA	9%	6%	12%	8%	14%	30%	10%	13%	4%	5%	5%
Child disability	12%	10%	6%	16%	9%	20%	10%	12%	35%	20%	17%
Sexual abuse	6%	3%	14%	3%	5%	0%	8%	5%	8%	17%	3%
Child DA	3%	2%	2%	5%	5%	3%	6%	4%	0%	7%	3%
Death of parent	4%	4%	4%	4%	0%	3%	1%	5%	0%	7%	8%
Child AA	1%	0%	0%	2%	0%	0%	2%	1%	0%	2%	1%
Relinquishment	1%	0%	0%	1%	0%	5%	1%	0%	4%	0%	1%

Counts

	MD	B. City	B. Coun..	Central	Frederick	L. Shore	Montg.	Prince G.	Southern	U. Shore	Western
Entries	1,352	467	231	190	22	40	105	136	26	60	75
Neglect	954	375	137	128	18	28	85	81	18	35	49
Caregiver DA	509	164	88	77	10	21	43	37	8	31	30
Abandonment	263	111	35	37	2	2	15	37	8	5	11
Physical abuse	208	93	26	23	2	3	10	21	5	10	15
Child behavior	248	79	37	37	3	10	11	27	7	18	19
Inad. housing	328	136	63	37	4	9	17	25	4	17	16
Inability to cope	183	81	16	32	3		16	25	1	4	5
Parental incar.	150	48	18	25	8	3	16	4	2	3	23
Caregiver AA	123	30	27	16	3	12	10	17	1	3	4
Child disability	164	49	13	31	2	8	11	16	9	12	13
Sexual abuse	85	16	33	6	1	0	8	7	2	10	2
Child DA	41	8	5	9	1	1	6	5	0	4	2
Death of parent	55	19	10	7	0	1	1	7	0	4	6
Child AA	12	2	1	4	0	0	2	1	0	1	1
Relinquishment	7	1	0	1	0	2	1	0	1	0	1

Past and current placements

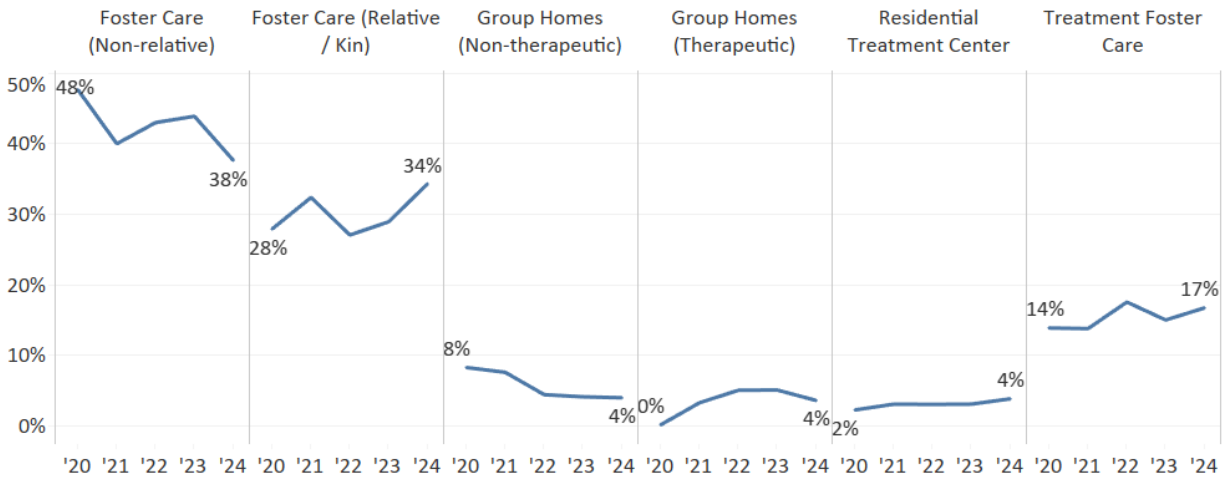
Using past and current placement settings as an indicator or proxy of need is complicated because many placement decisions may not best reflect child's need. Similarly, placement patterns could reflect the workers' *assessment* of what the child needs, which may be incorrect. Placement decisions could also reflect resource constraints and availability instead of what is in the best, long-term interest of the child and the best match for their needs. These caveats should be kept in mind when making inferences about Maryland's historic use of different placement types and how they relate to child needs.

Figure 5 and Table 9 show the percentage and number of children who entered care by SFY and first placement. If the placement the child was in at entry started prior to the child's removal (e.g. most likely informal living arrangements) or the first placement was not a countable placement (e.g. THV,

hospitalization, respite care, runaway, etc.), the child's *subsequent* countable placement (if any) was selected and considered the child's first placement.

In SFY 2024, the most common first placement settings were Foster Care (Non-relative) (38%) and Foster Care (Relative/Kin) (34%). Both types of foster care settings have trended in opposite directions over the last five years, with use of non-relative foster care declining and relative/kin care increasing. Further, the use of Group Homes (Non-therapeutic) as a first placement setting has declined every year since SFY 2020, from 8% to 4%.

Figure 5. Percentage of children entering care, by SFY and first placement



A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

If the first placement was not a countable placement (e.g., THV, respite care, hospitalization, runaway, etc.) the child's subsequent countable placement (if any) was selected as the first placement.

Table 9. Number and percentage of children entering care, by SFY and first placement

Placement	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Total	1,940	1,482	1,598	1,348	1,317	100%	100%	100%	100%	100%
Foster Care (Non-relative)	926	597	689	590	497	48%	40%	43%	44%	38%
Foster Care (Relative / Kin)	541	479	432	392	451	28%	32%	27%	29%	34%
Group Homes (Non-therapeutic)	160	112	70	55	52	8%	8%	4%	4%	4%
Group Homes (Therapeutic)	2	46	79	68	47	0%	3%	5%	5%	4%
Residential Treatment Center	42	45	48	42	50	2%	3%	3%	3%	4%
Treatment Foster Care	269	203	280	201	220	14%	14%	18%	15%	17%

A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

If the first placement was not a countable placement (e.g., THV, respite care, hospitalization, runaway, etc.) the child's subsequent countable placement (if any) was selected as the first placement.

In SFY 2024, Foster Care (non-relative) was the most common first placement in all regions except Baltimore City, where Foster Care (relative/kin) was the most frequent first placement setting (49%) (Table 10).

Table 10. Number and percentage of children entering care, by first placement and region (SFY 2024)

Region	Total	Total	FC (non-rel)	FC (rel/kin)	GH (non-ther)	GH (ther)	RTC	TFC	FC (non-rel)	FC (rel/kin)	GH (non-ther)	GH (ther)	RTC	TFC
Maryland	1,317	100%	497	451	52	47	50	220	38%	34%	4%	4%	4%	17%
B. City	461	100%	81	228	22	23	1	106	18%	49%	5%	5%	0%	23%
B. County	227	100%	82	69	9	7	6	54	36%	30%	4%	3%	3%	24%
Central	187	100%	98	51	5	6	17	10	52%	27%	3%	3%	9%	5%
Frederick	19	100%	16	2			1		84%	11%			5%	
Lower S.	37	100%	15	9		2	5	6	41%	24%		5%	14%	16%
Montg.	101	100%	65	30	2	2	2		64%	30%	2%	2%	2%	
Prince G.	130	100%	52	34	3	4	2	35	40%	26%	2%	3%	2%	27%
Southern	25	100%	12	8	1	2	2		48%	32%	4%	8%	8%	
Upper S.	59	100%	40	2	8	1	7	1	68%	3%	14%	2%	12%	2%
Western	71	100%	36	18	2		7	8	51%	25%	3%		10%	11%

A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

If the first placement was not a countable placement (e.g., THV, respite care, hospitalization, runaway, etc.) the child's subsequent countable placement (if any) was selected as the first placement.

RTC = Residential Treatment Center, TFC = Therapeutic Foster Care

The use of Foster Care (non-relative) as a first placement decreases with age. Among children < 1 year of age, 53% had Foster Care (non-relative) as their first placement compared to only 32% for youth aged 14 – 17. As expected, higher percentages of older youth (14 – 17) had a Group Home (17%), Treatment Foster Care (11%), or Residential Treatment Center (9%) as their first placement (Table 11).

Table 11. Number and percentage of children entering care, by first placement and age (SFY 2024)

Age At Placement	Total	Total	FC (non-rel)	FC (rel/kin)	GH (non-ther)	GH (ther)	RTC	TFC	FC (non-rel)	FC (rel/kin)	GH (non-ther)	GH (ther)	RTC	TFC
Total	1,348	100%	590	392	55	68	42	201	44%	29%	4%	5%	3%	15%
< 1	265	100%	141	84	3			37	53%	32%	1%			14%
1 - 4	288	100%	149	96	2			41	52%	33%	1%			14%
5 - 10	293	100%	127	92	7	3	2	62	43%	31%	2%	1%	1%	21%
11 - 13	190	100%	74	52	12	13	12	27	39%	27%	6%	7%	6%	14%
14 - 17	310	100%	98	67	31	52	28	34	32%	22%	10%	17%	9%	11%
18+	2	100%	1	1					50%	50%				

A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

If the first placement was not a countable placement (e.g., THV, respite care, hospitalization, runaway, etc.) the child's subsequent countable placement (if any) was selected as the first placement.

RTC = Residential Treatment Center, TFC = Therapeutic Foster Care

Placement instability

Placement instability – multiple moves from placement to placement – is not enough to know what is contributing to these moves. For example, multiple moves could suggest that the needs of the child are not being adequately met or that some placements were not a good fit for the child. Alternatively, if multiple moves follow a path from more to less restrictive settings, this trajectory could reflect an appropriate continuum of care for some children. Further, unavoidable crises in the child's life could necessitate a placement move for a need that did not previously exist. Analysis on the percentage of moves based on level of placement, such as moves to more or less restrictive settings, was not conducted as SSA is still refining the criteria it wants to use to designate the level of each placement. This limitation should be kept in mind when interpreting placement instability, as important context is missing.

To understand placement stability in Maryland, we examined the number and timing of placement moves that each child who entered care in the past five SFYs experienced. Consistent with the

Children's Bureau's guidance on counting placement moves,[15] movements into the following placement settings were not considered a placement move: trial home visit, respite care, hospitalization, select community-based residential placements (i.e., college, halfway house, homeless shelter, job corps, or summer camp), adult correctional institution, secure juvenile detention, homeless, runaway, unknown whereabouts, and missing. These settings represent a temporary or planned absence from the child's ongoing foster care placement and are generally not considered a formal placement.

In addition, if the subsequent placement had the same Provider ID as the previous placement, the subsequent placement was not considered a move. Some of these records signify a change in a setting's licensing status and not a physical move. Other instances occur when the child moves *within* an institution at a single location (e.g. from one building, dorm, cottage, or wing to another within the institution). Despite what might constitute a physical move, the Children's Bureau considers the child as remaining in the same institution[16] and is therefore not a placement move. For a smaller number of records, a subsequent record with the same Provider ID appears to be due to the worker erroneously creating a subsequent placement record (with a new start date) to update another detail for the placement, and there is no indication the child changed settings. Lastly, when counting a child's moves the first placement is not considered a move.

Table 12 shows the percentage of children with 0, 1, 2, 3, 4 or 5+ moves, by length of stay in care and SFY. Length of stay was calculated as the number of days from when the child entered care to when they exited. If the child was still in care as of the date the file was provided to the assessment team (the censor date, or July 12, 2024), the length of stay is calculated as of the censor date. Note that for SFY 2024, the percentages for children in care 12+ months are based on very low counts (only 24 children) and should be interpreted with caution, as the low counts could significantly impact the observed trends.[17]

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[15] Children's Bureau (March 5, 2024). Child Welfare Policy Manual: 1.2B.7 - AFCARS, Data Elements and Definitions, Foster Care Specific Elements, Placements (https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=150)

[16] See Question 25 in the Child Welfare Policy Manual.

[17] For example, in SFY 2024 there were 24 children who have been in care for 12 + months, 11 of whom had 0 moves (46%). Compare this to SFY 2023, when there were 945 children in care for 12 + months, 318 of whom had 0 moves (34%).

Table 12. Number and percentage of children entering care, by number of placement moves, length of stay, and SFY

LOS in Care	Number & Percentage of Moves / Entry Sfy																													
	0					1					2					3					4					5 +				
	'20	'21	'22	'23	'24	'20	'21	'22	'23	'24	'20	'21	'22	'23	'24	'20	'21	'22	'23	'24	'20	'21	'22	'23	'24	'20	'21	'22	'23	'24
< 8 days	94%	96%	98%	93%	96%	5%	4%	2%	7%	4%	1%																			
8 days to < 1 mo	66%	79%	66%	59%	74%	32%	20%	28%	35%	26%	2%	1%	5%	6%																
1 mo to < 6 mos	62%	58%	51%	51%	57%	25%	32%	36%	31%	32%	9%	6%	9%	12%	9%	3%	3%	3%	5%	2%	0%		1%	1%		0%	0%			
6 to < 12 mos	46%	47%	38%	39%	43%	32%	35%	38%	37%	37%	15%	14%	18%	19%	13%	4%	3%	4%	3%	4%	2%	1%	1%	2%	2%	0%	1%	2%		1%
12 mos +	26%	28%	27%	34%	46%	28%	25%	30%	29%	33%	18%	16%	18%	19%	8%	12%	11%	11%	7%	4%	6%	8%	5%	4%		10%	12%	9%	6%	8%

The data consistently shows high stability for children who stayed in care for less than eight days, with the vast majority experiencing no placement moves across all SFYs. This stability is further underscored by the fact that no children in this category experienced more than two moves during any SFY.

As expected, as the length of stay in foster care increases, the stability of placements begins to decline. Among children with a LOS between eight days and one month, the percentage of those with no moves fluctuated each year, with a high of 79% in SFY 2021 and a low of 59% in SFY 2023. Similar yearly fluctuations are seen for children in this group with 1 move, which ranged from 20% in SFY 2021 to 35% in SFY 2023. A small but noticeable proportion of children in this category also experienced two or more moves, indicating a trend toward increased instability as time in care lengthens. For children with a LOS between one month and six months, the data shows a more pronounced decline in stability. The percentage of children with no moves decreased significantly from 62% in SFY 2020 to 51% in SFY 2022, before recovering slightly to 57% in SFY 2024. During this period, the proportion of children experiencing one move fluctuated between 25% and 36%, while a notable percentage, ranging from 9% to 12%, experienced two moves.

The trend toward increased movement becomes more apparent among children who remain in care for six to twelve months. In this category, the percentage of children with no moves averaged about

43% across all five years, with some minor fluctuations. Simultaneously, the proportion of children experiencing two moves peaked at 19% in SFY 2022, then decreased to 13% by SFY 2024. Additionally, a consistent percentage of children — around 3 to 4% — experienced three or more moves during these years. The most significant instability is observed among children who remain in care for twelve months or longer. A substantial portion of children in this category experienced two or more moves, including 8% to 12% experiencing five or more moves. The number of moves for this 5 + group ranged from 5 to 22 moves.

To examine placement stability by region, the format in Table 12 would become unwieldy. A more efficient method that facilitates regional comparisons in placement stability is calculating a rate of moves per 1,000 days of care.[18] This method controls for the number of days children are in care in each region which facilitates more fair and meaningful comparisons across regions. Without controlling for days in care, a region that happens to have longer lengths of stay than another region will invariably have more moves, simply because their children have more opportunity to move. For this assessment, a region's placement stability for children who entered care in SFY 2024 is calculated as the total number of moves children in that region experienced, divided by the total number of days these children were in care as of the end of the SFY 2024. The result of this division, the quotient, is multiplied by 1,000 to translate the result as *moves per 1,000 days of care*.

For children who entered care in SFY 2024 in Maryland, there were 4.0 moves per 1,000 days of care. Four regions had rates higher than the state rate, ranging from 6.5 moves per 1,000 in Montgomery to 4.2 moves per 1,000 in Southern (Figure 6). Frederick and Baltimore County had the lowest number of moves per 1,000 (2.5 and 2.8, respectively).

[18] This method aligns with the CFSR 4 statewide date indicator for placement stability.

Figure 6. Number of moves per 1,000 days for children entering care, by region (SFY 2024)

Region	Moves	Days in care	Number of moves per 1,000 days
Maryland	803	200,714	4.0
B. City	279	69,119	4.0
B. County	112	40,639	2.8
Central	126	27,131	4.6
Frederick	9	3,546	2.5
Lower S.	17	5,497	3.1
Montg.	82	12,536	6.5
Prince G.	70	19,816	3.5
Southern	14	3,311	4.2
Upper S.	34	9,734	3.5
Western	60	9,385	6.4

A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

The rate of moves per 1,000 days is based on children who entered care during SFY 2023. It is calculated as the total number of moves for these children divided by the number of days they were in care during the SFY, multiplied by 1,000 to get a rate of moves per 1,000 days.

These counts exclude 40 children whose placement dates (due to data quality) overlapped for one or more of their placements.

Pregnant and parenting youth (PPY)

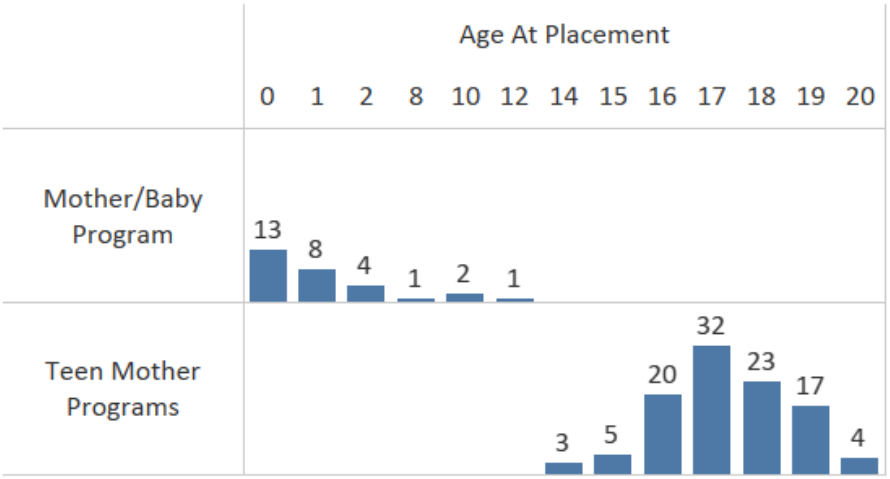
The CJAMS reproductive health data on PPY includes, with varying degrees of accuracy, whether the youth was documented as being pregnant, pregnancy due date, number of pregnancies, number of children, and whether the youth is parenting. CJAMS does not collect data on pregnancy start and delivery dates. CJAMS does not retain a history of changes made to the pregnancy indicator field, so it is possible that a youth was once documented as pregnant but is no longer (i.e. the pregnancy indicator was changed from Yes to No or blank). These limitations should be kept in mind when reviewing the following data on PPY.

Among youth who entered care at any point during SFY 2020 to 2024, 36 were flagged as being pregnant, including 34 females and 2 males. This includes 4 “pregnant” youth who reportedly entered care when they were age 1-4 (2 children) and 5-10 (2 children). The counts for very young “pregnant” children reveal obvious data quality problems and the counts for older male youth documented as pregnant would benefit from a case review to determine if these are transgender

males. 45 youth were documented as having one or more pregnancies and 40 were documented as having one or more children. As with other data, the counts of pregnant youth include males and the counts of pregnant or parenting children includes children under 5 years of age, which is unlikely. No youth were documented as parenting a child; the field was empty for all youth in the file.

PPY may also be inferred based on the use of two placement settings: Mother/Baby Program and Teen Mother Program. For children and youth who entered care during the reporting period, 26 had at least placement in a Mother/Baby Program and 73 had at least one placement in a Teen Mother Program. The age for individuals placed in Mother/Baby programs ranged from < 1 year old to 13 years old and included females and males, which could suggest that most or all of these placements are for the child rather than the PPY. On the other hand, the age for individuals placed in Teen Mother Programs ranged from 14 to 20 and were all female, making it more likely that these are PPY (Figure 7).

Figure 7. Number of placements in Mother/Baby Programs (29 placements for 26 children) and Teen Mother Programs (104 placements for 73 youth), by age at placement (SFY 2020 – SFY 2024)



A child or youth is counted once for each distinct placement. For example, if a youth had two distinct placements in a Teen Mother Program at age 17, or a placement at age 17 and another at age 18, they are counted once for each placement.

Table 13 shows the number and percentage of youth with at least one placement in a Teen Mother Program, by SFY of entry and region. Baltimore City has routinely had the highest percentage of youth with at least one placement in a Teen Mother Program.

Table 13. Number and percentage of youth with at least one placement in a Teen Mother Program, by SFY of entry and region

Region	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Maryland	30	14	16	9	4	100%	100%	100%	100%	100%
B. City	19	9	10	4	2	63%	64%	63%	44%	50%
B. County	3		1		1	10%		6%		25%
Central	1	1	3	2		3%	7%	19%	22%	
Lower S.		1		1			7%		11%	
Montg.	3					10%				
Prince G.	4	3	1	2	1	13%	21%	6%	22%	25%
Upper S.			1					6%		

A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

Central = Anne Arundel, Carroll, Harford, & Howard
Lower Shore = Dorchester, Wicomico, Somerset, Worcester
Upper Shore = Caroline, Cecil, Kent, Queen Anne's, Talbot
Southern = Calvert, Charles, St. Mary's
Western = Allegany, Garrett, Washington

Given the significant data quality issues with PPY data from the reproductive health section of CJAMS, the University of Maryland provided the assessment team with an additional file which listed youth served in care who were identified as having a relationship of "biological mother" or "biological father" to another known individual with an age that is appropriately younger than the youth. No other details are available with these data, including whether these youth are actively parenting their child(ren). Table 14 shows the number and percentage youth identified as a "biological mother" or "biological father" by SFY of entry and region.

Table 14. Number and percentage of youth identified as having a relationship of "biological mother" or "biological father" with another individual, by SFY of entry and region

Relationship	Region	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Total		40	21	23	11	3	100%	100%	100%	100%	100%
Father	Total	2	3	1	1	1	5%	14%	4%	9%	33%
	B. City	1	2		1		3%	10%		9%	
	Central			1					4%		
	Prince G.					1					33%
	Western	1	1				3%	5%			
Mother	Total	38	18	22	10	2	95%	86%	96%	91%	67%
	B. City	20	8	11	4	1	50%	38%	48%	36%	33%
	B. County	2	2	2			5%	10%	9%		
	Central	2	2	5	3	1	5%	10%	22%	27%	33%
	Frederick				1					9%	
	Lower S.	1	3		1		3%	14%		9%	
	Montg.	4					10%				
	Prince G.	4	2	2			10%	10%	9%		
	Southern	2					5%				
	Upper S.	2	1	1			5%	5%	4%		
	Western	1		1	1		3%		4%	9%	

A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

Central = Anne Arundel, Carroll, Harford, & Howard
Lower Shore = Dorchester, Wicomico, Somerset, Worcester
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Southern = Calvert, Charles, St. Mary's
Western = Allegany, Garrett, Washington

Over the past five SFYs, 92 youth who entered care, including 8 males and 88 females, were identified as biological fathers and mothers, respectively. Baltimore City regularly has the highest percentage of biological mothers entering care compared to other regions.

Children considered medically fragile or with developmental disabilities

To identify children considered medically fragile or with a developmental disability, we identified children in CJAMS with at least one placement with a Developmental Disabilities Administration (DDA)-approved or -licensed provider. To be eligible to receive services from the DDA, the individual

must "have a disability which keeps you from meeting your daily activities independently and meet specific criteria."[19] Children who meet DDA eligibility may have a range of diagnoses. SSA provided a list of 11 DDA providers, with 40 Provider IDs representing the addresses where these providers have facilities, whose contract term overlapped with the reporting period (i.e. SFY 2020 to SFY 2024).[20] We identified children in the served file who had at least one placement with a Provider ID that matched one on the DDA provider list.

During the reporting period, 117 children had at least one placement in a DDA-approved or -licensed provider (Table 15). Only 61% (71) of these 117 children had "child disability" endorsed as a circumstance of their removal from home and 45% (n = 53) had at least one diagnosis listed in CJAMS.[21] Given the eligibility requirements for DDA providers, it is reasonable to assume 100% of children placed there have at least one health, behavioral, or mental health diagnosis, which means the CJAMS circumstance of removal and diagnosis data for many children is an undercount. For the 53 children with a DDA-placement who had a diagnosis in CJAMS, Figure 8 shows the diagnoses workers documented.

[19]Eligibility criteria is available at https://health.maryland.gov/dda/Pages/DDA_Eligibility_Application_Process.aspx. For more general information about DDA providers, see https://health.maryland.gov/dda/Pages/providers.aspx.

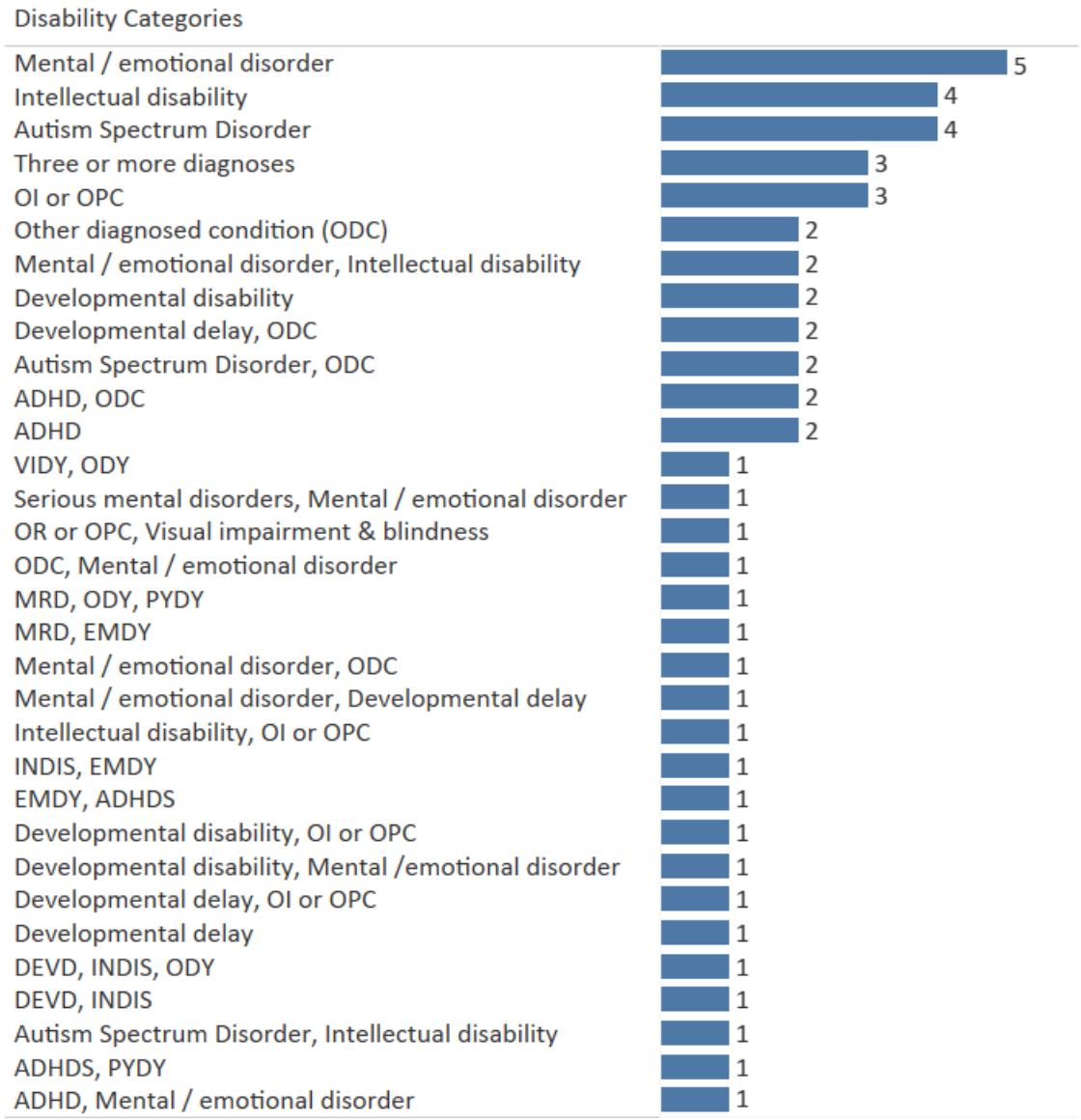
[20]Two addresses were excluded due to missing a Provider ID.

[21]In CJAMS, workers can endorse up 11 health, behavioral, or mental health diagnosis in the child's disability tab. Anecdotally, SSA staff have expressed concern over the reliability of this information, so caution is warranted when drawing conclusions.

Table 15. Number and percentage of children with at least one placement in a DDA-approved or -licensed provider, by SFY and region

Region	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Maryland	24	28	21	25	22	100%	100%	100%	100%	100%
B. City	3	8	3	2	12	13%	29%	14%	8%	55%
B. County	5	4	2	6	1	21%	14%	10%	24%	5%
Central	5		7	8	4	21%		33%	32%	18%
Frederick		2	1				7%	5%		
Lower S.	1	2	1	2		4%	7%	5%	8%	
Montg.	4	3	2	2	1	17%	11%	10%	8%	5%
Prince G.	1	3			1	4%	11%			5%
Southern	1	1	2	1		4%	4%	10%	4%	
Upper S.	1	3	3	3	1	4%	11%	14%	12%	5%
Western	3	2		1	2	13%	7%		4%	9%

Figure 8. Diagnoses in CJAMS for children in a DDA-placement



ODC = Other diagnosed condition
OI or OPC = Orthopedic impairment or other physical condition

For children who entered care in SFY 2024 and had a DDA placement, 14% were aged 1 – 4 when placed and the rest were roughly evenly distributed for ages 5 – 10, 11 – 13, and 14-17 (Table 16).

Table 16. Number and percentage of children with at least one placement in a DDA-approved or -licensed provider, by age at placement (SFY 2024)

Region	Total	Total	1 - 4	5 - 10	11 - 13	14 - 17	1 - 4	5 - 10	11 - 13	14 - 17
Maryland	22	100%	3	6	7	6	14%	27%	32%	27%
B. City	12	100%	1	3	3	5	8%	25%	25%	42%
B. County	1	100%				1				100%
Central	4	100%	1	1	2		25%	25%	50%	
Montg.	1	100%		1				100%		
Prince G.	1	100%	1				100%			
Upper S.	1	100%			1				100%	
Western	2	100%		1	1			50%	50%	

A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

Central = Anne Arundel, Carroll, Harford, & Howard
Lower Shore = Dorchester, Wicomico, Somerset, Worcester
Upper Shore = Caroline, Cecil, Kent, Queen Anne's, Talbot
Southern = Calvert, Charles, St. Mary's
Western = Allegany, Garrett, Washington

Children placed out of state

Table 17 shows the number and percentage of children with at least one out-of-state (OOS) placement in Maryland by SFY and region. (See Appendix F for this data by jurisdiction.) The number of OOS placements has declined by 67% from SFY 2020 (n= 100) to SFY 2024 (n = 33). In SFY 2024, the largest percentage of OOS placements were for children in Baltimore County (18%) and Central (18%).

Table 17. Number and percentage of children entering care with at least one out of state placement, by SFY and region

Region	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Total	100	60	66	57	33	100%	100%	100%	100%	100%
B. City	15	9	7	4	3	15%	15%	11%	7%	9%
B. County	18	4	9	7	6	18%	7%	14%	12%	18%
Central	13	7	13	12	6	13%	12%	20%	21%	18%
Frederick	7	5	1		2	7%	8%	2%		6%
Lower S.		2	3	2	1		3%	5%	4%	3%
Montg.	11	4	1	4	3	11%	7%	2%	7%	9%
Prince G.	14	7	9	10	2	14%	12%	14%	18%	6%
Southern	1	3	4	2	1	1%	5%	6%	4%	3%
Upper S.	8	3	9	6		8%	5%	14%	11%	
Western	13	16	10	10	9	13%	27%	15%	18%	27%

A child is counted once per SFY if they had at least one out of state placement in that SFY.

Counts exclude out of state placements into these settings: trial home visit, respite care, hospitalization, college, halfway house, homeless shelter, job corps, or summer camp, adult correctional institution, secure juvenile detention, homeless, runaway, unknown whereabouts, and missing

Central = Anne Arundel, Carroll, Harford, & Howard
Lower Shore = Dorchester, Wicomico, Somerset, Worcester
Upper Shore = Caroline, Cecil, Kent, Queen Anne's, Talbot
Southern = Calvert, Charles, St. Mary's
Western = Allegany, Garrett, Washington

As shown in Figure 9, most OOS placements in SFY 2024 occurred with youth who entered at age 14 – 17 (30%) and 5 – 10 (27%).

Figure 9. Number and percentage of children entering care with at least one out of state placement, by region and age at entry (SFY 2024)

Region	Total	Total	< 1	1 - 4	5 - 10	11 - 13	14 - 17	< 1	1 - 4	5 - 10	11 - 13	14 - 17
Maryland	33	100%	3	6	9	5	10	9%	18%	27%	15%	30%
B. City	3	100%	1				2	33%				67%
B. County	6	100%			1	2	3			17%	33%	50%
Central	6	100%		1	3		2		17%	50%		33%
Frederick	2	100%		1	1				50%	50%		
Lower S.	1	100%					1					100%
Montg.	3	100%	1	1			1	33%	33%			33%
Prince G.	2	100%				2					100%	
Southern	1	100%					1					100%
Western	9	100%	1	3	4	1		11%	33%	44%	11%	

A child is counted once per SFY if they had at least one out of state placement in that SFY.

Counts exclude out of state placements into these settings: trial home visit, respite care, hospitalization, college, halfway house, homeless shelter, job corps, or summer camp, adult correctional institution, secure juvenile detention, homeless, runaway, unknown whereabouts, and missing

Central = Anne Arundel, Carroll, Harford, & Howard
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Presence of an Individualized Education Program (IEP)

Children with special education needs, including those with IEPs, may need additional supports and services while in a placement. Under the Individuals with Disabilities Education Act, biological and adoptive parents retain their parental educational rights even when their child is in foster care, unless a court has taken away those rights. Children with IEPs in placements will need additional advocacy and coordination with the placement provider to ensure their parents can participate in their child's IEP process. If the parent is not available, some providers like foster care parents are legally allowed to fill the parental role in the IEP process, but providers in other settings – like group home workers – cannot fill that role. Table 18 shows the number and percentage of children who entered care each SFY with an IEP documented in CJAMS, by region.

Table 18. Number and percentage of children who entered care with an IEP documented in CJAMS, by SFY and region

Region	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Maryland	237	214	187	136	69	100%	100%	100%	100%	100%
B. City	68	63	46	19	12	29%	29%	25%	14%	17%
B. County	41	35	30	23	16	17%	16%	16%	17%	23%
Central	23	29	28	29	11	10%	14%	15%	21%	16%
Frederick	11	9	1	4	2	5%	4%	1%	3%	3%
Lower S.	5	17	8	8	8	2%	8%	4%	6%	12%
Montg.	22	14	25	8	2	9%	7%	13%	6%	3%
Prince G.	11	9	10	7	6	5%	4%	5%	5%	9%
Southern	15	11	4	5	2	6%	5%	2%	4%	3%
Upper S.	18	12	14	9	4	8%	6%	7%	7%	6%
Western	23	15	21	24	6	10%	7%	11%	18%	9%

A child is counted for each entry they had. For example, if a child entered two times in the SFY, and had an IEP documented both times, they are counted twice.

Central = Anne Arundel, Carroll, Harford, & Howard
Lower Shore = Dorchester, Wicomico, Somerset, Worcester
Upper Shore = Caroline, Cecil, Kent, Queen Anne's, Talbot
Southern = Calvert, Charles, St. Mary's
Western = Allegany, Garrett, Washington

Maintaining accurate educational data in child welfare information systems is notoriously difficult, so whether the counts in Table 18 are an accurate reflection of IEP use would require an extensive case review of a much larger sample of children, a comparison with educational data from the Maryland State Department of Education, or both. In addition, to be eligible for an IEP a child must have a qualifying condition, disability, or disorder. Among the 69 children who entered care in SFY 2024 and had an IEP documented, 42 (61%) had no diagnoses in CJAMS. Assuming the IEP indicator is accurate, this provides further evidence that diagnoses data in CJAMS is significantly underreported.

Limitations

Intensive efforts were made to isolate and remedy data quality problems that could impact the accuracy of findings. Many of the data quality problems identified in the served data (and outlined in Appendix A) could be mitigated by the consistent enforcement of logical rules in CJAMS, particularly those related to placements: placements missing start dates; children with two or more placement records that have the same start date; children with multiple placement records for the same

provider, for the same placement; children with placements whose start and end dates overlap; and placements with no end dates even though the child has a subsequent placement or has exited care. Guidance to workers and supervisors could also reduce some data quality problems, such as zero-day "placements" that appear to indicate the setting to which the child was discharged. These kinds of data quality issues will complicate efforts to reliably track the placement experiences of children, such as placement stability and the nature and timing of placement changes.

Another significant limitation is the lack of explicit needs data captured in CJAMS, including accurate documentation of special populations like PPY and children with significant physical and mental health diagnoses and disabilities. One opportunity for capturing useful needs data includes structured assessments like the Child and Adolescent Needs and Strengths (CANS), but as already noted there are documentation issues. There is a high percentage of children missing a CANS or with a CANS but with no needs documented.[22] Our efforts to obtain more detailed needs data led us to conduct a case review of placement information referral forms for a sample of children, but similar limitations were encountered with these forms – particularly a lack of detailed documentation. A full discussion of the case review is described later.

For children with high placement instability, understanding *why* placements are disrupted would be invaluable. For example, knowing what services and supports were needed and provided or not provided to children, families, and foster care or kin providers for placements that disrupted would shed light on the extent to which needs went unmet and the kinds of changes MDDHS should explore. Detailed service data, including warning signs that a placement disruption might be imminent due to unmet or changing needs (e.g. number of calls made from a provider to a worker in a given time period) are not well documented in CJAMS. Until this information can be adequately documented in CJAMS, the most effective way to obtain this information is likely through interviews with children, families, and providers involved in such cases, complimented by an extensive review of case notes and other documentation.

Finally, the scope and timeframe of the assessment did not permit an expansive assessment of needs that required new data collection; extensive review of documentation stored in text form in or outside of CJAMS; or interviews with youth, families, caseworkers, supervisors, and providers. These

[22]The Institute for Innovation and Implementation, University of Maryland, Baltimore (May 2022). Baltimore City Placement Review. Available at https://dhs.maryland.gov/documents/Local%20Offices/Baltimore%20City/Consent%20Decree/69th%20Compliance%20Report/69th%20Report/Att.%201%20to%2069th%20Court%20Report.pdf.

activities are worth pursuing and would provide valuable insights into the placement needs of children.

Discussion & Conclusions

Maryland continues to have one of the lowest foster care entry rates in the country (the second lowest entry rate according to the most recent data from the Children's Bureau).23 Moreover, the SFY trend data shows the number of children entering Maryland's foster care system continues to decline each year, most notably in Baltimore City and the Southern Region (Charles, Calvert, and St. Mary's). Although these numbers do not convey specific needs, they do inform the size of the service array needed to support the providers who foster these children, and the families and kin to whom many should be reunified.

Across Maryland, older children aged 5 to 10 and youth aged 14 to 17 represented the largest groups entering foster care. Baltimore County and Prince George's County exhibited a higher proportion of entries for older children (14 to 17 years). In contrast, Frederick and the Southern had the highest percentages of infants entering care. While some regions displayed a relatively even distribution of entries among age groups, most regions demonstrated more significant skews toward, or away from, specific age cohorts. The service array in each region needs to ensure that the number and type of settings and services available are tailored to and able to support the age mix typically seen in the region. There is significant regional variation in the racial and ethnic composition of children entering care in Maryland. In some cases, these patterns are related to the racial and ethnic composition of the child population in the region, but for many jurisdictions and regions these patterns point to disproportionate representation of Black or African American children in Maryland's foster care system.24 These findings align with broader literature indicating that children from minority backgrounds often face unique challenges and systemic biases that affect their placement stability and permanency outcomes. Addressing these disparities requires culturally competent services and supports tailored to the specific needs of these children and their families.

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[23]Children's Bureau (February 2024). National – Supplemental Context Data (a supplement to Maryland's Child and Family Services Review Round 4 Data Profile). A state's foster care entry rate is the number of children who enter care in a 12-month period divided by the state's census child population as of July 1st of each year. The entry rate per 1,000 creates a standard reference point (in this case, every 1,000 children in a state's child population) which facilitates comparisons across states whose population sizes might differ.

[24]Maryland's most recent Headline Indicator Performance dashboard (6/11/2024) shows that Black or African American children are 2.5 times more likely than White children to enter foster care. Among the larger jurisdictions, where disproportionality rates can be reliably measured, Prince George's has the highest disproportionality, where Black or African American children are 11.1 times more likely than White children to enter foster care.

The circumstances of removal vary in important ways by age and for some regions. For children who enter care with caregiver drug abuse as a concern, 35% of them are infants. Primary prevention efforts to address community and family challenges like substance use are critical for preventing these young children from entering foster care. For those children who must be removed, the service array needs sufficient expertise in treating families with substance abuse problems so their children can be safely reunited. The circumstances of removal for older youth are also distinct, with the majority having concerns related to child alcohol and drug abuse, behavior problems, and disabilities. These youth will have associated needs that continue long into the child's placement and life, and the service array for regions with high concentrations of older youth needs to be designed with these needs in mind. The proportions of children entering care with these circumstances have been relatively stable over time and therefore can be considered in advance when planning the service array and anticipating the services and supports children may need in a given region.

According to the CJAMS data, the first placement for most children – 73% – is a non-relative (44%) or relative/kin foster care setting (29%). This is laudable as it means congregate care is not the first placement for most children. Unfortunately, a high percentage of these children stay in MDDHS custody for more than a year25 which suggests either the needs of the child, their family network to whom they could be reunified, or both, are not being met. In other words, a high percentage of placements in non-congregate settings is, on its own, not a reason to celebrate unless it is matched with placement stability, improvement in child and family functioning, and timely reunification. MDDHS is doing important work in understanding the key barriers to permanency, especially for older youth in MDDHS custody.26 This work will undoubtedly reveal some of the factors that are contributing to long stays in foster care and the kinds of innovations needed to address the problem.

The analysis of children considered medically fragile or with developmental disabilities reveals a significant underreporting of diagnoses in CJAMS. This gap in data presents challenges in appropriately addressing the needs of these children. Similarly, the analysis identified substantial data quality issues in recording pregnant and parenting youth (PPY), which further complicates efforts to even identify these youth in order to understand their needs and placement experiences.

There has been a noticeable decline in out-of-state placements over the past five years, though some of these placements are still occurring, particularly for older youth. This trend suggests

[25]Children's Bureau (February 2023). Maryland CFSR 4 Data Profile. Maryland's performance on indicators that measure permanency in 12 months is consistently and statistically worse than national performance, even after risk-adjusting for its low entry rate.

[26]mylife is an interactive hub of information and resources designed to assist Maryland's youth and young adults connected to the Maryland Child Welfare system, providing them with the tools needed to achieve the life they choose. See: https://mylife.mymdthink.maryland.gov/

ongoing challenges in finding appropriate in-state placements for some youth, but the factors which led to these out-of-state placements are not captured in the CJAMS data. Additionally, the presence of children with Individualized Education Programs (IEPs) highlights the need for coordinated efforts between child welfare and educational systems to ensure these children receive the necessary support and advocacy within their educational environments.

Population 2 – Children historically served by Maryland's Child Welfare System who experienced a hospital overstay.

Data

SSA provided the assessment team with a list of children in foster care with hospital admission dates that spanned December 2018 to November 2023. After data cleaning, this list included 1,788 hospitalizations for 870 children. At the time of this assessment, a designated staff member at each LDSS had been providing this data weekly to the SSA Placement Unit who compiled it into a master spreadsheet for the entire state;[27] this information was not routinely captured in CJAMS. Variables in the hospitalization file included child identifiers (i.e. CJAMSPID, child name), demographic information, hospitalization type (e.g. Psychiatric or Medical), admission type (e.g. inpatient psychiatric, ER), reasons for hospitalization, anticipated dates of discharge (based on prognosis) and actual dates of discharge, and discharge placement recommendations (e.g. RTC, group home, etc.). The file included one record per child, per hospitalization (i.e. a child can experience more than one hospitalization).

We defined children who experienced a hospital "overstay" as those whose *actual* length of stay in the hospital (*Date of Discharge* minus *Date of Admission*) exceeded their *expected* length of stay by 10 or more days.[28] The expected length of stay was calculated as the difference between the child's *Date of Admission* and the *Date of Medical Necessity Discharge*. The *Date of Medical Necessity Discharge* represented the hospital's best estimate of the child's expected discharge date based on their reason for hospitalization and prognosis. When calculating the length of stay, if the discharge date was missing the child was assumed to still be in the hospital in which case the length of stay

[27]Initially, the assigned DSS worker is notified by the placement provider or caregiver that a child in the care of DSS has been hospitalized or taken to the ER. The DSS worker contacts the provider and hospital for additional information and provides this information to a designated staff at the LDSS responsible for completing the weekly hospitalization report. The LDSS provides via email weekly updates to the Placement Unit.

[28]"Ten or more" days was used to better identify children who had experienced a prolonged episode of hospital overstay that was more likely due to challenges in finding an appropriate placement for the child vs. factors unrelated to placement availability.

was as of November 9, 2024 (i.e., the censor date), when the file was provided to the assessment team.

We created a new "Admission Type" variable based on the original Hospitalization Type and Admission Type variables to create four categories: 1) Medical – ER, 2) Medical – Non-ER, 3) Psychiatric ER, and 4) Psychiatric Non-ER. Table 19 shows how the original values for Hospitalization Type and Admission Type were mapped to these four new categories.[29]

Table 19. Mapping used to create new admission type variable for children with hospital overstays

New variable Admission Type	Original variables and values Hospitalization Type & Admission Type Combinations
Medical - ER	Medical & ER Medical & ER-medical
Medical – Non-ER	Medical & Inpatient Medical Medical & Medical Hospital
Psychiatric – ER	Psychiatric & ER Psychiatric & ER-Psychiatric
Psychiatric – Non-ER	Medical & Inpatient Psychiatric Hospital Psychiatric & Medical Hospital Psychiatric & Psychiatric

We also created a new "Reasons for Hospitalization" variable by grouping free-text responses in the original *Reasons for Hospitalization* variable into six categories: 1) Aggressive Behavior, 2) Behavioral/Psychological Health, 3) Medical, 4) Self-Harm/Suicidal, 5) Co-Occurring, and 6) Other. For example, reasons that mentioned words like "mental health," "behavior," "dysregulation", and "psych issues" were mapped to Behavioral/Psychological Health; "punched", "combative," and verbal or physical threats were mapped to Aggressive Behavior; and so forth. The "Co-Occurring" category was included to identify children whose reasons spanned multiple categories.

[29] A small number of hospitalizations that did not meet the mapping criteria due to missing data or apparent data entry errors were manually reviewed and assigned to one of the four categories based on other information in the hospital file.

Lastly, we reduced the file to only children who could be found in the served file based on our matching efforts.[30] The final dataset used for analysis contained data on 1,788 hospitalizations for 870 children. 262 of these hospitalizations (for 195 children) met the criteria for a hospital overstay. If the child had more than one hospitalization overstay, the hospital episode with the most recent admission date was used for analysis. For this data set, note that SFY 2019 and 2024 do not represent a full year of data collection. As a result, the lower counts in these two years can lead to seemingly large fluctuations in percentages, which may not accurately reflect actual trends if a full year of data were available.

Results

Fifteen percent (15%) of the hospitalizations (262 out of 1,788), involving 195 children, met the criteria for a hospital overstay. 52 (27%) of these children experienced more than one hospital overstay.

Overstay episodes by SFY, region, age, and gender

Table 20 shows counts for the 195 children with at least one hospital overstay, by SFY of admission and region. In SFY 2023, the most recent year with a full year of data, the regions with the highest percentage of children with hospital overstays were Baltimore City (28%) and Baltimore County (22%).

[30] 31 records for children in the hospital file could not be found in the served file, using either CJAMSPID or by a fuzzy match with name and exact match for date of birth. These children were excluded from analysis.

Table 20. Number and percentage of children with hospital overstays, by SFY of admission and region

Region	2019	2020	2021	2022	2023	2024	2019	2020	2021	2022	2023	2024
Maryland	1	18	28	63	67	18	100%	100%	100%	100%	100%	100%
B. City		4	11	29	19	7		22%	39%	46%	28%	39%
B. County			1	13	15	2			4%	21%	22%	11%
Central		2	5	6	6	1		11%	18%	10%	9%	6%
Frederick		1			3			6%			4%	
Lower Shore			1	1	4				4%	2%	6%	
Montgomery		10	4	6	8	3		56%	14%	10%	12%	17%
Prince G.	1		4	1	2	4	100%		14%	2%	3%	22%
Southern				3	4	1				5%	6%	6%
Upper Shore		1	2	3	3			6%	7%	5%	4%	
Western				1	3					2%	4%	

If a child had more than one hospital overstay, the most recent overstay was selected for analysis.
Children with hospital overstays that could not be found in the served file were excluded.
SFY 2019 and SFY 2024 do not represent a full year of data collection.

Figure 10 shows the number and percentage of children with hospital overstays in SFY 2023 by age at admission and region. Most children with hospital overstays were aged 14 – 17 at admission (69%), followed by children aged 11 – 13 (13%). This greater prevalence among older youth was similar for most regions.

Figure 10. Number and percentage of children with hospital overstays, by age at admission and region (SFY 2023)

Region	Total	< 1	1 - 4	5 - 10	11 - 13	14 - 17	18+
Maryland	67	1% (1)	1% (1)	7% (5)	13% (9)	69% (46)	7% (5)
B. City	19	5% (1)		11% (2)	16% (3)	68% (13)	
B. County	15				7% (1)	80% (12)	13% (2)
Central	6					100% (6)	
Frederick	3				33% (1)	67% (2)	
Lower S.	4			25% (1)	25% (1)	50% (2)	
Montg.	8		13% (1)		38% (3)	50% (4)	
Prince G.	2					50% (1)	50% (1)
Southern	4			50% (2)		25% (1)	25% (1)
Upper S.	3					100% (3)	
Western	3					67% (2)	33% (1)

If a child had more than one hospital overstay, the most recent overstay was selected for analysis. Children with hospital overstays that could not be found in the served file were excluded.

Females were more likely to have a hospital overstay in SFY 2023 than males (57% vs. 42%). This greater prevalence of females was most pronounced in Central (83% female), Baltimore County (73% female), Upper Shore (67% female), and Montgomery (63% female) regions (Figure 11). (In SFY 2022, the percentage of overstays by gender was more balanced, with 48% female and 51% male.)

Figure 11. Number and percentage of children with hospital overstays, by gender and region (SFY 2023)

Region	Total	Female	Male	Transg.
Maryland	67	57% (38)	42% (28)	1% (1)
B. City	19	47% (9)	47% (9)	5% (1)
B. County	15	73% (11)	27% (4)	
Central	6	83% (5)	17% (1)	
Frederick	3	33% (1)	67% (2)	
Lower S.	4	50% (2)	50% (2)	
Montg.	8	63% (5)	38% (3)	
Prince G.	2	50% (1)	50% (1)	
Southern	4	25% (1)	75% (3)	
Upper S.	3	67% (2)	33% (1)	
Western	3	33% (1)	67% (2)	

If a child had more than one hospital overstay, the most recent overstay was selected for analysis.
Children with hospital overstays that could not be found in the served file were excluded.

Overstay episodes by length of stay (LOS)

In SFY 2023, the median length of stay (LOS) for children with overstays, from admission to discharge (or censored date), was 47 days (mean = 73.1, SD = 64.9). These children tended to stay about 37 days (median) more than their expected medical discharge date (mean=62.9 days [about two months], SD = 60.9). Across the state, 40% of children with overstays had an overstay of 10-30 days, 27% had an overstay of 31-60 days, and 33% had an overstay of 61 or more days (Figure 12).

Figure 12. Number and percentage of hospital overstay children by number of overstay days and region (SFY 2023)

Region	Total	10-30 days	31-60 days	61+ days
Maryland	67	40% (27)	27% (18)	33% (22)
B. City	19	53% (10)	21% (4)	26% (5)
B. County	15	40% (6)	27% (4)	33% (5)
Central	6	33% (2)	33% (2)	33% (2)
Frederick	3	33% (1)		67% (2)
Lower S.	4	25% (1)	50% (2)	25% (1)
Montg.	8	25% (2)	25% (2)	50% (4)
Prince G.	2	50% (1)	50% (1)	
Southern	4	50% (2)	50% (2)	
Upper S.	3	33% (1)		67% (2)
Western	3	33% (1)	33% (1)	33% (1)

If a child had more than one hospital overstay, the most recent overstay was selected for analysis. Children with hospital overstays that could not be found in the served file were excluded.

Overstay episodes by admission type

The majority of overstay episodes occurred among children with psychiatric admissions, both non-ER psychiatric (60%), which includes inpatient settings, and ER psychiatric (28%) (Figure 13). For some children with psychiatric inpatient hospitalizations, it is plausible that they started with an ER psychiatric admission and were moved to inpatient psychiatric. In these cases, the counts in Figure 13 would pick up the latter event given our choice to select the most recent hospitalization for children with more than one.

Figure 13. Number and percentage of hospital overstays by admission type and region (SFY 2023)

Region	Total	Psych (Non ER)	Psych (ER)	Medical (Non ER)	Medical (ER)
Maryland	67	60% (40)	28% (19)	9% (6)	3% (2)
B. City	19	47% (9)	47% (9)	5% (1)	
B. County	15	60% (9)	33% (5)		7% (1)
Central	6	67% (4)	17% (1)		17% (1)
Frederick	3	100% (3)			
Lower S.	4	50% (2)	25% (1)	25% (1)	
Montg.	8	63% (5)	13% (1)	25% (2)	
Prince G.	2	50% (1)	50% (1)		
Southern	4	75% (3)		25% (1)	
Upper S.	3	67% (2)	33% (1)		
Western	3	67% (2)		33% (1)	

If a child had more than one hospital overstay, the most recent overstay was selected for analysis. Children with hospital overstays that could not be found in the served file were excluded. "Non ER" admission types would include inpatient hospitalizations.

In SFY 2023, the majority of psychiatric admissions, both ER and non-ER, were for youth aged 14-17 (69%; Figure 14) and females (57%; Figure 15). Youth aged 14-17 made up 80% of non-ER psych admissions and 63% of ER psych admissions. Females made up 58% of non-ER psych admissions and 53% of ER psych admissions.

Figure 14. Number and percentage of hospital overstays by age and admission type (SFY 2023)

Admission Type	Total	< 1	1 - 4	5 - 10	11 - 13	14 - 17	18+
Total	67	1% (1)	1% (1)	7% (5)	13% (9)	69% (46)	7% (5)
Psych (Non ER)	40			5% (2)	10% (4)	80% (32)	5% (2)
Psych (ER)	19			5% (1)	21% (4)	63% (12)	11% (2)
Medical (Non ER)	6	17% (1)	17% (1)	33% (2)	17% (1)		17% (1)
Medical (ER)	2					100% (2)	

If a child had more than one hospital overstay, the most recent overstay was selected for analysis. Children with hospital overstays that could not be found in the served file were excluded. "Non ER" admission types would include inpatient hospitalizations.

Figure 15. Number and percentage of hospital overstays by gender and admission type (SFY 2023)

Admission Type	Total	Female	Male	Transg.
Total	67	57% (38)	42% (28)	1% (1)
Psych (Non ER)	40	58% (23)	40% (16)	3% (1)
Psych (ER)	19	53% (10)	47% (9)	
Medical (Non ER)	6	50% (3)	50% (3)	
Medical (ER)	2	100% (2)		

If a child had more than one hospital overstay, the most recent overstay was selected for analysis. Children with hospital overstays that could not be found in the served file were excluded. "Non ER" admission types would include inpatient hospitalizations.

Overstay episodes by reason for hospitalization

Fifty percent (50%) of hospital overstays in SFY 2023 occurred among children hospitalized due to behavioral/psychological health issues (25%) and self-harm and suicidal behavior (25%), followed closely by youth with aggressive behaviors (21%). Admissions due to aggressive behaviors were highest in Baltimore City (42%) and admissions due to behavioral/psychological health issues were highest in Frederick (67%) and Baltimore County (53%) but these are small counts (Figure 16).

Figure 16. Number and percentage of hospital overstays by reason for hospitalization and region (SFY 2023)

Region	Total	Beh. / Psych. Health	Self-Harm / Suicidal	Aggressive behavior	Medical	Other	Co-Occur.
Maryland	67	25% (17)	25% (17)	21% (14)	10% (7)	10% (7)	7% (5)
B. City	19	11% (2)	21% (4)	42% (8)	5% (1)	16% (3)	5% (1)
B. County	15	53% (8)	27% (4)	13% (2)	7% (1)		
Central	6		50% (3)	17% (1)		17% (1)	17% (1)
Frederick	3	67% (2)				33% (1)	
Lower S.	4	50% (2)			25% (1)	25% (1)	
Montg.	8	13% (1)	25% (2)	25% (2)	25% (2)		13% (1)
Prince G.	2		50% (1)	50% (1)			
Southern	4		50% (2)		25% (1)		25% (1)
Upper S.	3	33% (1)				33% (1)	33% (1)
Western	3	33% (1)	33% (1)		33% (1)		

If a child had more than one hospital overstay, the most recent overstay was selected for analysis. Children with hospital overstays that could not be found in the served file were excluded. "Behavioral / psychological health" reasons include admission reasons that include words like "mental health, "behavior", "AWOL," dysregulation," and "psych issues." "Co-occurring" comprises children whose reasons spanned multiple categories.

Youth aged 14-17 constituted the majority age group for every hospital overstay admission reason except Medical, which was more common for children younger than 11 (Figure 17).

Figure 17. Number and percentage of hospital overstays by age at admission and reason for hospitalization (SFY 2023)

Reason For Hosp.	Total	< 1	1 - 4	5 - 10	11 - 13	14 - 17	18+
Total	67	1% (1)	1% (1)	7% (5)	13% (9)	69% (46)	7% (5)
Beh. / Psych. Health	17				12% (2)	82% (14)	6% (1)
Self-Harm / Suicidal	17			6% (1)		82% (14)	12% (2)
Aggressive behavior	14			7% (1)	29% (4)	57% (8)	7% (1)
Medical	7	14% (1)	14% (1)	29% (2)	14% (1)	14% (1)	14% (1)
Other	7				14% (1)	86% (6)	
Co-Occur.	5			20% (1)	20% (1)	60% (3)	

If a child had more than one hospital overstay, the most recent overstay was selected for analysis. Children with hospital overstays that could not be found in the served file were excluded. "Behavioral / psychological health" reasons include admission reasons that include words like "mental health, "behavior", "AWOL," dysregulation," and "psych issues." "Co-occurring" comprises children whose reasons spanned multiple categories.

The largest differences by gender in reasons for hospitalization were for Behavioral/Psychological Health (65% female), Self-Harm/Suicidal (59% female), and Aggressive Behavior (71% male) (Figure 18).

Figure 18. Number and percentage of hospital overstays by gender and reason for hospitalization (SFY 2023)

Reason For Hosp.	Total	Female	Male	Transg.
Total	67	57% (38)	42% (28)	1% (1)
Beh. / Psych. Health	17	65% (11)	35% (6)	
Self-Harm / Suicidal	17	59% (10)	35% (6)	6% (1)
Aggressive behavior	14	29% (4)	71% (10)	
Medical	7	57% (4)	43% (3)	
Other	7	86% (6)	14% (1)	
Co-Occur.	5	60% (3)	40% (2)	

If a child had more than one hospital overstay, the most recent overstay was selected for analysis. Children with hospital overstays that could not be found in the served file were excluded. "Behavioral / psychological health" reasons include admission reasons that include words like "mental health, "behavior", "AWOL," dysregulation," and "psych issues." "Co-occurring" comprises children whose reasons spanned multiple categories.

Overstay episodes by hospital discharge recommendations

Overall, the most common discharge recommendation for children with hospital overstays was Residential Treatment Center (33%) and Group Home (33%) (Figure 19). Unsurprisingly, these

recommendations were highest for Psych ER (18%) and Psych Non-ER admission types (73%), and youth aged 14-17 (73% for both) (tables not shown).

Figure 19. Number and percentage of hospital overstays by discharge recommendation and region (SFY 2023)

Region	Total	RTC	Group Home	TFC	DETP	Psychiatric Hospital	Community	Reunification	Medically Fragile
Maryland	67	33% (22)	33% (22)	12% (8)	7% (5)	4% (3)	4% (3)	4% (3)	1% (1)
B. City	19	21% (4)	26% (5)	26% (5)	11% (2)	11% (2)		5% (1)	
B. County	15	40% (6)	27% (4)	7% (1)	13% (2)		13% (2)		
Central	6	50% (3)	50% (3)						
Frederick	3		33% (1)	33% (1)	33% (1)				
Lower S.	4	50% (2)				25% (1)	25% (1)		
Montg.	8	50% (4)	25% (2)					13% (1)	13% (1)
Prince G.	2		50% (1)					50% (1)	
Southern	4	25% (1)	75% (3)						
Upper S.	3	33% (1)	33% (1)	33% (1)					
Western	3	33% (1)	67% (2)						

If a child had more than one hospital overstay, the most recent overstay was selected for analysis. Children with hospital overstays that could not be found in the served file were excluded. RTC = Residential Treament Center; TFC = Treatment Foster Care; DETP = Diagnostic, Evaluation, and Treatment Program

Overstay episodes by prior setting and history

Of the 67 children with hospital overstays in SFY 2023 who were also found in the served file, we were able to reliably determine for 46 children the non-hospital setting that they were in immediately prior to the start of their hospital stay, along with details like number of prior foster care episodes, length of stay and number of moves for the current episode (as of the start of the hospitalization), and whether the youth was identified as having children.[31] The most common settings prior to the hospitalization were Treatment Foster Care (Private) (15%), Therapeutic Group Home (13%), and Relative/Fictive Kin Home (11%) and Regular Foster Care (11%). See Table 21.

[31] The other 21 children were excluded due to data quality problems related to placement dates.

Table 21. Placement setting prior to start of the overstay hospitalization (SFY 2023) (n = 46)

Placement category	Placement setting	Children	%
First entry into care	No prior placement	2	4%
Foster Care (Non-relative)	Regular Foster Care	5	11%
	Foster Care - Non-FH Setting	3	7%
	Emergency Foster Home Care	1	2%
	Respite Care	1	2%
Foster Care (Relative / Kin)	Relative/Fictive Kin Home	5	11%
	THV (Trial Home Visit)	4	9%
	Formal Kinship Care	1	2%
	Restricted (Relative) Foster Care	1	2%
Group Homes (Non-ther.)	Residential Group Home	4	9%
	Alternative Living Units	1	2%
Group Homes (Therapeutic)	Therapeutic Group Homes	6	13%
RTC	RTC	3	7%
Treatment Foster Care	Treatment Foster Care (Private)	7	15%
Other	Runaway	2	4%

Counts include only children with hospital spells who could be found in the served file, and for whom the previous placement setting could be reliably determined.

Table 22 provides additional information about the foster care history for the 46 children who experienced a hospital overstay in SFY 2023 and for whom prior history could be reliably determined. The majority of the children (67%) were in their first foster care episode, while 24% had two prior episodes, and 9% had three prior episodes.

Table 22. Foster care history prior to the start of the hospitalization (SFY 2023) (n = 46)

Characteristic	Children	%
Total	46	100%
Prior care episodes		
1	31	67%
2	11	24%
3	4	9%
LOS since removal		
< 8 days	5	11%
8 days to < 1 mo	5	11%
1 mo to < 6 mos	8	17%
6 to < 12 mos	6	13%
12 to < 24 mos	13	28%
24 to < 36 mos	7	15%
36 mos or more	2	4%
No of prior moves		
0	2	4%
1	15	33%
2	7	15%
3	8	17%
4	10	22%
5 +	4	9%
Relationship		
No children	46	100%

Counts include only children with hospital spells who could be found in the served file, and for whom the previous placement setting could be reliably determined.

Regarding the length of stay (LOS) since removal, 11% of the children had been in care for less than 8 days when their hospitalization started. (For 2 of these children, the hospitalization coincided with their removal from home). Another 11% were in care between 8 days and less than one month, 17% for one to six months, and 13% for six to twelve months. The remainder (47%) had been in care for at least one year prior to the start of their hospitalization.

In terms of the number of prior moves during their current foster care episode, 33% had one prior move, 15% had two prior moves, 17% had three prior moves, 22% had four prior moves, and 9% had

five or more prior moves (range 5 to 13). None of the youth were identified as having children of their own.

Limitations

The hospital data that the assessment team received had numerous errors in CJAMSPIDs, names, dates of birth, and overstay calculations. Recent changes which allow workers to track hospital data directly in CJAMS instead of in tracking sheets outside of CJAMS will invariably improve the quality and accuracy of information for this population. However, persistence and quality control efforts are still needed to ensure data on children in hospitals is documented accurately. The nature of acute hospitalizations and the evolving nature of prognoses, recommended discharge timeframes, and discharge recommendations will always pose challenges to keeping data current and accurate.

A key assumption of our defining the hospital overstay population is that the child's *Date of Medical Necessity Discharge* (which is compared to their *actual* discharge date to determine overstay status) is accurate. Our consultation with the SSA hospital liaison and other SSA staff revealed that this date, naturally, will often change over the course of a child's hospitalization due to updates in the child's prognosis and response to treatment. However, discussions with SSA staff and the hospital liaison indicated that the hospital (or worker documenting the hospital's recommendations) may not always update the record to capture the most current date of medical necessity discharge. Thus, it is possible that some children identified as having an overstay may not have experienced an overstay; the converse is also possible.

Finally, our discussions with SSA staff and the hospital liaison revealed that a child's discharge recommendation (e.g. RTC, group home, etc.) may not always be informed by the child's *needs* at discharge, but instead may reflect the types of placement settings currently available. And, as with the date of medical necessity discharge, the discharge recommendation may not be consistently updated as new information becomes available. As such, some caution is warranted when considering the discharge recommendations described in this assessment for children with hospital overstays.

Discussion & Conclusions

The analysis of hospital overstays highlights significant challenges in securing appropriate and timely placements for these children when they are ready for discharge. The findings indicate that 15% of hospitalizations resulted in overstays, involving 195 children, of whom 27% experienced more than one overstay. These overstays reflect difficulties in transitioning children from hospital settings to a suitable placement, particularly for those with significant behavioral or psychological health issues who were admitted for psychiatric reasons.

The results show that hospital overstays are more prevalent among older youth, particularly those aged 14-17, who made up the majority of overstay cases. This age group, along with females, appears to be disproportionately affected, especially in regions like Baltimore City and Baltimore County, where the highest percentages of hospital overstays were observed. The overrepresentation of older youth and females suggests that this population may have specific needs that are not adequately met, leading to extended hospital stays as workers struggle to find appropriate placements.

The length of stay (LOS) data further emphasizes the severity of the issue, with a median LOS of 47 days, and children overstaying their expected discharge by an average of 62.9 days. This extended duration prolongs the disruption in these children's lives, potentially exacerbating their behavioral and psychological issues. The fact that 88% of the children with hospital overstays were psychiatric admissions, involving significant behavioral issues, self-harm /suicide attempts, and aggression, underscores the complexity of their needs and the importance of securing placements that can provide the specialized care they require.

The data on prior placements reveals that many of these children were already in settings designed to provide higher levels of care, such as Treatment Foster Care and Therapeutic Group Homes, before their hospitalizations. This suggests that even specialized placements may not always be sufficient to meet the needs of these children, or that their needs change, leading to hospital admissions and subsequent overstays. Additionally, the significant number of prior moves experienced by these children indicates a high degree of instability in their foster care episodes due to unmet or changing needs, which likely contributes to the challenges in finding appropriate placements post-hospitalization.

Given these findings, several critical actions are needed to address the issue of hospital overstays youth in MDHHS care. First, there is a clear need to expand the availability of specialized placements that can accommodate the complex behavioral and psychological needs of older youth, particularly those aged 14-17. This may involve increasing the capacity of Residential Treatment Centers (RTCs) and Therapeutic Group Homes, as well as developing new programs specifically tailored to meet the needs of these high-risk populations.

Second, efforts should be made to improve the coordination and communication among hospitals, child welfare workers, and foster care providers to ensure that discharge recommendations are based on the most current and accurate assessments of a child's needs. This includes updating records to reflect changes in a child's prognosis and ensuring that discharge plans are informed by a thorough understanding of the child's behavioral and psychological profile.

Third, there is a need for ongoing quality control and data accuracy improvements within CJAMS to ensure that the information used to track hospital stays and discharge recommendations is reliable. This is particularly important given the potential for discrepancies in the documentation of the Date of Medical Necessity Discharge, which could lead to misclassification of hospital overstay cases.

Unfortunately, the administrative hospitalization data does not provide information about what factors led up to the hospitalization, such as whether the crises (in the case of psychiatric admissions) could have been anticipated and if services were being provided to support the child and caregiver. The data also does not indicate *why* these children overstayed their expected discharge date; but, given the acute nature of most admissions, one possibility is that some congregate care settings may have been reluctant to take some youth if they were concerned about continued suicidal or violent behavior. Alternatively, it is possible that workers' efforts to secure an appropriate placement were not sufficient. These open questions were among those which led the assessment team to conduct a case review (described later in this report) for a sample of children with hospital overstays, in the hopes that additional documentation would shed more light on the nature of these overstays and the needs of the youth who experienced them.

Population 3 – Children historically served by Maryland's Child Welfare System who experienced a hotel stay

Data

SSA provided the assessment team with a list of children in foster care with hotel stays that started between April 2022 to October 2023. After data cleaning, this list included data on 162 hotel stays for 142 unique children. SSA extracted this data from a centralized spreadsheet that local departments use to report hotel stays; this data was not routinely collected in CJAMS during this period. Variables in the hotel file included child identifiers (i.e. CJAMSPID, child initials), the date the child entered and exited the hotel, the recommended placement type (*Placement type that is needed*), and a note about whether any admission or placement interviews are pending. The file included one record per child, per hotel entry and exit.

For children with multiple hotel start and end dates that were close together, we combined these into unique hotel spells. A hotel spell was any period of entries and exits that occurred within six consecutive days of each other. For example, if a child entered the hotel on Monday, exited on Wednesday, and then had another hotel start on Friday, these two stays were considered one hotel spell. If a subsequent entry occurred more than six days after the previous exit, this constituted a new hotel spell. When calculating length of stay, if the exit date was missing the child was assumed to still be in the hotel, in which case the length of stay was as of November 30, 2023 (i.e. the censor date), when the file was provided to the assessment team. In some cases, the assumption that a missing

discharge means the child is still in the hotel may be wrong. If their start date was long ago, the use of the censor date could lead to a very high LOS. If the child had more than one hotel spell, the spell with the most recent start date was used for analysis.

The *Placement type that is needed* field was a free-text field, and many children had multiple placement types listed. We parsed each type mentioned into its own placement type field (yes/no).

Results

Hotel stays by SFY, region, age, gender, and race

Table 23 shows counts for the 142 children with at least one hotel stay, by SFY and region. Note that SFY 2022 and 2024 do not represent a full year of data collection. In SFY 2023, Baltimore County had the highest percentage of children with hotel stays (40%), followed by Baltimore City (19%) and Prince George's (15%). Sixteen (11%) of these children experienced more than one hotel stay, meaning two or more hotel stays that were more than 6 days apart.

Table 23. Number and percentage of children with hotel stays, by SFY and region

Region	2022	2023	2024	2022	2023	2024
Maryland	3	102	37	100%	100%	100%
B. City		19	1		19%	3%
B. County		41	12		40%	32%
Central		7	2		7%	5%
Frederick		2			2%	
Lower Shore	1	4	1	33%	4%	3%
Montgomery		5	7		5%	19%
Prince G.	2	15	3	67%	15%	8%
Southern		1	1		1%	3%
Upper Shore		2	6		2%	16%
Western		6	4		6%	11%

If a child had more than one hotel stay, the most recent stay was selected for analysis.
Children with hotel stays that could not be found in the served file were excluded.
SFY 2022 and SFY 2024 do not represent a full year of data collection.

Table 24 shows the number and percentage of children with hotel stays in SFY 2023 by age and region. SFY 2023 was selected because it is the most recent year for which a full year of data was available. Most children with hotel stays were aged 14-17 (56%) and 18+ (25%). The higher prevalence among older youth was similar for most regions.

Table 24. Number and percentage of children with hotel stays, by age and region (SFY 2023)

Region	Total	Total	5 - 10	11 - 13	14 - 17	18+	5 - 10	11 - 13	14 - 17	18+
Maryland	102	100%	3	17	57	25	3%	17%	56%	25%
B. City	19	100%			9	10			47%	53%
B. County	41	100%	2	12	22	5	5%	29%	54%	12%
Central	7	100%			6	1			86%	14%
Frederick	2	100%			2				100%	
Lower Shore	4	100%	1		2	1	25%		50%	25%
Montgomery	5	100%		1	2	2		20%	40%	40%
Prince G.	15	100%		3	8	4		20%	53%	27%
Southern	1	100%			1				100%	
Upper Shore	2	100%			2				100%	
Western	6	100%		1	3	2		17%	50%	33%

If a child had more than one hotel stay, the most recent stay was selected for analysis.
Children with hotel stays that could not be found in the served file were excluded.
SFY 2022 and SFY 2024 do not represent a full year of data collection.

Fifty-two percent (52%) of children with hotel stays were female. The proportion of females was higher in all regions except Lower Shore (50%) and Montgomery (20%) (Table 25).

Table 25. Number and percentage of children with hotel stays, by gender and region (SFY 2023)

Region	Total	Total	Female	Male	Transg.	Female	Male	Transg.
Maryland	102	100%	53	47	2	52%	46%	2%
B. City	19	100%	11	7	1	58%	37%	5%
B. County	41	100%	22	19		54%	46%	
Central	7	100%	4	3		57%	43%	
Frederick	2	100%	2			100%		
Lower Shore	4	100%	2	2		50%	50%	
Montgomery	5	100%	1	4		20%	80%	
Prince G.	15	100%	6	8	1	40%	53%	7%
Southern	1	100%		1			100%	
Upper Shore	2	100%	1	1		50%	50%	
Western	6	100%	4	2		67%	33%	

If a child had more than one hotel stay, the most recent stay was selected for analysis.
Children with hotel stays that could not be found in the served file were excluded.

The majority of children with hotel stays were Black or African American (64%). This was true in all regions except Frederick, Upper Shore, and Western (Table 26).

Table 26. Number and percentage of children with hotel stays, by race/ethnicity and region

Region	Total	Total	Black	Hispanic	White	Two or More	UTD	Black	Hispanic	White	Two or More	UTD
Maryland	102	100%	65	8	21	6	2	64%	8%	21%	6%	2%
B. City	19	100%	18			1		95%			5%	
B. County	41	100%	22	7	10	1	1	54%	17%	24%	2%	2%
Central	7	100%	6		1			86%		14%		
Frederick	2	100%			2					100%		
Lower Shore	4	100%	3			1		75%			25%	
Montgomery	5	100%	3		2			60%		40%		
Prince G.	15	100%	12	1	1	1		80%	7%	7%	7%	
Southern	1	100%	1					100%				
Upper Shore	2	100%			2					100%		
Western	6	100%			3	2	1			50%	33%	17%

If a child had more than one hotel stay, the most recent stay was selected for analysis.
Children with hotel stays that could not be found in the served file were excluded.

Hotel stays by length of stay (LOS)

In SFY 2023, the median length of stay (LOS) for children with hotel stays, from the start of the spell to the end (or censor date), was 43 days (mean = 87.6, SD = 102). Recall that we created hotel *spells*, so if a child entered the hotel on Monday, exited on Wednesday, and then had another hotel start on Friday, these two hotel stays were considered one hotel spell, so the LOS in days is calculated from the first day to the last day. In other words, for some children who were in and out of the hotel for multiple days within proximity to each other, the *actual* number of days they spent in the hotel may be lower than their calculated LOS.

Figure 20 shows the median LOS in days by region, age, gender, and race and ethnicity. Note the count of children to determine the number of children the LOS is based on, because in some cases the number is low. In six jurisdictions (Baltimore City, Central, Frederick, Lower Shore, Montgomery, and Prince George's), the median LOS was higher than the overall statewide LOS (43 days). The median LOS was highest among children aged 11-13 (64 days), males (64 days),[32] and children who identify as Black or African American (59 days) or as two or more races (98 days).

[32]Youth who identify as transgender had a higher LOS (68 days), but this was based on only two youth.

Figure 20. Median length of stay (in days) for children in hotel spells, by region, age, gender, and race (SFY 2023)

by Region

Region	Children	Median LOS
Maryland	102	43
B. City	19	44
B. County	41	25
Central	7	83
Frederick	2	71
Lower S.	4	49
Montg.	5	82
Prince G.*	15	203
Southern	1	7
Upper S.	2	32
Western	6	4

by Age

Age At Start	Children	Median LOS
Total	102	43
5 - 10	3	21
11 - 13	17	64
14 - 17	57	39
18+	25	41

by Gender

Gender	Children	Median LOS
Total	102	43
Female	53	35
Male	47	64
Transg.	2	68

by Race

Race Eth	Children	Median LOS
Total	102	43
Black	65	59
Hispanic	8	33
White	21	35
2 or More	6	98
UTD	2	33

If a child had more than one hotel stay, the most recent stay was selected for analysis. Children with hotel stays that could not be found in the served file were excluded.

A hotel spell was any period of hotel entries and exits that occurred within six consecutive days of each other. The LOS is calculated from the first day to the last day of the spell. If the hotel exit date was missing the child was assumed to still be in the hotel in which case the length of stay was as of November 30, 2023 (i.e. the censor date), when the file was provided to the assessment team.

* Many hotel stays for Prince George's were missing a hotel exit date, so the assumption they were still in the hotel as of November 30, 20223 may not be correct and may explain the high median LOS in this jurisdiction.

Hotel stays by placement type that is needed

Figure 21 shows the number and percentage of children with a hotel stay in SFY 2023 by the worker's recommended placement setting(s). The most frequently recommended settings were Group Home (Non-Therapeutic) (52%) and Treatment Foster Care (32%). Many children had multiple recommended settings listed.

Figure 21. Recommended placement settings for children in hotels (SFY 2023)

Recommended placement setting	Children	# with this rec.	
Group Home (Non Therapeutic)	102	53	52%
Treatment Foster Care	102	33	32%
Group Home (Therapeutic)	102	22	22%
Foster Care	102	18	18%
RTC	102	16	16%
Independent Living	102	12	12%
No recommendation provided	102	8	8%
Mother Baby Program	102	5	5%

A child can have one or more recommended settings. Therefore, the counts of recommended settings will exceed the number of children.

Figure 22 shows how the recommended placement settings vary by region, for children in hotels in SFY 2023. Note that counts for several regions and placement settings are low.

Figure 22. Recommended placement settings for children in hotels, by region (SFY 2023)

Percentages

Recommended placement setting	MD	B. City	B. County	Central	Frederick	L. Shore	Montg.	Prince G.	Southern	U. Shore	Western
Group Home (Non Therapeutic)	52%	58%	46%	71%	50%	50%	80%	40%	100%	50%	50%
Treatment Foster Care	32%	58%	22%	43%	50%	0%	40%	27%	100%	50%	17%
Group Home (Therapeutic)	22%	53%	15%	57%	50%	0%	0%	0%	0%	50%	0%
Foster Care	18%	42%	24%	0%	0%	0%	0%	0%	0%	0%	0%
RTC	16%	5%	12%	0%	50%	25%	0%	47%	0%	50%	0%
Independent Living	12%	11%	7%	29%	0%	25%	0%	13%	0%	0%	33%
No recommendation provided	8%	0%	20%	0%	0%	0%	0%	0%	0%	0%	0%
Mother Baby Program	5%	16%	0%	0%	0%	25%	0%	0%	0%	0%	17%

Counts

Recommended setting	MD	B. City	B. County	Central	Frederick	L. Shore	Montg.	Prince G.	Southern	U. Shore	Western
Children	102	19	41	7	2	4	5	15	1	2	6
Group Home (Non Therapeutic)	53	11	19	5	1	2	4	6	1	1	3
Treatment Foster Care	33	11	9	3	1	0	2	4	1	1	1
Group Home (Therapeutic)	22	10	6	4	1	0	0	0	0	1	0
Foster Care	18	8	10	0	0	0	0	0	0	0	0
RTC	16	1	5	0	1	1	0	7	0	1	0
Independent Living	12	2	3	2	0	1	0	2	0	0	2
No recommendation provided	8	0	8	0	0	0	0	0	0	0	0
Mother Baby Program	5	3	0	0	0	1	0	0	0	0	1

Hotel stays by prior setting and history

Of the 102 children with hotel stays in SFY 2023 who were also found in the served file, we were able to reliably determine for 80 children the setting they were in immediately prior to the start of their hotel spell, along with details like number of prior foster care episodes, length of stay and number of moves for the current episode (as of the start of the hotel spell), and whether the youth was identified as having children.[33] For 20 children (25%), their hotel spell started on the same day they were removed from home, which means this was their first documented stay with MDDHS for their current episode. Twenty-one children (26%) were previously in a non-relative foster care setting, 13

[33]The other 22 children were excluded due to data quality problems related to placement dates.

(16%) were in a group home, and 12 (15%) were in an "Other" setting, such as runaway, homeless, and secure juvenile detention (Table 27).

Table 27. Placement setting prior to start of the hotel spell (SFY 2023) (n = 80)

Placement category	Placement setting	Children	%
First entry into care	No prior placement	20	25%
Foster Care (Non-relative)	Foster Care - Non-FH Setting	8	10%
	Regular Foster Care	5	6%
	Respite Care	3	4%
	Independent Living Res. Program	2	3%
	SILA home/Apartment	2	3%
	Intermediate Foster Care	1	1%
Foster Care (Relative / Kin)	Relative/Fictive Kin Home	2	3%
	Biological Parent	1	1%
Group Homes (Non-ther.)	Residential Group Home	4	5%
	Alternative Living Units	1	1%
Group Homes (Therapeutic)	Therapeutic Group Homes	8	10%
Treatment Foster Care	Treatment Foster Care (Private)	4	5%
	TFC, Level 3	1	1%
Hospitalizations (Psych)	Inpatient Psychiatric Hospital	3	4%
	ER Psychiatric	2	3%
Hospitalizations (General)	ER Medical	1	1%
Other	Runaway	8	10%
	Homeless	3	4%
	Secure Juvenile Detention	1	1%

Counts include only children with hotel spells who could be found in the served file, and for whom the previous placement setting could be reliably determined.

Table 28 provides additional information about the foster care history for the 80 children who experienced hotel stays in SFY 2023 and for whom prior history could be reliably determined. Most children had limited prior foster care episodes, with 69% being on their first foster care episode with MDDHS, 16% having two prior episodes, and a smaller proportion (15%) having three or more prior episodes.

Regarding the length of stay since removal, a little over a quarter of the children (28%) had been in care for less than 8 days when their hotel stay started. (Recall that 20 children started their hotel stay the same day they entered care.) Sixteen percent had been in care for 8 days to 6 months, 10% had

been in care between 6 and 12 months, and the remainder (46%) had been in care for more than a year.

In terms of the number of prior moves during their current episode, 25% of the children had no prior moves, 18% had one prior move, and 28% had between two to four prior moves. Notably, nearly a third of the children (29%) had experienced five or more prior moves as of the start of their hotel spell (range = 5 to 15).

The parent status of the children revealed that the overwhelming majority (93%) were not identified as having children. Only a small number of children were identified as parents, with 1% having a father status and 6% a mother status.

Table 28. Foster care history prior to the start of the hotel spell (SFY 2023) (n = 80)

Characteristic	Children	%
Total	80	100%
Prior care episodes		
1	55	69%
2	13	16%
3	9	11%
4	2	3%
6	1	1%
LOS since removal		
< 8 days	22	28%
8 days to < 1 mo	7	9%
1 mo to < 6 mos	6	8%
6 to < 12 mos	8	10%
12 to < 24 mos	12	15%
24 to < 36 mos	13	16%
36 mos or more	12	15%
No of prior moves		
0	20	25%
1	14	18%
2	8	10%
3	8	10%
4	7	9%
5 +	23	29%
Parent status		
No children	74	93%
Father	1	1%
Mother	5	6%

Counts include only children with hotel spells who could be found in the served file, and for whom the previous placement setting could be reliably determined.

Limitations

As with the hospitalization file, the hotel data documents only basic information; in this case, which children are in hotels, when they entered and left, and the placement setting the worker recommends. Tracking such data is critical in terms of monitoring whether hotel stays are on the decline and what regions and age groups are most impacted, but it is not sufficient to understand the child's needs, what clinical or historical events led to their hotel stay, and reasons a more appropriate placement was not available.

Discussion & Conclusions

The analysis of data on children who experienced hotel stays during their foster care episodes reveals several critical insights that highlight the unique and complex needs of this population. Hotel stays, like office stays, are an undesirable and last-resort option, typically used when no appropriate placement is available. The findings from the hotel data underscore the need for more strategic and targeted efforts to address the placement needs of these children.

Hotel stays are more prevalent among older youth, particularly those aged 14-17, and among those who identify as Black or African American. The majority of children with hotel stays are in their first foster care episode, suggesting that these children may be particularly vulnerable to instability and the trauma of removal early in their time with the child welfare system. However, a significant portion of these children also have extensive foster care histories, with multiple prior episodes and moves, possibly indicating a high degree of instability and ongoing placement challenges.

The median LOS in hotels of 43 days, with some children remaining in hotels for extended periods, reflects the challenges in securing timely and appropriate placements. This is particularly concerning given that extended stays in non-therapeutic, temporary settings like hotels can exacerbate trauma these children have already experienced. The longer LOS among specific groups, such as males and those identifying as Black or African American or multiracial, suggests that these groups may face additional barriers to finding appropriate placements.

The recommended placement settings for children with hotel stays, predominantly group homes and treatment foster care, indicate that these children have significant needs that require specialized care. However, it is unclear from the available data if use of hotel placements is due to a shortage of appropriate placements, particularly for children with complex behavioral and emotional needs, or other factors, such as youth preference or inappropriate provider rejections.

Furthermore, the data on the prior placement settings of these children, with many coming directly from non-relative foster care or other unstable situations such as runaways or juvenile detention, suggests that these children are already experiencing significant instability before their hotel stay

begins. Further evidence of instability is the high number of prior moves within their current foster care episode.

Given these findings, there is an urgent need to develop placement options that meet the changing needs of children in foster care; particularly those who are older, have complex needs, or have experienced significant placement instability. Strategies could include increasing the availability of therapeutic foster care and group home settings, developing specialized programs for older youth, and ensuring that children entering care for the first time are placed with kinship caregivers whenever possible.

Additionally, the data highlights the importance of addressing racial disparities in foster care placements. The overrepresentation of Black and African American children in hotel stays suggests that these children may face systemic barriers to receiving appropriate placements. Efforts to address these disparities should include culturally competent placement practices and targeted recruitment of foster care providers who can meet the needs of these children.

Population 4 – Children historically served by Maryland's Child Welfare System who experienced an office stay (Baltimore City only)

Data

SSA provided the assessment team with a list of children in foster care, in Baltimore City, with office stays that started between June 2021 to January 2024.[34] After data cleaning, this list included data on 740 office stays for 494 children. The data is from the front desk visitor log which individuals must complete each time they enter and exit the building; this information is not captured in CJAMS. Variables in the office file included child identifiers (i.e., CJAMSPID, child name), demographic information, and the date and time the child entered and exited the office. The file included one record per child, per office entry and exit.

We defined children who experienced an office stay as those who spent more than four hours in the office.[35] Many children entered and exited the office multiple times, either in a given day or over the course of several days. For children with multiple entries and exits that were close together, we combined these into unique office spells. An office spell was any period of entries and exits that

[34]The Modified Consent Decree in *L.J., et al. v. Ruth Massinga, et al.* requires BCDSS to track and report on children in BCDSS custody who experience office stays.

[35]If the exit date was missing, the child was assumed to still be in the office in which case the length of stay was as of January 12, 2024 (i.e., the censor date), when the file was provided to the assessment team.

occurred within six consecutive days of each other. For example, if a child entered and exited the building three times on Tuesday, and two more times on Wednesday, these multiple entries and exits were considered one office spell. If a subsequent entry occurred more than six days since the previous exit, this constituted a new office spell. The "four-hour" rule was applied to the child's entire office spell, instead of the individual entries and exits that comprised the spell. For example, if a child spent two hours in the office on a Monday and three hours on Tuesday, this was considered a spell that lasted five hours. Given this context, LOS is measured in hours instead of days. If the child had more than one office spell, the spell with the most recent start date was used for analysis.

Results

Office stays by SFY, age, gender, and race

Table 29 shows counts for the 203 children in Baltimore City with at least one office stay during the past four SFYs. Note that SFY 2021 and 2024 do not represent a full year of data collection. The most office stays occurred in 2022 (95 children) and dropped by 51% in 2023 (47 children). Fifty-five (27%) of these children experienced more than one office stay, meaning two or more office stays that were more than 6 days apart.

Table 29. Number and percentage of Baltimore City children with office stays, by SFY

Region	2021	2022	2023	2024
B. City	5	95	47	56

If a child had more than one office stay, the most recent stay was selected for analysis.
Children with office stays that could not be found in the served file were excluded.
SFY 2021 and SFY 2024 do not represent a full year of data collection.

Table 30 shows the number and percentage of Baltimore City children with office stays in SFY 2023 by age, gender, and race and ethnicity. SFY 2023 was selected because it is the most recent year for which a full year of data was available. Most children with office stays were aged 14-17 (53%), female (53%), and Black or African American (89%).

Table 30. Number and percentage of Baltimore City children with office stays, by age, gender, race & ethnicity (SFY 2023)

Characteristic	#	%
Total	47	100%
Age At Start		
1 - 4	1	2%
5 - 10	6	13%
11 - 13	7	15%
14 - 17	25	53%
18+	8	17%
Gender		
Female	25	53%
Male	21	45%
Transgender	1	2%
Race & Ethnicity		
Black or AA	42	89%
Hispanic	2	4%
White	3	6%

If a child had more than one office stay, the most recent stay was selected for analysis. Children with office stays that could not be found in the served file were excluded. Hispanic can be of any race. UTD = Unable to determine.

Office stays by length of stay (LOS)

In SFY 2023, the median length of stay in hours (LOS) for children with office stays was 12 hours (mean = 17.5, SD = 13.9, range = 4.7 to 78.6 hours). Recall that we created office *spells* which may include multiple entries and exits into the building over the course of one or more days, up to six days before a new spell was defined. In other words, for children who entered and exited the building multiple times, their LOS reflects the time they spent when in the office, which may have spanned more than one day.

Figure 23 shows the median LOS in hours by age, gender, and race and ethnicity. The median LOS was highest for children aged 14 and older (14.9 hours), males (13.9 hours),[36] and children who identify as Black or African American (14.4 hours).

Figure 23. Median length of stay (in hours) for Baltimore City children in office spells (SFY 2023)

by Age

Age At Start	Children	Median Los (Hours)
Total	47	12.1
1 - 4	1	11.2
5 - 10	6	10.2
11 - 13	7	8.5
14 - 17	25	12.1
18+	8	19.4

by Gender

Gender	Children	Median Los (Hours)
Total	47	12.1
Female	25	11.8
Male	21	13.9
Transgender	1	14.9

by Race

Race & Ethnicity	Children	Median Los (Hours)
Total	47	12.1
Black or AA	42	14.4
Hispanic	2	12.1
White	3	8.5

If a child had more than one office spell, the most recent spell was selected for analysis. Children with office spells that could not be found in the served file were excluded.

A office spell was any period of office entries and exits that occurred within six consecutive days of each other. The LOS is the total hours spent in the office during the spell based on the building entry and exit times.

Office stays by prior setting and history

Of the 47 Baltimore City children with office stays in SFY 2023 who were also found in the served file, we were able to reliably determine for 33 children the setting they were in immediately prior to the start of their office spell, along with details like number of prior foster care episodes, length of stay and number of moves for the current episode (as of the start of the office spell), and whether the youth was identified as having children.[37] For 10 children (30%), their office spell started on the same day they were removed from home, which means this was their first documented stay with MDDHS for their current episode. Seven children (21%) were previously in a non-relative foster care setting, 7 (21%) were on runaway status or homeless, and four (12%) were in a therapeutic group home. See Table 31.

[36]Youth who identify as transgender had a higher LOS (68 days), but this was based on only two youth.

[37]The other 14 children were excluded due to data quality problems related to placement dates.

Table 31. Placement setting prior to start of the office spell (SFY 2023) (n = 33)

Placement category	Placement setting	Children	%
First entry into care	No prior placement	10	30%
Foster Care (Non-relative)	Foster Care - Non-FH Setting	3	9%
	Regular Foster Care	2	6%
	Intermediate Foster Care	1	3%
	Own Home/Apartment	1	3%
Foster Care (Relative / Kin)	Relative/Fictive Kin Home	2	6%
	Fathers Home	1	3%
Group Homes (Therapeutic)	Therapeutic Group Homes	4	12%
Treatment Foster Care	Treatment Foster Care (Private)	1	3%
Hospitalizations (Psych)	Inpatient Psychiatric Hospital	1	3%
Other	Runaway	6	18%
	Homeless	1	3%

Counts include only children with office spells who could be found in the served file, and for whom the previous placement setting could be reliably determined.

Table 32 provides information about the foster care history for the 33 Baltimore City children who experienced office stays in SFY 2023 and for whom prior history could be reliably determined. A significant portion of these children had multiple prior foster care episodes, with 75% having one or two prior episodes—36% with one prior episode and 39% with two. A smaller number of children had more extensive histories, with 15% having three prior episodes, 6% having four, and 3% having six prior episodes.

Table 32. Foster care history prior to the start of the office spell (SFY 2023) (n = 33)

Characteristic	Children	%
Total	33	100%
Prior care episodes		
1	12	36%
2	13	39%
3	5	15%
4	2	6%
6	1	3%
LOS since removal		
< 8 days	12	36%
8 days to < 1 mo	1	3%
1 mo to < 6 mos	3	9%
6 to < 12 mos	5	15%
12 to < 24 mos	5	15%
24 to < 36 mos	2	6%
36 mos or more	5	15%
No of prior moves		
0	10	30%
1	4	12%
2	5	15%
3	3	9%
5 +	11	33%
Parent status		
No children	29	88%
Father	1	3%
Mother	3	9%

Counts include only children with office spells who could be found in the served file, and for whom the previous placement setting could be reliably determined.

In terms of the length of stay (LOS) since removal, the largest proportion of children (36%, n = 12) had been in care for less than 8 days at the start of their office stay. (Recall that 10 of these children started their office stay the same day they entered care.) A smaller percentage of children had been in care for 8 days to 6 months (12%), 15% had been in care for 6 to 12 months, and the remainder (36%) had been in care for more than a year.

The number of prior moves during the current foster care episode varied among the children. While 30% had not experienced any prior moves, 12% had one prior move, 24% had experienced between two and four prior moves, and a significant portion (33%) had five or more prior moves (range = 5 to 19). Regarding parent status, the majority of children (88%) were not identified as having children. A small percentage were identified as parents, with 3% being fathers and 9% being mothers.

Limitations

Like the hotel data, the office data provides limited information and can be used only to assess the frequency and magnitude of office stays in Baltimore City, by age and gender. The numerous errors in the spelling of children's names and dates of birth, presumably both transcribed from the building logs, meant that 85 children could not be located in the served file, even with fuzzy logic that is somewhat forgiving with minor spelling differences. The placement histories for an additional 14 children who were in the served file, could not be determined due to data quality problems related placement dates. Improving the accuracy of office logs and placement dates in CJAMS would help SSA identify more of these children in CJAMS if deeper analysis and context is needed to understand the nature of these office stays. Further, LDSS are not required to capture information in CJAMS or on a file related to events leading up to office stay, placement before an office stay, or child needs that may have contributed to a youth's office stay. Expanding the types of information collected would further allow SSA to understand the nature of office stays and identify if factors that contributed to them could be prevented or mitigated.

Discussion & Conclusions

The findings from the analysis of children who experienced office stays in Baltimore City during their foster care episodes reveal critical challenges that need to be addressed to better support this vulnerable population. Office stays, much like hotel stays, are an undesirable solution when no appropriate placements can be found. The data highlights the frequency and duration of these office stays, as well as the needs of the children who experience them.

The data indicates that the number of office stays decreased significantly between SFY 2022 and SFY 2023, which may reflect efforts to reduce reliance on office stays . Older youth ages 14-17 experience BCDSS office stays more frequently than younger children. This age group is disproportionately represented in office stays, which suggests underlying issues in the availability of foster care placements for older youth. The majority of office stays occurred with Black or African American youth, but this is easily attributable to the large Black or African American child population in Baltimore City.

The median length of stay (LOS) in offices was 12 hours, with some children spending up to 78 hours in the office for a given spell. Although the median LOS is relatively short, the fact that children are spending significant time in offices, often spanning multiple days, raises concerns about the adequacy of these environments for meeting their needs. Extended stays in offices may exacerbate trauma children already experienced, highlighting the need for more suitable and stable placement options.

The placement history data further underscores the instability many of these children face. A significant proportion of children who had office stays were removed from home on the same day their office stay began, indicating a lack of immediate, appropriate placement options. Additionally, many of these children have experienced multiple prior foster care episodes and numerous moves within their current episode, reflecting a high degree of instability and ongoing placement challenges. 33% of these children had five or more prior moves; this is particularly concerning, as frequent moves are associated with disrupted social networks, educational instability, and emotional and behavioral issues. Given these findings, several key actions are needed to reduce office stays.

First, there is an urgent need to expand the availability of appropriate placement options for older youth, who are disproportionately represented in office stays. This could involve developing more specialized foster care programs and therapeutic group homes that are equipped to meet the complex needs of these children. Second, efforts should be made to reduce office stays by ensuring that children are placed in stable, long-term environments as quickly as possible after entering care. Reducing office stays may require improving the processes for matching children with placements that meet their needs and increasing support to families and foster care providers to prevent placement disruptions.

Finally, the limitations identified in the data collection process, particularly related to the accuracy of office logs and placement dates, must be addressed. Improving data quality and expanding the types of information collected would allow for a deeper understanding of the factors contributing to office stays and inform strategies to reduce their use. By capturing more detailed information about the needs of the children SSA can develop more targeted interventions to prevent office stays.

Further insights into the office population are provided in the following case review section.

Case Review

Introduction

To further our understanding of youth-specific placement needs given the data quality issues with each population investigated, the team conducted a limited case review for a stratified sample of children with hospital overstays, hotel stays, and office stays. The case review was designed to extract

information about placement needs from placement information forms and similar forms not readily available in the administrative data. The key forms of interest were the Child Placement Information Form, Placement Referral Form, Form 818, and Form 872. Caseworkers are expected to use these forms when seeking an initial placement or a subsequent placement change for a child. In preparation for the review, SSA staff obtained these or similar forms for each child in the sample.[38]

The case review consisted of a quantitative analysis of the needs of children who experienced hospital overstays, hotel stays, and office stays and a two-step qualitative analysis. For the quantitative portion, a team of volunteer case reviewers indicated in a case review survey whether reviewed documentation suggested or indicated the presence or absence of 37 distinct needs, detailed in the Methods section below. The first part of the qualitative analysis consisted of a review of three open-text responses in the case review survey tool. The three open-text questions were included to solicit and capture any additional contextual information the case reviewers might have felt was important to fully understand the 'story' behind why a child may have experienced a hospital overstay, or a hotel or office stay, or why a case reviewer may have struggled with answering any in the case review survey. The second component of the qualitative analysis consisted of a follow-up debriefing session with a convenience sample of case reviewers. This component was added to allow case reviewers the opportunity to expand on the observations and insights they shared in the open-text fields.

Method

Sample

Each sample was based on a 90% confidence interval and 10% margin of error and stratified according to Table 33. We applied a proportional stratified sampling approach for sample selection to ensure that our sample for each index event in the case review reflected the overall distribution of regions, ages, and index event specific parameters observed in the overall population of children in each of the three populations. We also applied a minimum size constraint to each stratum to ensure at least one child was included for each criterion; otherwise, stratums with very few children may have been completely excluded from the sample.

[38] Initially, forms for five children in the sample could not be located; these children were replaced with five alternates.

Table 33. Sampling frame for the case review

	Hospital Overstay	Office Stay	Hotel Stay
Population Size	187	196	142
Sample Size	51	46	51
Strata	• Region (B. City, All others) • Age at admission (0-4, 5-13, 14-17, 18+) • Admission type (Medical - ER ; Medical - Non-ER ; Psych – ER ; Psych - Non-ER)	• Age at start of stay (0-4. 4-13, 14-17, 18+) • Number of office stays (1, 2-5, 6+)	• Region (B. City, B. County, Montgomery, Prince George's, All Others) • Age at start of stay (0-4. 5-13, 14-17, 18+)

The sample included 148 events for 141 unique children (seven children were selected twice, for different events). If a child had multiple events of the same type (e.g. a child with two hospital overstays), only the child's most recent event was selected for review. To be considered in the population, the child must have met the criteria for the stay (i.e. hospital overstay of more than 10 days, office stay of more than 4 hours, or hotel stay). In addition, to be in the population the child must have been found in the served file by matching on their CJAMS Person ID or by a fuzzy match by name and exact match by date of birth. The served file requirement was to ensure we could provide additional information to reviewers about these children and have additional data for analysis. As noted previously, not all children in the hospital, hotel, and office files could be found in the served file due to mistyped or missing CJAMSPIDs, names, and dates of birth.

Case Review Tool

The team developed a case review survey tool (Appendix G) designed to confirm or collect the following details on each child based on their review of the documentation provided:

1. Jurisdiction at the time of the event.
2. Event start and end date.
3. Pregnant or parenting status.
4. Setting immediately prior to the event.
5. Date DSS identified the need for a placement.

6. Date DSS search for placement began.
7. Any other relevant notes about what led up to the child's hospitalization, hotel, or office stay.[39]
8. Any additional information the reviewer found in the child's documentation that they believed could be relevant to understanding the child's placement needs and challenges, at or around the time of their experiencing a hospital, hotel, or office stay.
9. Whether the reviewer struggled to answer any of the questions in the survey, and if so, a list or brief description of those questions.

The tool also asked reviewers to indicate whether documentation suggested or indicated the presence or absence of 37 needs, which were grouped into three domains: Child Functioning Needs, Child Risk Behaviors, and Child Behavioral/Emotional Needs. Table 34 shows the items that correspond to each domain.

Table 34. Needs items by domain

Child Functioning Needs (15 items)	Child Risk Behaviors (11 items)	Child Behavioral /Emotional Needs (10 items)
Social Functioning (*peers*)	Suicide Risk	Psychosis
Social Functioning (*adults*)	Self-Injurious Behavior (*for self-soothing*)	Attention Deficit/Impulse Control
Medical/Physical	Reckless Behavior (*w/out intent to harm self or others*)	Depression/Mood Disorder
Enuresis/Encopresis	Danger to Others (with intent to harm)	Anxiety
Sleeping	Sexual Aggression	Oppositional Behavior (*non-compliance with authority*)
Intellectual Functioning (*IQ only*)	Sexually Reactive Behaviors	Conduct/Antisocial Behavior
Speech/Language Delay	Runaway	Substance Abuse
Autism Spectrum/PDD	Delinquent Behavior	Eating Disturbance
Job Functioning	Fire-Setting	Anger Control
Legal (*DJS/criminal court*)	Bullying	Attachment Difficulties
Judgment/Decision-Making	Exploited	
Sexual Development		
School Attendance		
School Achievement		
School Behavior		

[39] Items 7, 8, and 9 are referenced in this report as the open-ended text responses.

Needs items, domains, and definitions are consistent with the LDSS caseworker Maryland CANS. Reviewers identified if the need was present in the documentation they reviewed, using a dichotomous 'yes' or 'no' rating for each item. A 'yes' indicates a need or concern was present and a 'no' indicates a need was not present or documented in the provided supporting documentation.

In addition to the above-noted placement referral documentation, reviewers were provided with a face sheet for the child, which provided additional information obtained from CJAMS, including details on disabilities, diagnoses, and medications; information about the foster care episode the child was in when the event occurred (e.g. removal date, circumstances of removal, number of prior episodes); and information on the setting the child was in when the event occurred (or was in) immediately prior to the event.

Review Team

SSA recruited forty-four LDSS staff to serve as potential case reviewers. After an initial training, reviewers were asked to complete a test case using an initial draft of the case review tool. Each reviewer's results were compared against the team's 'gold standard' answers for the test case. Reviewers with a Cohen's Kappa[40] of at least .75 were recruited for the official case review on the full sample.

Thirty-four reviewers were selected, including 27 LDSS staff and 7 from Chapin Hall. Prior to beginning the full case review, one training was held to introduce reviewers to the case review objectives, tool, and the online REDCap® database where responses were entered. Cases to review were assigned randomly with the constraint that no LDSS staff reviewed a case from their own jurisdiction. Reviews were conducted over the course of approximately two weeks with support provided by project staff as needed.

Data

Case Review Survey Quantitative Responses

As previously mentioned, child needs were measured through a series of yes/no questions in the categories of child functioning needs (CFN), child behavioral and emotional needs (CBE), and child risk behaviors (Risk). The cumulative number of positive ('yes') responses to the items in each category was used to create three continuous variables: CFN score (i.e. total 'yes' responses in the

[40]Cohen's Kappa is a technique used to measure the agreement between two raters who each classify items into mutually exclusive categories. It accounts for the possibility of the agreement occurring by chance.

child functioning section), CBE score (i.e. total 'yes' responses in the child behavioral and emotional needs section), and Risk score (i.e. total 'yes' responses in the risk behaviors section). We then assigned children into 'low,' 'medium', or 'high' levels of need in each domain based on the distribution of their CFN, CBE, or Risk scores. All children with scores ranging from the minimum value to the first quartile were assigned to the 'low' level group in each domain; children with scores greater than the first quartile and less than or equal to the third quartile were assigned to the 'medium' group; children with scores equal to the third quartile and up to the maximum possible value were assigned to the 'high' group. Children with scores of '0' for any domain were included in the 'low' level group, rather than assigned to their own 'no needs' group, given the fact that the children included in this case review were all involved with the child welfare system and, therefore, were unlikely to present with no needs at the time of the index event.

Open Text Responses

The open-text responses in the case review tool included the following survey questions:

1. Please provide any other relevant notes about what led up to the child's hospitalization, hotel, or office stay. For example, information to help explain why the child was placed in a hospital, hotel, or office.
2. Please provide any additional information you found in the child's folder that you think could be relevant to understanding this child's placement needs and challenges, at or around the time of their placement in a hospital, hotel, or office.
3. Did you struggle to answer any of the questions in this survey? If so, please list or briefly describe those questions here.

Reviewers' free text responses to these questions were captured in the variables 'index event notes,' 'any additional notes,' and 'difficult question' respectively.

Debriefing Session

All case reviewers were invited to attend via Zoom a virtual, voluntary, debriefing session, which was held one week after the case review data collection phase. The debriefing session consisted of a single 60-minute semi-structured interview and was recorded with the case reviewers' verbal consent. The following questions were asked during the debriefing:

1. What did you learn about the needs of children experiencing office stays, hotel stays, and hospital overstays through your review of chart documentation?
2. What were some of your notable findings (striking or unexpected findings) during the case review process?
3. Can you describe any patterns or themes that emerged across the cases you reviewed?

4. What challenges did you experience while completing the case reviews?
5. What about your experience would you want reflected in the final report?
6. Did the case review process impact your thinking or approach to working with these populations in the future?

The transcript of the recorded debriefing session was obtained from Zoom and incorporated into the thematic analysis, along with case reviewer responses to the three open-text questions discussed above. The thematic analysis of all available textual data followed the six-step procedure proposed by Braun and Clarke (2006) and was performed using Excel and Delve, a qualitative analysis data coding tool (Table 35).

Table 35. Braun and Clarke's Six Phase Framework for thematic analysis

Step 1: Become familiar with the data	**Step 4**: Review themes
Step 2: Generate initial codes	**Step 5**: Define themes
Step 3: Search for themes	**Step 6**: Write-up

All textual data was first reviewed to gain a broad sense of who these children and families were, what might have been occurring in their lives at or around the time of the index event, and what needs these children may have had at the time of their stay in a hotel or office, or when experiencing a hospital overstay. Responses were then reviewed again, but this time for the purpose of assigning 'labels' or 'codes' to capture all significant aspects of case reviewers' responses, with multiple codes assigned as needed. For instance, this response, *"Child was placed at [program] and was issued a 72-hour notice, citing they couldn't manage her AWOL behavior, health, and mental health"* was assigned the codes of, "Provider initiated removal", "Runaway", and "Behavioral or mental health challenges".

After the initial codes had been generated, the responses and codes were reviewed again to identify any patterns or relationships across groups of codes, and to search for overall themes in the experiences and needs of these children and/or their families at or near the time of the index event. The themes were then further refined and defined for discussion in this report.

Results

Reviews were completed for 140 of the 148 events in the sample (for 133 unique children), comprising 48 hospital overstays, 42 hotel stays, and 50 office stays. Reviews could not be completed for eight children due to insufficient detail in the documentation. Results are organized into two sections: one for the quantitative analysis of need level (low, medium, and high) by the three

domains; and one for the qualitative analysis of the open-ended text questions on the case review tool and results from the follow-up debriefing with several case reviewers.

Quantitative Analysis

Table 36 shows the number and percentage of children in the sample by SFY of their event. The percentages are lower for 2020, 2021, and 2024. Recall that data collection for these events was not fully in place until SFY 2022, and SFY 2024 was not over when the files for these events were provided.

Table 36. Number and percentage of children in the sample by SFY of index event

Event Type	Total	Total	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Total	140	100%	3	9	40	60	28	2%	6%	29%	43%	20%
Hospital	48	100%	3	8	14	18	5	6%	17%	29%	38%	10%
Hotel	42	100%			1	32	9			2%	76%	21%
Office	50	100%		1	25	10	14		2%	50%	20%	28%

Table 37 shows for each sample the composition by age, gender, and race and ethnicity. For all three samples, most youth were aged 14-17 (52% to 63%) and Black or African American (62% to 86%). Gender was evenly split for the hotel and office samples, but 58% were female in the hospital sample.

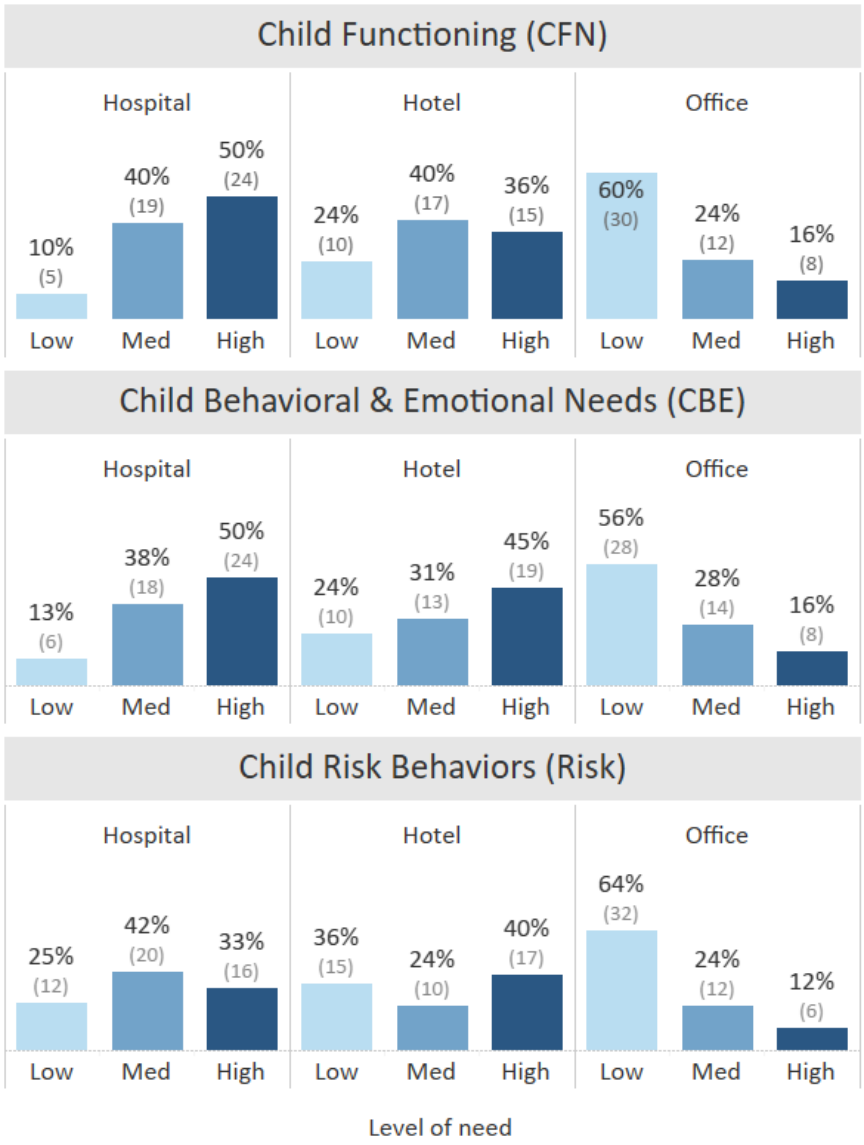
Table 37. Composition by age, gender, and race and ethnicity for hospital, hotel, and office stay samples

Characteristic	Hospital	Hotel	Office	Hospital	Hotel	Office
Total	48	42	50	100%	100%	100%
Age At Start						
0 - 4	1		3	2%		6%
5 - 10	2	1	2	4%	2%	4%
11 - 13	10	8	14	21%	19%	28%
14 - 17	30	24	26	63%	57%	52%
18+	5	9	5	10%	21%	10%
Gender						
Female	28	21	25	58%	50%	50%
Male	19	21	25	40%	50%	50%
Transgender	1			2%		
Race & Ethnicity						
Black or AA	31	26	43	65%	62%	86%
Hispanic	3	5	1	6%	12%	2%
White	11	6	4	23%	14%	8%
Two or More	1	4	1	2%	10%	2%
UTD	2	1	1	4%	2%	2%

Hispanic can be of any race. UTD = Unable to determine.

Figure 24 shows the number and percentage of children in each sample by level of need – measured as low, medium, high – for the three domains of Child Functioning (CFN), Child Behavioral and Emotional Needs (CBE), and Risk Behaviors (Risk). A significant proportion of children with hospital stays have high needs (50%) in CFN and CBE. For the hotel sample, the highest proportion of needs occurred in the CBE (45%) and Risk (40%) domains. A notable contrast is seen for children with office stays, with the majority having low needs in all three domains.

Figure 24. Number and percentage of children in each sample by level of need for each domain



The next three sections show which specific needs were identified among children in the three samples, for each of the three domains. The data are limited to children in the "high" needs groups for each domain. Because a child can have multiple needs documented, which was always the case for the high needs group, the total number of needs documented will exceed the number of children. The results are presented separately for each sample.

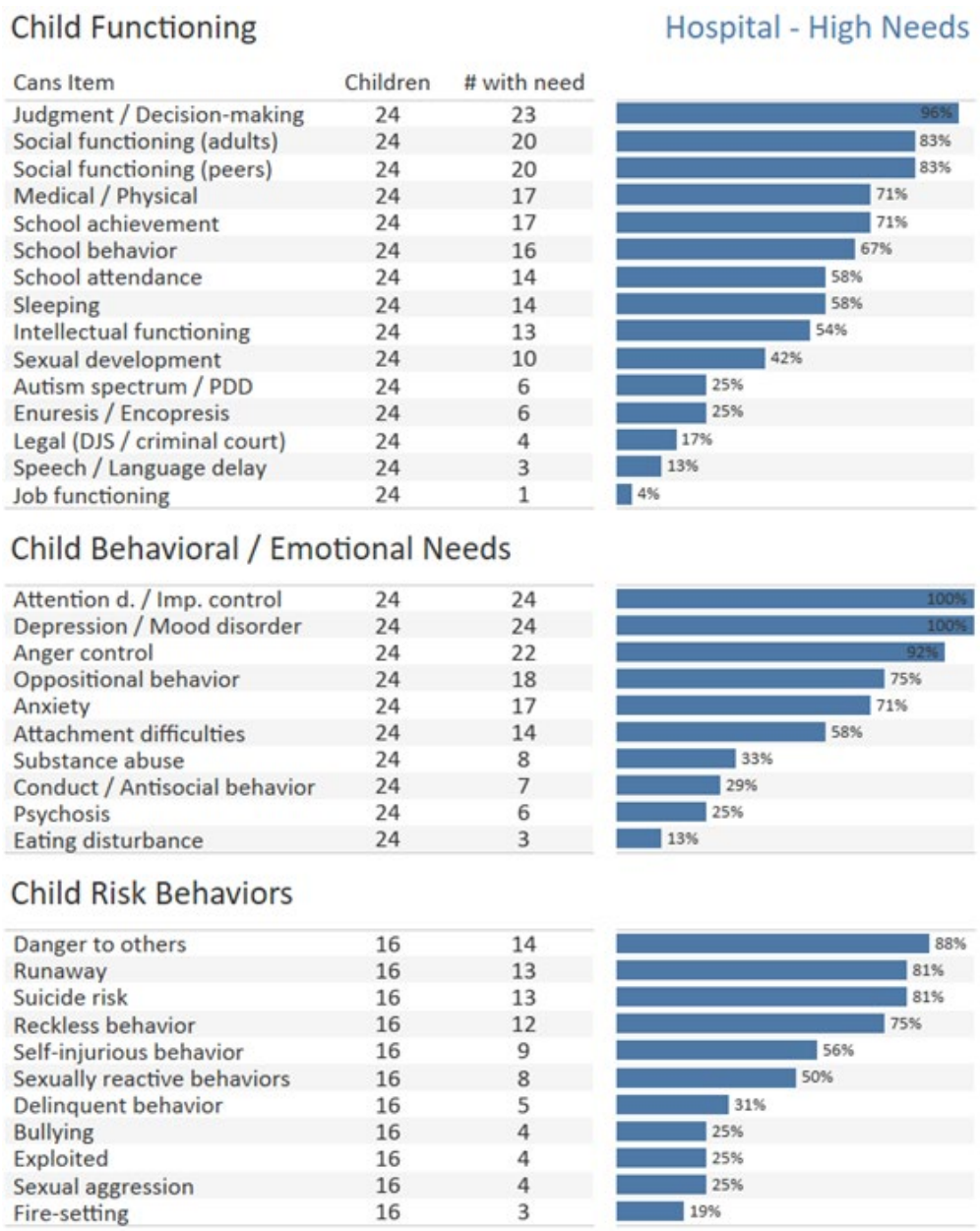
Children with Hospital Stays, High Needs groups (Figure 25)

Fifty percent (50%) of the children who experienced hospital overstays had high needs in the **Child Functioning domain**. Of the Child Functioning Domain needs (15 needs), these children had an average of 7.7 needs identified (range 6 to 11 needs). The most frequent needs for these children were related to judgment/decision making (96% of children); social functioning among adults (83%) and peers (83%); educational functioning, specifically school achievement (71%), behavior (67%), attendance (58%); sleeping in school (58%); and intellectual functioning (54%).

Similarly, fifty percent (50%) of the children who experienced hospital overstays had high needs in the **Child Behavior/Emotional Needs domain.** Within this domain (10 needs), children had an average of 6 needs identified (range 5 to 8). 100% of these children had attention-deficit/impulse control and oppositional behavior identified as needs. The next four most common needs were anger control (92%), oppositional behavior (75%), anxiety (71%), and attachment difficulties (58%).

Thirty-three percent (33%) of children who experienced hospital overstays had high needs in the **Child Risk Behaviors domain**. Within this domain (11 needs), children had an average of 5.6 needs identified (range 4 to 8). The most frequent needs identified were danger to others (88%), runaway and suicide risk (both 81%), reckless behavior (75%), self-injurious behavior (56%), and sexually reactive behaviors (50%).

Figure 25. Children with hospital stays, high needs groups



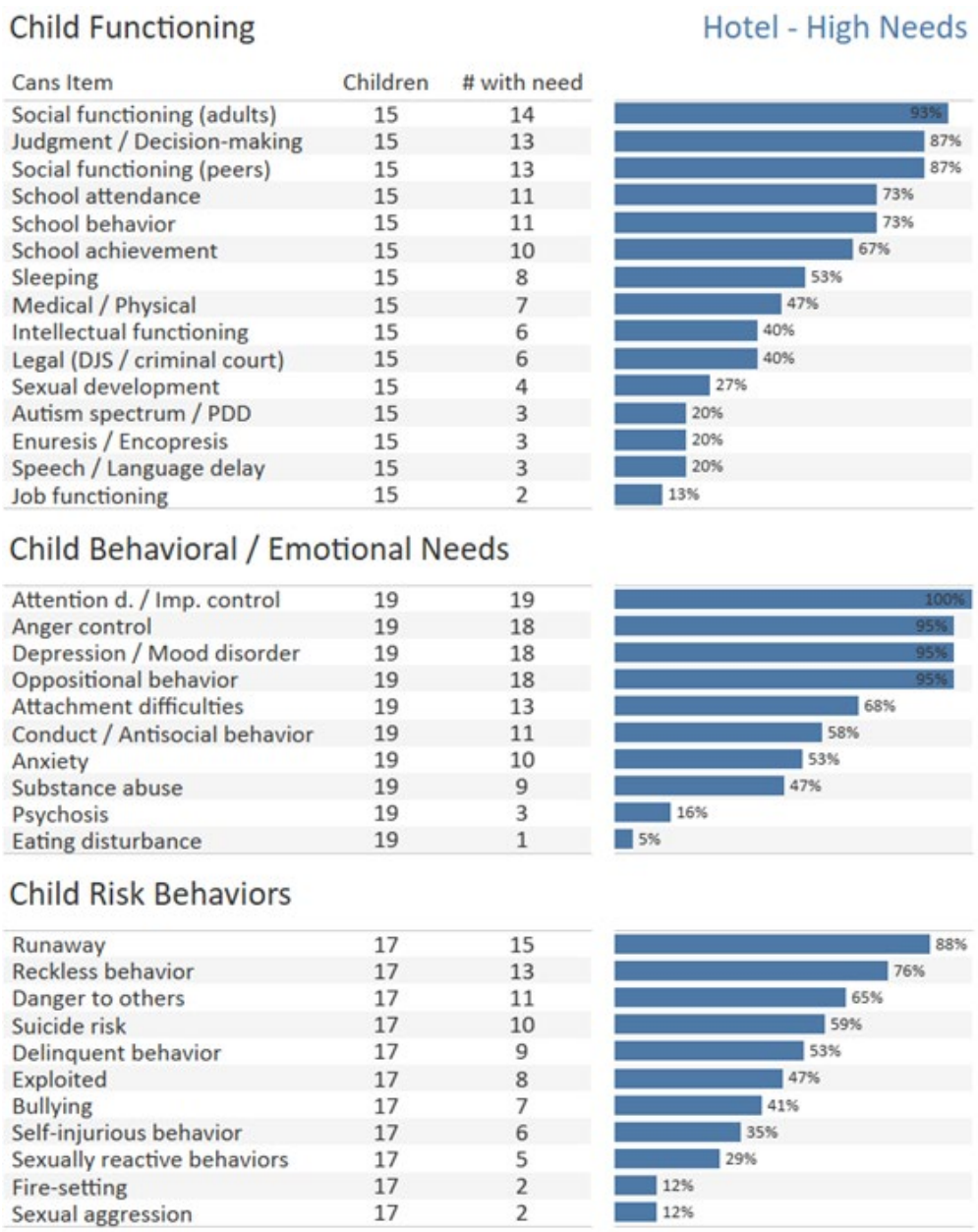
Children with Hotel Stays, High Needs groups (Figure 26)

Thirty-six percent (36%) of children with hotel stays had high needs in the **Child Functioning domain**. Within this domain (15 needs), children had an average of 7.6 needs identified (range 6 to 11). The most frequent needs for these children were related to social functioning among adults (93%); judgment/decision making (87%); social functioning among peers (87%); needs related to school attendance (73%), behavior (73%), and achievement (67%); and sleeping in school (53%).

Forty-five percent of children with hotel stays had high needs in the **Child Behavior/Emotional Needs domain.** Within this domain (10 needs), children had an average of 6.3 needs identified (range 5 to 8). One hundred percent of these children had attention-deficit/impulse control and 95% had needs related to anger control, depression/mood disorder, or oppositional behavior. The next three most common needs were attachment difficulties (68%), conduct/antisocial behavior (58%), and anxiety (53%).

Forty percent (40%) of children with hotel stays had high needs in the **Child Risk Behaviors domain.** Within this domain (11 needs), children had an average of 5.2 needs identified (range 4 to 10). The most frequent needs identified were runaway (88%), reckless behavior (76%), danger to others (65%), suicide risk (59%), and delinquent behavior (53%).

Figure 26. Children with hotel stays, high needs groups



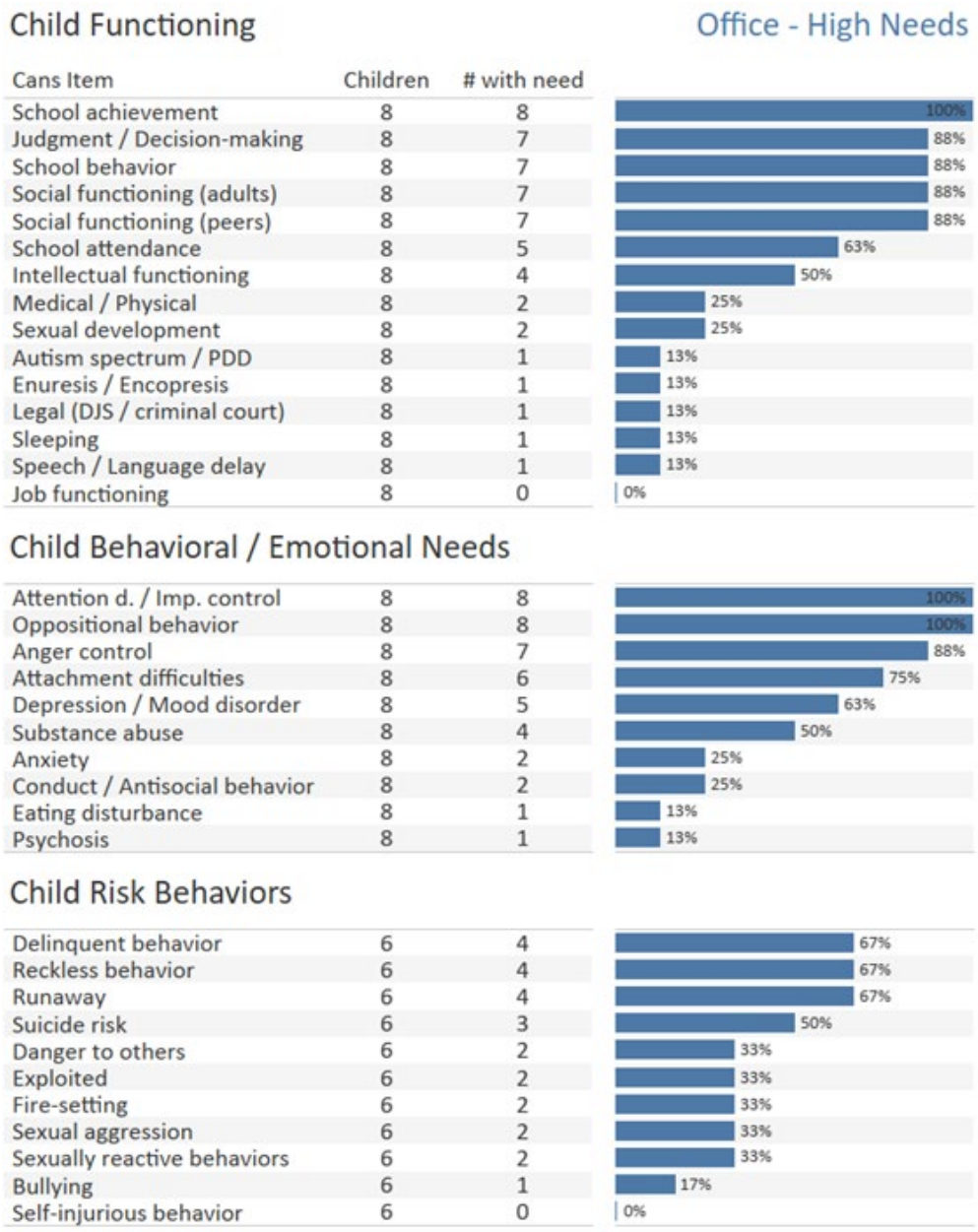
Children with Office Stays, High Needs groups (Figure 27)

Sixteen percent (16%) of children with office stays had high needs in the **Child Functioning domain**. Within this domain (15 needs), children had an average of 6.8 needs identified (range 6 to 8). One hundred percent of children had a need related to school achievement and 88% had needs related to judgment/decision-making, school behavior, and social functioning among adults or peers. The next two most common needs were school attendance (63%) and intellectual functioning (50%).

Similarly, sixteen percent (16%) of children with office stays had high needs in the **Child Behavior/Emotional Needs domain**. Within this domain (10 needs), children had an average of 5.5 needs identified (range 5 to 8). All of these children had attention-deficit/impulse control and oppositional behavior identified as a need (100%). The next four most common needs were anger control (88%), attachment difficulties (75%), depression/mood disorder (63%), and substance use (50%).

Twelve percent (12%) of children with office stays had high needs in the **Child Risk Behaviors domain**. Within this domain (11 needs), children had an average of 4.3 needs identified (range 4 to 5). Sixty-seven percent of these children had needs related to delinquent behavior, reckless behavior, and runaway. Fifty percent (3 out of 6 children) had suicide risk.

Figure 27. Children with office stays, high needs groups



Limitations

The domain and item-level case review data have several limitations that should be considered when interpreting the findings. First, the needs identified by case reviewers were based on a limited number of forms reviewed for each child. The comprehensiveness and detail of these forms varied significantly, with some containing thorough information while others were sparse. Consequently, there is a risk that some needs are underreported or not documented at all. The absence of a

documented need does not necessarily imply that the need does not exist. Second, the process of identifying needs relied on the subjective judgment of case reviewers (e.g. inferences or interpretation), which can introduce variability in the identification and classification of needs. Differences in interpretation among reviewers could influence the consistency and accuracy of the findings, although we attempted to mitigate many of these concerns with the case reviewer training and selection process. Lastly, the findings from this case review are based on a specific sample of youth in foster care who experienced hospital overstays, hotel, or office stays. Therefore, the results may not be generalizable to other populations of youth in foster care or those experiencing different types of placements. Caution should be exercised when extrapolating these findings to broader contexts.

Discussion

The case review of youth in foster care who experienced hospital overstays, hotel stays, and office stays reveals significant insights into the needs and challenges these children face. By examining the high-needs groups across the Child Functioning, Child Behavior/Emotional Needs, and Child Risk Behaviors domains, we can draw comparisons and identify themes that can inform targeted interventions and practice and policy recommendations.

Children with hospital overstays and hotel stays tend to have higher needs across all three domains compared to those with office stays. This suggests that children placed in hospitals and hotels face more severe challenges and may require more intensive support and interventions. Further, children with hospital overstays appear to face substantial challenges in functioning and managing their emotions and behaviors, which is unsurprising given that 88% of hospital overstays involved psychiatric admissions. The low level of needs for children with office stays – in all three domains – raises the question as to what factors led to the workers' inability to find a suitable placement. The case review data suggests that, for most youth with office stays, the key factors that led to their office stay may not be related to needs specific to child functioning, managing emotions and behaviors, and risk behaviors.

The item-level analysis within each domain provided information about the specific needs children in each sample faced. For the Child Functioning domain, the high prevalence of social functioning and school-related needs across all three groups highlights the critical importance of social skills development and educational support for these youth. In the Child Behavior/Emotional domain, the consistent identification of attention-deficit/impulse control and oppositional behavior across all groups indicates a pervasive need for behavioral and emotional support for these children. Lastly, the Child Risk Behaviors domain showed a high prevalence of risky behaviors, particularly running away and reckless behavior, which underscores an urgent need for effective risk management and safety planning.

Qualitative Analysis

There are two components to the qualitative analysis of the case review: the three text fields in the case review tool and the case reviewer debriefing. As mentioned previously, the three open-text questions were included in the case review tool to solicit and capture any additional contextual information the case reviewers might have felt was important to fully understand the 'story' behind why a child may have experienced a hospital overstay, or a hotel or office stay, or why a case reviewer may have struggled with answering any question in the case review survey. The follow-up debriefing session was conducted to allow case reviewers the opportunity to expand on the observations and insights they shared in the open-text fields, without being limited by word count restrictions, and to allow them to share their insights about child placements.

The three text fields were sufficiently populated to support analyses, and the case-reviewer debriefing was well attended. Ten out of the 34 (29%) reviewers attended the session. 81% of the 140 cases included in the case review contained sufficiently usable text responses for the 'index event notes' field (n=113), and 49% and 50% of the cases contained responses to the 'any additional notes' and 'difficult question' fields (n=69 and n=70), respectively. Overall, 57 cases had textual data for all three variables (41%), but all text responses were considered in the thematic analysis wherever available, even if present for only one of the three text fields. In total, 23 unique codes were assigned to the textual data in the thematic analysis. These codes were then grouped into nine broader categories, based on the underlying themes they each represented (refer to Appendix H for a detailed codebook with case definitions).

Overarching Themes

All case reviewer responses (i.e. from the open-text questions and the case reviewer debriefing) were categorized into the following overarching themes:

- Administrative and Documentation Challenges
- Complex Child Needs
- Crises Incidents
- Provider Issues
- Poor Casework Planning
- Lack of Agency Resources
- Child Preferences
- Caregiver Inability to Cope with Child Needs
- Case Reviewers' Recommendations

Table 38 includes the distribution of themes observed from case reviewers' open-text questions and debriefing.

Table 38. Percent distribution of observed themes across case reviewer responses from both the open-text questions and case reviewer debriefing

Theme	Number of References	% of Textual Data Represented by Theme
Complex child needs	58	22.3 %
Administrative and Documentation Challenges	46	17.7 %
Child Preferences	35	13.5 %
Caregiver Inability to Cope with Child Needs	35	13.5 %
Crises Incidents	31	11.9 %
Lack of Agency Resources	21	8.1 %
Case Reviewers' Recommendations	18	6.9 %
Poor Casework Planning	9	3.5 %
Provider Issues	7	2.7 %
Total	***260***	***100%***

Given the many administrative and documentation challenges encountered during the case review process, it is highly unlikely that the results of this thematic analysis captured the full range of the significant contextual factors implicated in all episodes of hospital overstays, or of children with stays in a hotel or an office. Nevertheless, these themes are discussed in more detail, starting with the theme of Administrative and Documentation Challenges, as this theme provides the requisite backdrop against which all subsequent findings of this analysis must be considered.

Thematic Analysis

Theme 1: Administrative and Documentation Challenges

Widespread data discrepancies and the unavailability of sufficient information about the child or a given index event in a child's file were key obstacles that limited case reviewers' ability to place index

events into necessary context and identify children's needs at the time of the index event. As one reviewer said, "*There was no documentation of child needs for this index event…The lack of detail in this record was astounding*."

However, even when mandated forms or documents were available in case files, frequently observed data discrepancies added to reviewers' confusion as to the nature and extent of child needs at or around the time of an index event, e.g. a child's CJAMS record of medications did not match the 818 listing of medications. Case reviewers were also struck by how infrequently clinical information regarding the child's needs carried over into the placement forms, even when this information was available in the child's records.

Insufficient communication between agencies and providers, such as the lack of responses from providers to placement referrals, and the lack of information provided to agencies as to reasons for placement denials by providers, were additional obstacles for understanding children's needs at the time of the index events and the story behind the occurrence or duration of index events.

Challenges related to the accuracy and availability of sufficient historical child placement information and needs data limited case reviewers' ability to assess what needs the children included in this analysis were experiencing at the time of their respective index events. Yet these challenges notwithstanding, case reviewers' responses illuminated certain patterns as to the broad factors that might have played a role in a child experiencing a hotel, office or hospital overstay, as reflected in the other themes identified during this thematic analysis.

Theme 2: Complex Child Needs

As expected, some of the children included in this case review had significant, oftentimes comorbid, behavioral, mental, or physical health challenges at or near the time of their index events. In fact, placement disruptions sometimes specifically referred to child behaviors or psychological health needs as the precipitating reason for an index event. Child behaviors were also frequently cited as the reason for a discharge notice being issued by providers of more specialized placement settings, such as therapeutic group or foster homes.

Some children also had complex medical needs which further contributed towards their respective index events. For instance, one reviewer said, *"[The child] was shot … and is paralyzed from his waist down. [The child's] mother is deceased, and his father is incarcerated. [The child] was living with fictive kin that cannot provide for his needs due to his recent disability*." Moreover, for some of the children included in this case review, case reviewers' felt that these children may have presented with specialized placement needs that might have made it difficult to identify a suitable placement for them in a timely manner, e.g. requirements for more structured supervision, medication management, or intensive therapeutic care.

Case reviewer responses, therefore, reflected the fact that some instances of hotel, office, or hospital overstays occurred in conjunction with significant behavioral, mental, or physical health challenges experienced by some of the children.

Theme 3: Crises Incidents

Conflicts with providers and multiple prior crises were additional precipitating factors in some of the index events explored in this case review. As one reviewer commented, *series* of prior crises (e.g. multiple consecutive placement rejections or behavioral or mental health incidents) contributed to index events:

> *"Youth was very unstable leading up to hospitalization - following discharge from RTC she had a month in group home, month in TFC, month in group home. Exhibiting very at-risk behaviors to self and others. Placement recommendation changing from TFC to diagnostic to RTC. unclear placement history prior to [this year]. Behavior not improved - unstable since out of home placement."*

Theme 4: Provider Issues

Case reviewers repeatedly stressed the importance of factoring in provider-related dynamics into any analyses regarding the occurrence of index events, and for holding providers and LDSS' equally accountable for making placement decisions that are in the best interest of the children they serve. As one case reviewer said, *"…providers who [say], 'we accept youth', and then 30, 60, 90 days later discharge youth because they exhibited the same exact behaviors that were in the referral that's in their provider profile that they say they accept*." Thus, some instances of hotel, office, or hospital overstays occurred in conjunction with placement challenges or instability experienced by some of the children.

Theme 5: Poor Casework Planning

Sometimes index events occurred not because of provider-related factors but because of the case management practices of some caseworkers, e.g. the lack of targeted placement referrals or insufficient planning for expected periods of transitions such as a child aging out of their current placement. For example, one reviewer noted that, *"Her frequent ED visits (monthly) indicated intensive treatment needs, however she was placed in group homes after each discharge with outpatient MH care."* Another reviewer said that an initial hotel stay that ultimately lasted for eighty-three days happened because the "*Client aged out of her current [group home] placement."* Case reviewers also commented on the lack of sufficient efforts made by caseworkers to preserve youths' existing placements or, when placement changes were unavoidable, to undertake appropriate placement

finding in a timely manner, e.g. "*…wow, we're just throwing these referrals out there. They're not landing anywhere" and "we have lost the ability to kind of connect kids with the places we know they would benefit from*."

Theme 6: Lack of Agency Resources

Some index events occurred because, despite caseworkers' best efforts or possible intentions, agency resources simply were too limited. For example, case reviewers reported that, "*The youth does not seem to have any behavioral challenges and appears to have been placed in a hotel due to lack of resources."* These capacity issues were especially challenging when it came to placing children who were part of a larger sibling group into a suitable home together. For example, one reviewer mentioned that "*Based on documents it appears that the major challenge for the Department in securing placement was securing a placement that had an opening for both [the child] and his brother so they could be placed together."* In addition, capacity issues related to the unavailability of appropriate emergency or short-term housing options, were also implicated in the occurrence of index events among children who experienced placement disruptions outside of normal agency operating hours, such as during holidays.

Theme 7: Child preferences

Runaway incidents and child preferences regarding placement decisions were additional factors that emerged as key correlates of some index events. These two types of occurrences were grouped together under 'child preferences,' instead of examined separately, based on the assumption that all behavior is communication. As such, instances of youth running away from their current or potential placements, as well as times when they expressly articulated their desires about their preferred placements, were both understood in this analysis as speaking to the same underlying concept, i.e., expressions of child preferences.

Multiple case reviewer responses referred to the fact that many of the index events studied in this assessment were precipitated by children running away from their placements. Sometimes, youths' desires about their preferred placement settings, or instances where their expressed placement preferences were articulated but ignored, were also implicated in the occurrence or duration of some of the index events. For instance, one reviewer said, *"The child expressed desire for higher level of MH treatment but was repeatedly placed in nontherapeutic group homes. As a result, child's [suicidal ideation/suicidal behavior] tendencies led to multiple ED visits and admissions over six months preceding index event."* During the debriefing session, case reviewers further commented that insufficient consideration of youth placement preferences was a commonly observed pattern among many of the index events explored in this analysis, and that sometimes youth behaviors were pathologized instead of being placed into context as an understandable reaction to having their expressed needs or preferences disregarded:

"In almost all the cases that were reviewed, they actually did list what the child's preference for placement was [on the placement form], which I think was a real strength. But unfortunately, there wasn't a single one where the child's desires for where they would like to live, that there had been any work [that was done] there. It [the placement form] stated, 'this is what the child desires, and this is why this can't happen.' And I know that's the reality of foster care sometimes, and it's a real strength that they captured that [the youth's preference] sometimes. But a pattern seemed to be that those kinds of desires were met with, 'that's not possible.'"

Theme 8: Caregiver Inability to Cope with Child Needs

Some of the index events included in this review also coincided with the presence of strained or fractured familial relationships between children and their biological families, or of instances of maltreatment, such as biological parents and/or relative caregivers harming the children. Other times, index events occurred because biological parents and/or caregivers were no longer able to cope with the multiple stressors involved in caring for children with significant mental and/or behavioral health needs. Caregiver frustration and stress thus sometimes culminated in refusals to come pick up children who had run away from home or had been hospitalized, or refusals to continue to care for children who were experiencing difficulties in regulating their behavior or following caregiver rules.

Placement disruptions sometimes also happened when stressed and depleted caregivers were not able to receive much needed respite, or other forms of support, from child welfare agencies. For example, a case reviewer noted that, *"...the caregiver was frustrated and needed a break. This disruption seemed avoidable if there could have been a formal or informal respite arrangement."* Commenting on this during the debriefing session, one of the case reviewers stressed the importance of proactively providing more supports to vulnerable families as a strategy for, not just preventing index events, but also protecting children from unnecessarily being removed from their families and entering foster care.

Theme 9: Case Reviewers' Recommendations

Finally, much of the conversation during the debriefing session centered around case reviewers' specific recommendations for improving Maryland's ability to adequately assess and document child needs, and to prevent the occurrence of unnecessary hospital, office, or hotel stays among Maryland's foster children. Case reviewers stressed the importance of, among other things, holding placement providers more accountable for adequately communicating with child welfare agencies in response to placement requests and for being more transparent as to their reasons for denying placements to children. In addition, case reviewers highlighted the need for a more targeted referral

process, so that caseworkers could be more intentional about which children they referred to which providers. Towards this end, case reviewers advocated for the creation of a provider dashboard, displaying real-time provider capacity information, detailed provider profiles, and official placement eligibility criteria.

Case reviewer recommendations also included suggestions for improving Maryland's ability to better tell the 'story' of the children in its care. Examples of improvements include making certain changes to placement forms; training the workforce to better document information about child needs and case history in official case records; and creating new documents, such as 'discharge forms', to better document these children's placement histories and trajectories.

Lastly, case reviewers advocated for placing youth behavior into developmental context, for caseworkers to do more to preserve children's existing placements, and to incorporate youth preferences into placement decisions, whenever doing so would not endanger child or staff safety.

A comprehensive list of these recommendations along with supporting examples of illustrative case reviewer comments from the follow-up debriefing session is provided in Appendix I.

Limitations

This analysis has some important limitations. First, the lack of adequate child needs information available for the children in this case review as well as widespread observed data discrepancies in available case records necessarily limits the generalizability of these findings to all episodes of hospital overstays, hotel stays, or office stays. Second, the textual data utilized for the thematic analysis is derived from a limited sample of case reviewer responses to only three open-text questions, and a small number of case reviewers who attended the follow up debriefing session. Lastly, some portion of the administrative or documentation challenges noted in this analysis may reflect challenges related to the case review process instead of actual limitations in the children's comprehensive case files or records.

Discussion & Conclusions

Despite these limitations, these themes shed some light on the experiences of foster children who had a hospital overstay or experienced an office or hotel stay in Maryland. The lack of sufficient and accurate information available about children's needs or prior history in CJAMS or their files could indicate that the complete picture of a child's placement needs and experience is, more than likely, incomplete. More accountability on the part of caseworkers to better document child needs and to share information critical for decision-making and placement-finding is needed as forms are not always completed, submitted, or utilized in a standardized or consistent way by caseworkers or jurisdictions and, therefore, are not an effective tool for capturing child needs with a consistent level

of confidence or accuracy. Additionally, caseworker practices may, inadvertently, be contributing towards the occurrence or duration of index events for some children due to insufficient advance planning for known and expected periods of transition (e.g. aging out of the eligibility criteria for the group home). Initiating placement finding efforts in a timely manner, especially when it is known or apparent that a placement disruption is on the horizon and when time is already limited, is an important potential area for improvement to avert hospital overstays and hotel and office stays. Furthermore, caseworkers have both the power and the responsibility to serve as faithful 'storytellers' on behalf of Maryland's children experiencing foster care, which underscores the importance of making space for youth voices by incorporating their developmental needs and perspectives into Maryland's overall placement decision-making process. To tell children's stories by documenting their histories, strengths, and placement experiences while recognizing that some assessments or criteria used for informing placement decisions may not be sufficient for all children (e.g. developmental needs of older youth's gradually increasing self-determination, independence, or both) will permit Maryland a greater understanding of children's placement needs and experiences.

In addition, greater accountability is needed with providers as it is not yet known whether any provider patterns exist as to the frequency, magnitude, or reasons of placement denials or the issuance of discharge notices over 'incidents' rather than youth behaviors. Particularly, specialized placement settings where youth are, by definition, expected to present with significant mental and/or behavioral health challenges is an important consideration given that case reviewer comments in the debriefing session raised the possibility that some providers might be rejecting placement requests or issuing discharge notices for the very behaviors they say their placement settings are designed to manage or address. Therefore, the number of placement disruptions due to incidents in specialized settings may, in some instances, reflect the need for placement providers to better train their staff to place youth behavior into developmental context, and for Maryland to hold placement providers more accountable for providing trauma-informed and developmentally appropriate caregiving to the youth in their care. On other hand, the lack of documentation discussed earlier must be kept in mind as it is possible, even likely, that the documentation did not provide the full context of what led to a placement disruption, so the extent which a provider's response was warranted is difficult to know with certainty. Nonetheless, the need exists for Maryland to more quickly identify and stabilize youth who are in the grip of multiple crises and/or placement disruptions, and to match them with the appropriate level of care they need, ideally from their first placement. This is necessary not just for mitigating the likelihood of index events but also for avoiding the risk of further compounding the trauma already carried by foster children by asking them to shoulder the additional, yet *preventable*, burdens of extensive relational losses and grief each time placements are disrupted.

Relatedly, Maryland should examine the 72-hour time frame for discharge notices and accessibility of provider profiles given that some index events included in this case review appeared to occur because of these themes. Case reviewer comments revealed some qualms as to whether a 72-hour

time frame is enough time for caseworkers to find appropriate alternative placements for youth who are asked to leave their current placements, which points toward the need to examine whether, and in which circumstances, a more extended buffer period could be adopted in between provider issuance of a discharge notice and a child's removal from that placement setting. Similarly, case reviewer remarks on whether caseworkers were able to assess which providers may adequately meet the needs of children given that caseworkers do not have real-time information for providers' placement capacity points toward the concern that an understanding of child's placements needs requires an understanding of the systems in which children are placed and the factors that may lead to children's needs going unidentified or unmet. The difficulties with provider profiles and discharge timeframe also highlight the need for increased transparency about providers – their profiles, their real-time placement capacities, and the distribution of their acceptances and denials for placement requests as well as discharges.

Likewise, many times, index events appeared to occur due to a lack of available placement resources, particularly for certain subgroups of children such as siblings or children with complex or specialized placement needs. However, given the wide range of factors that appear to be impacting Maryland's ability to meet children's needs strategies, scaling up the availability of certain placement settings are not sufficient on their own. An important factor to scale up as well would be caregiver resources. This thematic finding reflects the importance of greater coordination between child welfare agencies, mental health service providers, public health departments, and other allied partners, to develop a more effective system of care for meeting the complex placement and mental health needs of foster children in Maryland. Such a system of care can also help facilitate the pooling together of limited services and resources to better equip overwhelmed caregivers with more system level supports to prevent avoidable placement disruptions, such as the deployment of mobile crisis units or the provision of respite care. A powerful example of one such system of care can be found in Illinois' "Blueprint for Transformation" initiative.[41] Key strategies utilized in Illinois as part of this initiative included, among other things, centralized contracting of residential beds, required information sharing among providers about residential capacity, and the creation of an interagency family portal to allow parents and guardians to request assistance in securing mental and/or behavioral health services for the children in their care from one centralized location.[42]

Finally, as the case reviewers' recommendations illustrated, Maryland's workforce can serve as its most powerful ally in its efforts to prevent the occurrence of index events. The observations and perspectives of staff and caseworkers, many of whom served as case reviewers for this study, were

[41] https://www2.illinois.gov/sites/gov/Documents/childrens-health-web-021523.pdf

[42] https://www.dhs.state.il.us/page.aspx?module=17&item=143673&surveyid=1623

insightful, thoughtful, and, at times, deeply eloquent. As such, their recommendations and perspectives provide ample potential avenues for Maryland to further explore to better serve the placement needs of its foster children.

Conclusion

Although this thematic analysis was limited by documentation concerns on children's needs and a small sample of case reviewer responses, the findings of this portion of the case review still provide a valuable backdrop for placing the quantitative results of the case review and other analyses in this assessment in a richer context. A summary of all significant findings of this assessment, and relevant recommendations, is provided in Appendix J. However, the primary takeaway from this analysis is that the occurrence of index events among children in Maryland's foster care system is not simply due to factors such as the lack of sufficient placement availability and/or resources. Instead, other factors are also implicated, including some events and/or circumstances that could be fully addressed with more strategic planning, increased interagency coordination, an emphasis on caseworker practices, and additional research.

Accordingly, Maryland is highly encouraged to build upon the results of this thematic analysis by investing in more in-depth qualitative studies to better understand the complex underlying factors that may contribute towards hospital overstays and stays in hotels and offices. For instance, a natural place to start could be a closer examination of provider-related placement dynamics and/or factors to assess the extent to which they may also be implicated in the occurrence of index events. On this note, Maryland is also strongly encouraged to address case reviewers' requests for increased transparency about providers by improving caseworkers' ability to access information about provider profiles and their real-time placement capacity. For instance, it may be well worth the investment to develop the real-time provider dashboard as suggested by a case reviewer or, if something like that already exists, to extend access to caseworkers on a regular basis. This could help mitigate the culture of 'spamming' placement providers with placement referrals and ensuring that, when placement referrals are received, providers are consistently accepting the children their profiles say they accept. Towards this end, perhaps a strategy such as tying provider claims and reimbursements to certain standards of communication, such as requiring a placement referral response rate of a given percent (or a placement referral acceptance rate of a given percent), prior to the disbursement of requested funds or the renewal of relevant contracts, could be an effective strategy for increasing timely communication between caseworkers and placement providers, and for ensuring that all providers continue to honor their agreements to care for youth with certain kinds of behaviors or challenges.

However, improvements on the part of caseworkers, and in certain areas of their casework practice, are also essential. Specifically, more timely case planning and placement-finding efforts and more

attempts to preserve or salvage youths' existing placement settings are recommended. For example, it is worth considering whether it would be possible for Maryland to build upon its prior precedence of paying providers to hold placements for runaway youth by instituting a similar policy for discharge notices, absent any risks to child or staff safety.

Although Maryland does have some challenges related to placement availability and limited agency resources, there is still much it can do to address and prevent the occurrence of hospital overstays, hotel stays, and office stays by thinking beyond the solution of scaling up certain placement settings, and by partnering with its workforce and its providers to make some important changes to its placement decision-making processes to better protect the best interests and wellbeing of the children entrusted to its care.

Research Objective 2. Forecast the number of placements into each placement setting Maryland should anticipate in the next state fiscal year

Introduction

Based on the findings from Research Objective 1 and using placement data for children who entered care between SFY 2019[43] and SFY 2024, we used grouped hierarchical forecasting to forecast the number of placements Maryland can anticipate in SFY 2024, by region and placement setting. The "hierarchy" in this technique refers to the nested nature of the data, with regions nested within the state. The "grouped" refers to the fact that placement settings are not nested; instead, they are a feature shared by, or grouped with, each region. Grouped hierarchical forecasting ensures that forecasts at each level of the hierarchy add up in the same way. For example, the individual forecasts for each placement setting in Baltimore City will match the overall forecast for Baltimore City, and the overall forecasts for Baltimore City and remaining regions will match the overall forecast for the state. By using this method, we can create accurate and coherent forecasts for various administrative levels and placement settings. The placement settings and forecasted counts for each setting are limited to the six settings described at the start of this report, i.e., foster care, non-relative and relative/kin; group homes, non-therapeutic and therapeutic; RTC; and treatment foster care.

Three important caveats should be kept in mind when determining how to use this forecasted placement data. First, the forecasts assume no impactful change in policy, practice, the child welfare

[43]Data from SFY 2019 was included after model testing showed including this additional year of data improved the accuracy of the forecast.

population, or historical events (e.g. a global pandemic) that could impact placement decisions and volume. Second, the forecasts simply project, within a range of certainty, what might happen in the future based on what has occurred in the past. In other words, the forecasted placement setting counts should not be interpreted to suggest these are the *desired* distribution of placement settings for children. Whether past placements reflect the best placements for children, and whether these historical patterns should be repeated in the future, requires a deeper examination of the adequacy and appropriateness of these past placements, which was beyond the scope of this assessment. Third, the forecast numbers are estimated counts of *placements*, not children. For example, using a simplified example, if a child had three placements in SFY 2024 in three different group homes, the forecast would likely anticipate that *three* group home placements should be anticipated next year. As with the previous caveat, whether this child *needed* three different group home placements is not something the forecast can discern, so it simply predicts the future based on what occurred in the past.

Method

Forecasting was done using the R package *ffp3*. First, monthly placement counts for SFY 2019 through 2024 were tallied by state, region, and placement setting. These monthly counts were then converted into a time series format suitable for forecasting analysis. During data inspection, we identified significant outliers in the placement counts for March 2021 in the two group home types and residential treatment centers. SSA staff investigated these and could not explain the cause, so because these monthly counts departed so severely from other months, including the March counts for other years, we replaced these outliers with the median placement count for each respective setting to prevent distorting the forecasting models.

Next, we visually inspected the time series data for underlying trends, seasonality, and any remaining outliers. We used decomposition techniques to separate these components. No significant trends or seasonality that warranted special handling were identified. To identify the best-fitting forecasting model, we split the historical data into a training set (SFY 2019 – 2023) and a test set (SFY 2024). Using the *ffp3* package, we automated the selection of the best-fitting model for each time series within the training set.[44] This package tested various exponential smoothing models, considering different combinations of error, trend, and seasonality components. The model with the lowest

[44]Each specific combination of placement setting, region, and the state is treated as a separate time series for the purpose of forecasting. There were 245 time series.

forecast error metrics (e.g. AIC, BIC) was selected for each series. The ordinary least squares (OLS) reconciliation method was used to produce forecasts that add up at all levels of the hierarchy.[45]

Model performance was evaluated using a holdout sample from SFY 2024. In other words, we used data from SFY 2019 to 2023 (the "training data") to test the model's ability to predict placement counts by region and setting for SFY 2024 (the "test data"). Because we have actual data for SFY 2024, we compared the model's ability to forecast the future against what actually occurred. We used the overall Root Mean Squared Error (RMSE), a common forecast accuracy metric, to assess the predictive power of the selected models.[46] The models performed reasonably well, on average, so no adjustments were made.

Finally, we used all six SFYs to generate monthly forecasts for each placement setting, region, and state for SFY 2025. The monthly forecasts were summed to produce an annual forecast for each level. To calculate prediction intervals around the yearly forecasts, we simulated approximately 10,000 future possible forecasts.[47] This process creates a distribution of forecasted annual values which defines the level of uncertainty in the annual forecasts.

Results

Table 39 summarizes the performance of the forecast models using Root Mean Square Error (RMSE) as the evaluation metric. The RMSE values provide insight into the accuracy of the forecasts, with lower values indicating better model performance.

Table 39. RMSE summary statistics

Mean	Median	SD	Minimum	Maximum
2.89	1.47	4.05	0.0191	39.6

[45]The other reconciliation method tested was the bottom-up method, but forecasts using the OLS method were closest to the base (unreconciled) forecasts, as determined by visual inspection and smaller RMSE and MASE values.

[46]Mean Absolute Scaled Error (MASE) is another popular measure of forecast accuracy, but it does not work when there are many identical counts (i.e., constants) in the time series, like 0 placements month after month for a small region or rarely used placement setting.

[47]Summing the 12 monthly forecasts into one annual forecast means that traditional methods of calculating prediction intervals are not appropriate, due to correlations between forecast errors. One solution to this is to simulate many possible forecasts (e.g. 10,000), compute the mean of all simulations, and generate standard prediction intervals around that mean. We verified that the mean of the simulated data was close to the sum of the individual forecasts. For more details about this approach, see https://otexts.com/fpp3/aggregates.html.

The mean RMSE value of 2.89 indicates that, on average, the forecast models have an error of approximately 2.89 placements when predicting the monthly counts. This provides a general sense of the overall accuracy of the models. The median RMSE value of 1.47 suggests that half of the forecast errors are below this value, indicating that the typical forecast error is relatively low. This median value highlights the central tendency of the forecast errors, showing that the majority of the forecasts are fairly accurate. The standard deviation of 4.05 reflects the variability in the forecast errors. A higher standard deviation indicates that there is a significant spread in the accuracy of the forecasts across different time series. This variability suggests that while some forecasts are very accurate, others may have larger errors. The minimum RMSE value of 0.0191 shows that there are instances where the forecast models are extremely accurate, with almost negligible error in some time series. This indicates the potential for high accuracy in certain settings or regions. The maximum RMSE value of 39.6 reveals that there are certain time series where the forecast error is quite large. These outliers may be due to specific regions or placement settings with more unpredictable placement patterns or with very low counts, indicating areas where the model struggles to predict accurately.

The RMSE statistics suggest that the forecast models generally perform well, with the mean and median RMSE values indicating relatively low forecast errors for most time series. However, the high standard deviation and maximum RMSE values highlight the presence of significant variability in model performance across different series. This variability suggests that while the models are effective in many cases, there are certain regions or placement settings where forecast accuracy could be improved. Future work should focus on identifying and addressing the factors contributing to these larger errors to enhance the overall reliability of the forecasts.

Table 40 shows how well the model predicted placement counts for Maryland in SFY 2024, based on data from SFY 2019 to SFY 2023. The forecast was off by more than 100 placements Foster Care (Relative /Kin) and Group Homes (Therapeutic). The unusual low values in 2019 for these settings (and in 2020 for the group home) likely increased the forecast error.

Table 40. Comparing actual SFY 2024 placement counts in Maryland vs. those predicted by the model, using data from SFY 2019 – SFY 2023

Placement	2019	2020	2021	2022	2023	2024	2024 Forecast	difference
Foster Care (Non-relative)	1,640	1,715	1,358	1,830	1,917	1,805	1,876	71
Foster Care (Relative / Kin)	881	1,189	1,263	1,378	1,293	1,281	1,386	105
Group Homes (Non-therapeutic)	396	464	462	254	238	291	277	-14
Group Homes (Therapeutic)	0	1	234	318	331	273	388	115
Residential Treatment Center	72	98	165	101	105	117	115	-2
Treatment Foster Care	655	672	592	700	629	621	661	40

Table 41 shows the forecasted number of placements by region and placement setting for SFY 2025. These forecasted counts are based on actual placements counts from SFY 2019 to SFY 2024.

Table 41. Forecasted number of placements in SFY 2025, by region and placement setting

Region	Foster Care (Non-relative)	Foster Care (Relative / Kin)	Group Homes (Non-ther.)	Group Homes (Ther.)	RTC	Treatment Foster Care
Maryland	**1,802**	**1,333**	**254**	**247**	**98**	**635**
B. City	424	598	113	72	2	290
B. County	251	162	36	43	23	88
Central	280	226	21	27	27	34
Frederick	35	15	3	4	5	5
Lower Shore	69	34	7	9	7	15
Montgomery	207	103	8	32	-1	38
Prince G.	150	79	20	28	1	116
Southern	68	35	11	5	7	1
Upper Shore	145	9	21	18	16	19
Western	173	72	14	10	11	29

Research Objective 3. Develop needs profiles based on children historically served by Maryland's child welfare foster care system.

Introduction

In addition to forecasting placement needs for the State of Maryland, a long-term strategy for improving outcomes for youth is improving placement decision-making of caseworkers in the system. Many states that utilize the CANS assessment have developed decision support models (DSM) to (1) support caseworkers with placement decisions, (2) improve system resource allocation, (3) predict high-priority system-level outcomes, and (4) conduct system gap analyses. The first step in building decision support models based on the CANS is to conduct a Latent Class Analysis (LCA).

A LCA is a popular, unsupervised method of identifying subgroups of children and youth in care (Petersen et al., 2019), and is a model-based clustering method for improving research on child development (Lanza & Cooper, 2016), differential early education outcomes (Cooper et al., 2014), behavioral health constructs (Petersen et al, 2019), and treatment foster care populations (Chor et al, 2015).

Methods

For this report, we conducted a CANS-based LCA, which can be found in Appendix K. A CANS-based LCA uses CANS item predictors rated on a Communimetric scale to identify probable patterns of heterogeneity in the population (Chor et al., 2018). CANS scores of 0, 1, 2, 3 are dichotomized into "non-actionable" versus "actionable" status, where the former is defined as a score of 0 or 1 (i.e., no action required for the child in regard to an item), and the latter as a higher score of 2 or 3 (i.e., action required). Dichotomous CANS scores from core domains – Life Functioning, Risk Factors, Behavioral/Emotional Needs, and Youth Strengths (Praed Foundation, 2021) – are typically used as predictors.

Results

The analysis demonstrated a connection between the intensity of youth needs and placement in higher 'levels of care' that is consistent with other states. As an example, 43% of youth in the highest need category, as expected, were being served in congregate care settings (Appendix K). Additionally, very small percentages of youth placed in family-based placements fall into the highest need cluster (High Need/Externalizing) (Appendix K).

Alternatively, almost a third of the youth in each of the highest level of care settings (Psychiatric Hospitalization, Residential Treatment Centers, Therapeutic Group Homes, and Group Homes) are youth in the lowest need clusters. While the data set used was selected for its utility in model building, a more refined data set that includes assessments for a representative sample of youth currently placed in out-of-home care might suggest that higher-intensity services could be reduced by around a third as part of efforts to optimize the State's use of congregate care settings.

Discussion

While this analysis has demonstrated the potential for using Maryland CANS data to support and evaluate placement decisions, it is recommended that some current data limitations be addressed to take advantage of the placement decision support potential of the current model. Taking steps towards increasing the completion of CANS assessments for all youth, especially at the point of placement decision-making making, would help increase the effectiveness of a placement decision support model. Engaging supervisors/coaches in the support of timely and accurate assessments has proven effective in other state systems using the CANS assessment. Finally, enhancing the practice of collaborative assessment across private placement provider agencies and county caseworkers will be useful in establishing trust in the implementation of placement decision support models.

OVERALL FINDINGS AND DISCUSSION

As noted, the latest data from the Children's Bureau indicates that Maryland maintains the second lowest entry rate in the country, with only 0.91 entries per 1,000 children. Despite this overall low entry rate, Baltimore City consistently demonstrates higher entry rates compared to other regions within the state. This disparity suggests potential systemic issues or unique factors within Baltimore City that contribute to a greater proportion of children being removed from their homes. Moreover, specific regions within Maryland, including Baltimore City, Baltimore County, and Central exhibit higher proportions of young children entering foster care (Figure 2). This trend underscores the need for targeted interventions and support services tailored to the unique needs of these younger children and their families.

Demographically, a significant percentage of children entering care in Maryland are Black or African American, with Baltimore City and Prince George's County exhibiting the highest proportions. Neglect and caregiver drug abuse are prevalent reasons for removal across all regions, with Montgomery County reporting the highest percentage of neglect cases (81%) followed closely by Baltimore City (80%). These findings highlight the critical importance of addressing underlying issues such as substance abuse and neglect within communities to prevent the need for children to enter the foster care system.

The first placement for most children entering care in Maryland was a non-relative foster care setting, accounting for 38% of placements, followed by placement with relative/kin foster care at 34%. This trend is noteworthy as it indicates that congregate care is not typically the initial placement for most children in Maryland's foster care system. Further, an encouraging finding to note is the decline in the use of non-therapeutic group homes as a first placement setting, dropping from 8% to 4% since SFY 2020. This positive trend highlights the ongoing efforts to prioritize family-based placements and enhance placement stability within Maryland's foster care system. However, while non-relative placements serve as vital resources within Maryland's foster care system, it is important to underscore the significant benefits associated with prioritizing kin placements, as the above trend indicates a significant reliance on licensed foster families across the state. Strengthening and expanding kin placements within Maryland's foster care system is a current priority of SSA; this commitment reflects the state's dedication to promoting the best interests of children and supporting their healthy development.

Analysis of hospitalization data revealed that overstay episodes predominantly affect older children (ages 11-17) and occur primarily due to behavioral/psychiatric issues (25%), self-harm/suicide attempts (25%), or aggressive behavior (21%). 88% of the children with hospital overstays were psychiatric admissions. These overstays are more common among females and in regions like Baltimore City and Baltimore County. These findings underscore the importance of tailored interventions and comprehensive support services to address the complex needs of children experiencing prolonged hospital stays.

Hotel stays are also more common among older youth, particularly Black or African American children. A notable 25% of children placed in hotels entered care simultaneously, with others transitioning from non-relative foster care, group homes, or situations involving runaway or homeless status. Male children had a median hotel stay nearly twice that of females (35 days). The reliance on hotels underscores a shortage of placements for children with complex behavioral and emotional needs, contributing to longer stays, as the most frequent needs for these children were related to social functioning among adults (93%), judgment/decision making (87%), and social functioning among peers (87%).

Children who experience office stays have the lowest needs across all domains, compared to children who experience hospital overstays and hotel stays; however, improving the accuracy of office logs and expanding the types of information collected would contribute to a better understanding of the nature of office stays and ultimately reduce their use. Encouragingly, documented office stays have decreased significantly between SFY 2022 and SFY 2023 (from 95 to 47), the only two years for which a full year of data was collected.

The occurrence of hospital overstays, hotel stays, and office stays among children in Maryland's foster care system is not simply due to a lack of sufficient placement availability and/or resources. Some instances of hotel, office, or hospital overstays occurred in conjunction with placement challenges or instability, or significant behavioral, mental, or physical health challenges experienced by some of the children. Challenges related to complex child needs, crisis incidents, and caregiver inability to cope with child needs all contribute to hospital overstays, hotel stays, and office stays. Strategic planning, increased interagency coordination, an emphasis on caseworker practices, and additional research could improve youth-specific placement needs.

Recommendations that emerged from this assessment

Below are several recommendations for MDHHS to consider exploring. These are based on the key findings from this placement assessment. Appendix I and J include additional recommendations stemming directly from the qualitative portion of the case review.

Improve Worker Documentation of Youth Needs and Placement Histories

1. Enhance the accuracy of documentation on the needs and placement histories of children and youth, particularly those with hospital overstays and stays in offices and hotels (whose data was captured outside of CJAMS and had significant data quality issues). Data quality was a significant problem encountered during the assessment which impeded the assessment team's and case reviewers' ability to precisely identify child and youth needs and reasons for adverse outcomes such as hospital overstays and stays in hotels and offices. Below are four strategies to consider:

    a. Implement quality assurance protocols, such as secondary reviews and/or closer reviews by supervisors before approving documentation. These strategies will increase accurate documentation of placements, child needs, content on child placement and referral forms, and critical mental and physical health characteristics such as diagnoses and medications.

    b. Reduce or eliminate the use of external tracking forms (e.g., spreadsheets outside of CJAMS) by updating CJAMS to accommodate this information. If external tracking forms must be used, add data validation checks, formulas, look-up functions, and quality assurance protocols to increase the accuracy of information entered.

    c. Routinely track and report to a data quality assurance or CQI team on data quality problems in CJAMS related to placement histories so the data can be corrected and workers and supervisors trained on proper documentation. Appendix A of the assessment report lists several data quality checks to consider, which include children with duplicate placement entries, placements whose dates overlap (suggesting the child is in two places at the same time, and placements missing start and end dates.

    d. Provide additional worker and supervisor training on placement planning and needs documentation, emphasizing the critical value of this information to ensure continuity of care across different caregivers and workers, provider understanding of child needs and history, and MDHHS' ability to understand the placement needs and experiences of children in its custody.

Placement Review Panel

2. To address the complex challenges for children experiencing placement disruption, hospital overstays, hotel stays, and office stays, MDHHS should establish a **Placement Review Panel**. This multidisciplinary team would be modeled after child fatality review boards, focusing on case-level analysis and systemic recommendations to prevent these kinds of stays and improve placement outcomes. The Placement Review Panel would:

    e. Analyze Cases: Review individual cases of children who experience significant placement disruptions or extended hospital, hotel, or office stays to identify root causes and determine whether these events were preventable.

    f. Support Placement Efforts: Collaborate with caseworkers, providers, and other stakeholders to expedite placement finding and ensure alignment with the child's needs and preferences.

g. Propose Systemic Improvements: Develop recommendations for MDHHS leadership to address recurring issues, such as provider accountability, resource gaps, and systemic barriers.

Membership should include child welfare professionals with expertise in placements and casework, behavioral health specialists and clinicians, representatives from MDHHS leadership and local departments of social services, legal and advocacy representatives with expertise in foster care, and youth and caregiver representatives (when appropriate) to provide lived expertise.

Placement Assessments and Impact on Service Array

3. Assessing MDHHS' placement array and provider capacity was not part of the scope of this placement needs assessment. This exclusion made it difficult to examine how much provider capacity, as opposed to other factors (like insufficient placement efforts, youth preference, or providers' inappropriately rejecting referrals), contributed to hospital overstays and stays in hotels and offices. The case review method attempted to discern some of this, but the poor documentation reviewers noted on placement forms limited their ability to fully understand reasons for these stays. However, the data was sufficient to show that youth aged 14 – 17 and those with complex behavioral or psychological needs constituted the majority of hospital overstays and stays in hotels and offices.

   If lack of provider capacity proves to be a key factor in hospital overstays and stays in hotels and offices, MDHHS should focus on expanding specialized placement options:

   h. Phase Out Office Stays: Develop protocols that eliminate office stays by requiring immediate coordination between caseworkers and providers to find appropriate placements.

   i. Minimize Hotel Dependence: Prioritize expanding treatment foster care and emergency shelter options, as appropriate, to eliminate reliance on hotels as a placement option.

   j. Pilot Crisis Stabilization Units: Establish short-term crisis stabilization facilities as alternatives to hospital overstays, hotel, and office stays, providing immediate care in a more suitable setting while longer-term placements are secured.

   k. Create Step-Down Programs: Design transitional placements for youth leaving intensive care settings (e.g., hospitals) to prepare them for family-based or less restrictive environments.

Address Placement Disruptions, Matching, and Measurement of Placement Stability

4. Strengthen Placement Matching Tools: Implement evidence-based and standardized decision-support tools to match children with appropriate placements based on detailed assessments of their needs and the characteristics and current capacity of providers. It was not evident from this assessment that any such tools are being used. Although the CANS can be used to support placement decisions, it was beyond the scope of this assessment to examine the extent to which

the CANS is actively being used to inform placement decisions, or to inform ongoing needs for the child during their placement.

5. Support Kinship Placements: Invest in training and financial support for relative caregivers to reduce initial placements in non-relative settings and improve stability.
6. Create processes for consistently incorporating youth preferences into placement decisions, ensuring these preferences are considered unless safety is at risk.
7. In addition to tracking placement instability per the federal CFSR statewide indicator (i.e., moves per 1,000 days of care), MDHHS should begin to track and report on the *types* of moves children experience (e.g., least restrictive, lateral, or more restrictive) and set performance targets. In July 2024, Chapin Hall submitted to SSA's data team a recommended way to measure the frequency and type of moves.[48]
8. Increase Caseworker Training: Train caseworkers to:
    l. identify and respond to early warning signs of placement instability;
    m. incorporate trauma-informed care, cultural competence, and developmentally appropriate approaches to improve their understanding of youth behavior and needs;
    n. contextualize youth behaviors, including runaways, as communication of unmet needs or preferences rather than pathologizing such actions;
9. Explore the use of CJAMS alerts that notify workers and supervisors of early warning signs of placement stability, in which early intervention may prevent a disruption. These alerts could be based on many possible events, including repeated provider-initiated communication (e.g., multiple calls or emails from providers regarding a child's behavior within a specified timeframe); documentation of repeated runaway incidents or youth expressing dissatisfaction with the current placement; youth-reported placement dissatisfaction or requests for placement changes during visits; sudden changes in school attendance or reports of behavioral issues; unresolved placement requests or placement search delays (e.g., extended time between placement referral initiation and successful placement); multiple placement moves within a short period; behavioral and emotional indicators (e.g., frequent hospitalizations; documentation of escalating behaviors such as aggression, self-harm, or property damage), family and caregiver factors (e.g., repeated caregiver complaints, sibling separation, and multiple requests for respite care by foster parents or relative caregivers).

Improve Understanding of Efforts to Secure Placement

10. During the case review, the Chapin Hall assessment team discovered a form completed for some children called, *Effort to Secure Placement*, wherein the worker documents each facility or program to whom a placement referral was submitted, the date it was accepted or rejected, and the reason for rejection. SSA indicated that this form was recently introduced to workers. MDHHS should begin a systematic analysis of these forms to determine the extent to which they

[48] Heisler, K. Naqvi, S. (July 2024). Measuring placement stability for children in foster care: An alternative to the CFSR 4 measure.

are being used and to quantify the nature of rejection reasons. This information will help MDHHS determine how often workers' efforts to secure placements are sufficient, common reasons for provider rejections, and whether provider rejections align with the providers' contractual requirements or indicate a genuine capacity problem.

11. Require providers to respond to placement referrals with reasons for acceptance or denial, improving transparency and accountability.
12. Require providers to demonstrate their capacity to manage behaviors listed in their service profiles and avoid unnecessary rejections or discharges.

Support Older Youth and High-Need Populations

13. Develop Targeted Programs: Create specialized programs for older youth (14–17) addressing behavioral challenges, substance use, and independent living skills.
14. Prioritize placement settings for youth aged 14–17 and those with complex behavioral or psychological needs. As mentioned in another recommendation, these characteristics constituted the majority of hospital overstays and stays in hotels and offices.
15. Address Racial Disparities: Provide culturally responsive services and increase the recruitment of foster families reflective of the racial and ethnic composition of the children in care.

Enhance Interagency Coordination for Children with Hospital Stays due to Complex Medical or Psychiatric Reasons

16. Formalize Discharge Planning Protocols: Require routine, multidisciplinary discharge planning meetings involving hospitals, caseworkers, and potential placement providers to ensure smooth transitions.
17. Create Warm Handoff Procedures: Improve introductions between families and providers to facilitate engagement and continuity of care post-discharge.

Promote Prevention and Family Preservation

18. Expand Primary Prevention Programs: Invest in services addressing root causes of foster care entries, such as substance use, neglect, and family instability, particularly for regions with high entry rates.
19. Support Family Reunification Efforts: Provide specialized services for families of children entering care due to caregiver substance abuse or neglect to expedite reunification.
20. Prioritize targeted support for caregivers and family-setting providers with children exhibiting complex needs. Support could include trauma-informed training, readily available respite care, and crisis management resources like mobile crisis units trained to prevent placement disruptions.
21. Enhance family-based interventions and support to prevent initial foster care placements and reduce caregiver refusals to take children back after crises or hospitalizations.

Monitor and Evaluate Implementation

22. Establish Performance Metrics: Track key indicators like placement stability to include the nature of moves (see related recommendation), lengths of stay in temporary settings, and outcomes for children with complex needs to evaluate the effectiveness of implemented changes.
23. Conduct Regular Needs Assessments: Use annual or biannual placement needs assessments to adapt strategies based on emerging trends and challenges.

Future Research

24. Conduct in-depth, focused studies on the experience of children and youth with significant placement instability or stays in hospitals, hotels, or offices. The goal is to identify recurring patterns related to placement disruptions, denial practices of providers, factors contributing to each placement move and their course, the availability and adequacy of specialized placement settings, gaps in service provision, and systemic barriers that prevent timely and effective matching of children to appropriate and stable placements. These studies should also explore the root causes of placement instability, including challenges faced by caseworkers, resource limitations, and the extent to which youth preferences and developmental needs were considered in placement decisions.

Findings from these studies can inform targeted interventions, policy changes, and provider accountability measures to address underlying issues and improve MDHHS' ability to understand and meet the placement needs of children in care. Methods should not rely exclusively on administrative data but should include interviews or focus groups with youth, caregivers, providers, workers, and supervisors connected to specific cases under review.

Conclusion

As noted, Maryland's foster care system showcases several commendable practices that serve as a model for other states: the notably low foster care entry rate highlights the state's effective preventive measures and the strength of its support systems for families; the state's proactive efforts to enhance placement stability, particularly the prioritization of family-based placements over congregate care, demonstrate a deep commitment to the well-being of children in out-of-home care; and the significant decline in the use of group homes as initial placements is a positive trend reflecting the success of these efforts. In this assessment, we aimed to describe the historical placement needs of children served by Maryland's foster care system, forecast future placement needs, and develop needs profiles to guide future planning. While differences across regions and demographic groups were found specific to historical placement needs, by identifying these disparities, Maryland is now able to develop and employ the necessary targeted interventions to address them. By implementing the developed recommendations, such as enhancing regional support services, standardizing documentation practices, and focusing on demographic-specific

needs, Maryland is well-positioned to further strengthen the ability of its foster care system to better address the unique placement needs for all children in out-of-home care.

For many children, even a perfect accounting of their needs may not be indicative of the specific kind of placement setting they need. Instead, it may be more indicative of the kinds of *support and services* these children need, along with their families, to thrive in less restrictive, family-based settings and reunify earlier. This distinction is supported by interviews and surveys done in 2018 and 2019 with state and local child welfare leaders and organizations in Maryland.[49] As cited in the 2022 Baltimore City Placement Review by the Institute for Innovation and Implementation, "When [these leaders were] asked whether the youth's clinical or behavioral needs could have been met in a family setting, with few exceptions, the answer was "yes," *had the necessary home and community-based services been available* [emphasis added]".

We hope this report supports Maryland in its goal to not only address current disparities in placement needs but also paves the way for further improvements in tailoring placement decisions to children and youth's unique needs, ensuring a more supportive and effective foster care system for all children in Maryland's continuum of out-of-home care.

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APPENDICES

Appendix A – Data quality issues identified in the data and remedies

Prior to data cleaning the served file contained data on 28,924 placements for 7,865 child removals during SFY 2020 to 2024 for 7,334 unique children. Data cleaning resulted in removing 4,744 placements and 52 children. The final dataset used for this analysis contained data on 24,177 placements for 7,796 child removals for 7,282 unique children. Data quality issues were addressed as follows:[50]

Two or more placements with the same start date (for the same child's removal): 2405 of the 7,865 (31%) child entries during the reporting period had at least two placements with the same start date. These appear to be data errors in which workers created a new placement record instead of updating the existing one. When such duplicates were found, we selected the placement record with a placement end date or, if all duplicates had a placement end date, the record with the most recent placement end date. This logic assumed that an end-dated placement or a placement with a more recent end date was the more up-to-date record.

Placements that started on the same day the child exited care or started after the child exited care: 635 (2.2%) placements for 623 child removals started the same day as the child's exit from care. 56 (.2%) placements for 48 child removals started *after* the child exited care. These records were assumed to be in error, the setting to which the child was discharged, or informal living arrangements the agency was tracking after the child exited care.[51]

Placements missing a start date: 596 (2.1%) placements for 588 child removals had no start date. These records were excluded because analysis of placements often required knowing the placement order (e.g. first, second, etc.) or the length of stay in the placement.

[50]Minor data quality concerns, in which records were excluded from analysis, included two records where the placement start date occurred after the placement end date.

[51]In MDDHS, informal living arrangements are often entered into CJAMS for children who are not in DHS custody, but whose current whereabouts need to be known because the child is known to the agency (e.g. child is receiving a family preservation service or was placed in an informal living arrangement with a relative).

Placements that started before the child entered care: 304 (1.1%) placements for 228 child removals had a start date that occurred prior to the child's removal date. The number of days between the placement start date and removal date ranged from –6036 days to –1 day (median = -9 days). For 144 (47%) of these placements, the placement ended before or on the same day the child was removed from home.[52] Most of these placements that ended before or on the same day as the removal were living arrangements the agency was monitoring prior to the child entering care and were excluded.

Placements with no end date but a subsequent placement exists: After excluding 4,673 placements due to the aforementioned data quality concerns, 24,251 placement records remained. 399 (1.7%) of the remaining placements had no end date but there was a subsequent placement for the child. In these situations, we set the placement end date equal to the start date of the subsequent placement.

Placements with no end date but child has exited foster care: 175 (.7%) placements had no end date, but the child had exited foster care. In these situations, we set the placement end date equal to the child's exit date.

Placements that started and ended on the same day: 60 (.2%) placements started and ended on the same day, suggesting that these placements lasted fewer than 24 hours. 75% (45) of these placements had a family home setting as a placement type (e.g. biological parent, Mother's home, Father's home, etc.). SSA indicated most of these placements likely represent the setting to which the child was discharged. These records were considered errors or not representative of an official placement in care and were excluded.[53]

Placements with start and end dates that overlap: 640 child removals had at least one placement whose start and end dates overlapped with another placement. Overlapping placement dates suggests that the child is in two different placements at the same time. Removing these children and their placements would mean removing 5,513 placements from analysis. Instead, we retained these records and excluded them only for analysis specific to placement trajectories, in which having mutually exclusive placements is critical.

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[52] Several of these records appear to be duplicates or with date errors, so the actual number of placements with this condition is lower.

[53] Excluding placements lasting fewer than 24 hours is also consistent with Children's Bureau guidance on counting moves. See Question 21 in the Child Welfare Policy Manual at https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=150.

After imputing end dates, 14 placements whose imputed end dates were the same as the child's removal date were excluded. The final dataset used for analysis contained data on 24,177 placements for 7,796 child removals for 7,282 unique children.

Population 2 – Children historically served by Maryland's Child Welfare System who experienced a hospital overstay: Data quality problems in the hospital file included missing or mistyped CJAMSPIDs, missing Dates of Discharge and Dates of Medical Necessity Discharge, and duplicate records (i.e., the same child listed more than once for the same hospital episode). Many missing or mistyped CJAMSPIDs were corrected by manually looking up children in the served file by name and date of birth and using fuzzy matching based on name plus an exact match for date of birth.[54] When matches occurred, we used the date of birth and gender from the served file when these values differed from the values in the hospital file. Some missing discharge dates or admission and discharge date pairs that looked suspicious (e.g. producing a length of stay greater than 100 days) were verified by a member of the SSA Data Team by manually looking up the case in CJAMS and, if needed, correcting the dates based on case notes. Although the hospital file included calculated values for length of stay and overstay, many were incorrect or not calculated, so we calculated our own based on the dates. We removed 20 records where the admission type was "Residential Treatment Center" (RTC), as we could not confirm whether these represented hospital admissions. Records with critical data quality issues that could not be resolved were excluded from the analysis. After data cleaning, this list included 1,788 hospitalizations for 870 children.

Population 3 – Children historically served by Maryland's Child Welfare System who experienced a hotel stay: Data quality problems in the hotel file included date logic errors (e.g. hotel start dates greater than end dates; multiple hotel records for the same child whose dates overlap), missing exit dates, duplicate records (i.e. the same child listed more than once for the same hotel stay), and missing entries for some variables. The file did not include the child's full name and date of birth, so we were unable to verify the accuracy of CJAMSPIDs by looking up children in the served file by name and date of birth (or using fuzzy matching). Some missing exit dates or start and end date pairs that looked suspicious (e.g. producing a length of stay greater than 100 days) were verified by a member of the SSA Data Team by manually looking up the case in CJAMS and, if needed, correcting the dates based on case notes. Records with critical data quality issues that could not be resolved were excluded from analysis. Lastly, we reduced the file to only children who could

[54]Fuzzy matching is a technique used in data processing to match records from two separate files based on approximate string similarity rather than exact matches. We used the R package, *fuzzyjoin*, for this matching.

be found in the served file by matching on CJAMSPID.[55] The final dataset used for analysis contained data on 162 hotel spells for 142 unique children.

Population 4 – Children historically served by Maryland's Child Welfare System who experienced an office stay: Data quality problems in the office file included missing, mistyped, and inconsistent CJAMSPIDs and name spelling for the same child in subsequent stays; occasional date logic errors (e.g. an office entry date that was greater than the office end date); and occasional missing exit dates or times. Many missing or mistyped CJAMSPIDs were corrected by manually looking up children in the served file by name and date of birth and using fuzzy matching based on name plus an exact match for date of birth.[56] When matches occurred, we used the date of birth and gender from the served file when these differed from the values in the office file. Missing exit dates and times, or entry and exit information that was illogical, were corrected by imputing logical dates or times based on the timing of adjacent office visits for the same child. Records with critical data quality issues that could not be resolved were excluded from analysis. Lastly, we reduced the file to only children who could be found in the served file based on our matching efforts.[57] The final dataset used for analysis contained data on 740 office spells for 494 children. 317 of these office spells (for 203 children) met the criteria for an office stay (i.e., > 4 hours).

[55] 22 records for children in the hotel file could not be found in the served file, using CJAMSPID. These children were excluded from analysis.

[56] Fuzzy matching was described earlier for the hospital file.

[57] 85 records for children in the office file could not be located in the served file, using either CJAMSPID or by a fuzzy match with name and exact match for date of birth. These children were excluded from analysis.

Appendix B – Entry rates per 1,000 by SFY and jurisdiction

Jurisdiction	2020	2021	2022	2023	2024
Allegany	3.4	4.3	3.1	2.7	1.2
Anne A.	0.4	0.4	0.4	0.4	0.4
B. City	6.3	4.8	5.0	3.8	4.0
B. County	1.9	1.1	1.3	1.1	1.3
Calvert	0.9	1.4	0.9	0.8	0.4
Caroline	2.3	1.5	1.5	2.2	1.2
Carroll	1.0	0.4	0.6	0.6	0.4
Cecil	2.2	2.3	2.3	1.4	1.7
Charles	0.7	0.4	0.4	0.3	0.5
Dorchester	1.3	2.0	2.0	3.5	1.0
Frederick	0.9	0.6	0.6	0.3	0.4
Garrett	5.6	3.4	5.9	4.6	3.3
Harford	1.6	1.2	1.4	1.5	1.5
Howard	0.3	0.4	0.5	0.7	0.6
Kent		1.8	5.1	2.5	4.2
Montg.	0.7	0.5	0.5	0.4	0.4
Prince G.	0.7	0.6	0.9	0.6	0.7
Queen A.	1.4	0.6	1.0	1.5	1.0
Somerset	1.4	3.3	3.9	4.3	2.1
St. Mary's	1.1	1.5	0.5	0.5	0.5
Talbot	1.1	2.2	1.2	0.9	1.6
Wash.	1.1	0.8	1.2	1.7	1.6
Wicomico	0.5	0.6	0.7	0.5	0.5
Worcester	1.0	2.1	2.6	2.5	2.5

Entry rate = (number of entries / child population) * 1,000

Child population data is based on a special tabulation of the 2015-2019 American Community Survey (ACS) 5-year estimate (Citizen Voting Age Population [CVAP]).

Appendix C – Number and percentage of children entering care by SFY and jurisdiction

Jurisdiction	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Maryland	1,955	1,501	1,620	1,368	1,352	100%	100%	100%	100%	100%
Allegany	41	52	37	33	14	2%	3%	2%	2%	1%
Anne A.	50	55	52	47	46	3%	4%	3%	3%	3%
B. City	750	566	592	451	467	38%	38%	37%	33%	35%
B. County	333	205	241	194	231	17%	14%	15%	14%	17%
Calvert	20	9	20	16	5	1%	1%	1%	1%	0%
Caroline	15	9	6	17	7	1%	1%	0%	1%	1%
Carroll	35	16	18	21	13	2%	1%	1%	2%	1%
Cecil	50	54	53	33	38	3%	4%	3%	2%	3%
Charles	28	14	6	11	9	1%	1%	0%	1%	1%
Dorchester	8	13	13	23	6	0%	1%	1%	2%	0%
Frederick	56	39	37	21	22	3%	3%	2%	2%	2%
Garrett	30	18	31	24	8	2%	1%	2%	2%	1%
Harford	91	68	78	84	86	5%	5%	5%	6%	6%
Howard	24	33	37	55	45	1%	2%	2%	4%	3%
Kent		3	10	3	5		0%	1%	0%	0%
Montg.	168	115	109	106	105	9%	8%	7%	8%	8%
Prince G.	150	115	177	122	136	8%	8%	11%	9%	10%
Queen A.	12	3	7	8	5	1%	0%	0%	1%	0%
Somerset	1	12	8	3	5	0%	1%	0%	0%	0%
St. Mary's	31	40	13	11	12	2%	3%	1%	1%	1%
Talbot	7	10	8	5	5	0%	1%	0%	0%	0%
Wash.	37	26	38	56	53	2%	2%	2%	4%	4%
Wicomico	11	7	10	6	7	1%	0%	1%	0%	1%
Worcester	7	19	19	18	22	0%	1%	1%	1%	2%

A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

Appendix D – Number and percentage of children entering care by jurisdiction and age (SFY 2024)

Jurisdiction	< 1	1 - 4	5 - 10	11 - 13	14 - 17	< 1	1 - 4	5 - 10	11 - 13	14 - 17
Maryland	273	256	325	190	308	20%	19%	24%	14%	23%
Allegany	1	4	5	2	2	7%	29%	36%	14%	14%
Anne A.	10	9	8	6	13	22%	20%	17%	13%	28%
B. City	112	88	107	63	97	24%	19%	23%	13%	21%
B. County	44	32	59	32	64	19%	14%	26%	14%	28%
Calvert	1		1	3		20%		20%	60%	
Caroline			3	1	3			43%	14%	43%
Carroll	3		4	3	3	23%		31%	23%	23%
Cecil	8	14	11	3	2	21%	37%	29%	8%	5%
Charles	3	3			3	33%	33%			33%
Dorchester		1	1	1	3		17%	17%	17%	50%
Frederick	7	4	5	2	4	32%	18%	23%	9%	18%
Garrett	2			4	2	25%			50%	25%
Harford	9	17	24	20	16	10%	20%	28%	23%	19%
Howard	7	6	15	5	12	16%	13%	33%	11%	27%
Kent				1	4				20%	80%
Montg.	25	22	25	8	25	24%	21%	24%	8%	24%
Prince G.	20	30	27	21	38	15%	22%	20%	15%	28%
Queen A.	2			1	2	40%			20%	40%
Somerset		3	2				60%	40%		
St. Mary's	4	2	3		3	33%	17%	25%		25%
Talbot	1			2	2	20%			40%	40%
Wash.	10	15	17	6	5	19%	28%	32%	11%	9%
Wicomico	2	1		2	2	29%	14%		29%	29%
Worcester	2	5	8	4	3	9%	23%	36%	18%	14%

A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

Appendix E – Number and percentage of children entering care by jurisdiction and race /ethnicity (SFY 2024)

Jurisdiction	Black	Hisp.	White	Two or More	Other	UTD	Black	Hisp.	White	Two or More	Other	UTD
Maryland	658	108	310	94	4	178	49%	8%	23%	7%	0%	13%
Allegany	1	1	10	2			7%	7%	71%	14%		
Anne A.	15	8	14	6		3	33%	17%	30%	13%		7%
B. City	356	27	49	15		20	76%	6%	10%	3%		4%
B. County	78	13	75	11	1	53	34%	6%	32%	5%	0%	23%
Calvert	1		2	2			20%		40%	40%		
Caroline		2	4	1				29%	57%	14%		
Carroll	1	2	5			5	8%	15%	38%			38%
Cecil	1	3	26	2		6	3%	8%	68%	5%		16%
Charles	6		1	1		1	67%		11%	11%		11%
Dorchester	3		2			1	50%		33%			17%
Frederick	7	3	8	4			32%	14%	36%	18%		
Garrett	1		7				13%		88%			
Harford	34		37	11		4	40%		43%	13%		5%
Howard	17		16	5	2	5	38%		36%	11%	4%	11%
Kent	1		3			1	20%		60%			20%
Montg.	31	31	10	13		20	30%	30%	10%	12%		19%
Prince G.	72	16	1	1		46	53%	12%	1%	1%		34%
Queen A.			3			2			60%			40%
Somerset	2		2	1			40%		40%	20%		
St. Mary's	5		1	2		4	42%		8%	17%		33%
Talbot	2		2			1	40%		40%			20%
Wash.	13	2	18	15	1	4	25%	4%	34%	28%	2%	8%
Wicomico	2		3			2	29%		43%			29%
Worcester	9		11	2			41%		50%	9%		

A child is counted for each entry they had. For example, if a child entered two times in the SFY, they are counted twice.

Hispanic can be of any race. Other includes American Indian or Alaska Natie, Asian, Native Hawaiian or Pacific Islander, and Other. UTD = Unable to determine, which includes Declined, Missing, and Unknown.

Appendix F – Number and percentage of children entering care with at least one out of state placement, by SFY and jurisdiction

Jurisdiction	2020	2021	2022	2023	2024	2020	2021	2022	2023	2024
Maryland	100	60	66	57	33	100%	100%	100%	100%	100%
Allegany	4	12	7	1		4%	20%	11%	2%	
Anne A.	8	5	5	2	2	8%	8%	8%	4%	6%
B. City	15	9	7	4	3	15%	15%	11%	7%	9%
B. County	18	4	9	7	6	18%	7%	14%	12%	18%
Calvert	1		2	1		1%		3%	2%	
Caroline	2			1		2%			2%	
Cecil	5	3	8	5		5%	5%	12%	9%	
Charles		3	1		1		5%	2%		3%
Dorchester			2	1				3%	2%	
Frederick	7	5	1		2	7%	8%	2%		6%
Garrett				2					4%	
Harford	4	1	7	5	4	4%	2%	11%	9%	12%
Howard	1	1	1	5		1%	2%	2%	9%	
Montg.	11	4	1	4	3	11%	7%	2%	7%	9%
Prince G.	14	7	9	10	2	14%	12%	14%	18%	6%
Queen A.	1					1%				
Somerset			1					2%		
St. Mary's			1	1				2%	2%	
Talbot			1					2%		
Wash.	9	4	3	7	9	9%	7%	5%	12%	27%
Wicomico					1					3%
Worcester		2		1			3%		2%	

A child is counted once per SFY if they had at least one out of state placement in that SFY.

Counts exclude out of state placements into these settings: trial home visit, respite care, hospitalization, college, halfway house, homeless shelter, job corps, or summer camp, adult correctional institution, secure juvenile detention, homeless, runaway, unknown whereabouts, and missing

Appendix G – Case Review Tool

A copy of the full Case Review Tool can be found here:
https://drive.google.com/file/d/12zmZgr68GBS2mEIRw334HWL892lWzAFi/view?usp=drive_link

Appendix H – Codes and Case Definitions Utilized in the Qualitative Analysis Portion of the Case Review

1. Behavioral/Mental health challenges – this code captured any behavioral or mental health challenges displayed by the child or recorded about the child at or near the time of the index event. It encompassed, both, specific behaviors like suicide attempts or aggression, but also captured more vague references to problems related to the child's behavior in general.

2. Caregiver initiated removal – this code captured all instances where an existing placement was disrupted prior to the index event due to a parent, foster parent, or relative caregiver refusing to continue to care for the child. This field was only applied to caregivers in family home settings, including regular foster homes, but excluded caregivers at more specialized settings such as independent living programs, therapeutic foster homes, group homes, or residential treatment centers. Instead, those cases were captured in a separate, "Provider initiated removal" category.

3. Case Reviewers' recommendations - this code was used to capture case reviewers' recommendations shared during the follow-up debriefing session.

4. Child wanted to live somewhere else – this code was applied only when a child's stated preference for a placement or dissatisfaction with a current or potential placement was included in the text response. However, in cases where the child was only described as having runaway without any mention of a child's preferred placement, a separate "runaway" code was used.

5. Conflict (provider) – this code was applied whenever there was a reference to the child having had a fight, disagreement, or an altercation with a provider, such as a landlord or a caregiver at a specialized foster care setting, resulting in the disruption of the child's placement prior to the index event.

6. Conflict (relative/caregiver) – this code was used to capture specific references to altercations with, or assaults by, a parent or relative caregiver, as well the presence of strained, absent, or fractured relationships between the child and his or her family at the time of the index event.

7. Data discrepancies - this code was used to capture concerns related to conflictual information recorded in the child's file, such as incorrect dates or diagnoses.

8. Economic instability – this code was applied when a placement, such as a child's room rental, was disrupted due to financial difficulties.

9. Insufficient information (child needs) – this code represented a lack of sufficient available information about child needs at or around the time of the index event, either documented in the

placement form or 818s included in the case file or documented anywhere else in any of the material uploaded in the child's file for the case review.

10. Insufficient information (providers) - this code represented a lack of sufficient available information about providers, whether pertaining to their real time capacity data, their provider profiles, or their reasons for denying a placement request.

11. Insufficient planning/efforts - this code was applied whenever case reviewer responses discussed examples of poor planning, or insufficient efforts, on the part of caseworkers or case managers, such as a lack of planning for anticipated transitions, or the lack of timeliness in initiating placement searches.

12. Lack of placements for siblings – this code was assigned only in cases where the lack of a placement that could accommodate a sibling group was specifically mentioned as a precipitating reason for a given index event. All other responses that referred to the general unavailability of a placement, without references to siblings, were captured in a separate, "no placement available" code.

13. Lack of targeted referrals - this code captured case reviewers' responses regarding the lack of targeted placement referrals by caseworkers and/or case managers.

14. Medical needs – this code was used to capture cases where the child was either initially hospitalized due to a medical need, or where the child had any existing medical diagnoses or challenges at or around the time of any of the three index events.

15. Multiple prior disruptions or behavioral incidents – this code was applied when the child was described as having experienced multiple placement disruptions immediately prior to the index event, or when a reference was made to the steady escalation of behavioral or mental health challenges prior to the index event.

16. No placements available – this code was applied whenever the reason for a particular index event was attributed to the unavailability of other, more appropriate, placement settings, but excluded cases where placements were not available for siblings. Those cases were captured in a separate, "lack of placements for siblings" category.

17. Property damage – this code was assigned whenever specific references to property damage were mentioned in the textual data as part of the precipitating reasons for an index event.

18. Provider initiated removal – this code captured all instances of placement disruptions prior to the index event that were initiated by providers in more specialized placement settings, such as

independent living programs, therapeutic foster care, group homes, therapeutic group homes, or residential treatment centers.

19. Relative support not provided – this code represented any instance of a placement disruption that was at least partially attributed, by the case reviewer or the caseworker, to a relative caregiver failing to receive needed support from the agency.

20. Runaway – this code was used to represent any instances of a child running away from a placement prior to the index event.

21. Specialized placement needs– this code was applied whenever there were specific references to the child needing a particular type of placement and/or level of care.

22. Transitions or holidays – this code was used to represent instances of an index event that occurred during, or because of, short term transitional periods, or because a child was not able to be placed in a more appropriate setting due to a holiday or office closures on a weekend.

23. Youth – this code was applied to all case reviewer responses that either discussed the need to place youth behavior into its appropriate developmental context or to incorporate a more strengths-based approach when discussing youth needs.

Appendix I – Case Reviewer Recommendations and Illustrative Comments for Meeting Foster Youth Placement Needs in Maryland

Case Reviewers' Recommendations	Select Examples of Illustrative Case Reviewer Comments
Customize placement forms to address unique developmental needs of older youth	*"I'm looking at the case records. And it's [i.e., the placement forms] written for younger people. and you know, teens, and you know, 6, 14, 20-year-olds are going to have, you know, there's just kind of different assessment that you think about in that population. What kind of things we put in the assessment for placing children, they typically speak more to kids under 13. And as kids are, you know, really progressing towards adulthood – I just – it felt like, to me, some of those needs you'd expect around independence and things like that, those were not well addressed [in those forms]. So that struck me too."*
Ask providers to provide discharge documents whenever a youth is discharged from a placement	*"One thing I think we should do is, when the facilities are discharging a youth, we should be getting discharge documents that should, you know, follow the youth so that we can see why, you know, where they've been, why they've asked them to leave, you know, that kind of thing."*
Make efforts to honor youth preferences for placement and try to preserve their current placement	*"[there wasn't enough being done to] try to listen to the kid- what the kid is expressing is their need? There was this kid that was adopted out of the country. And now he's older and trying to be, like, independent. But his needs, there's like a lot of his needs were not being met. Which, they kinda put it like, "oh, it's just his behavior" and it's like, no – this kid is trying to be independent, but nobody's listening to help him get the support that he's expressing [needing]."* *"In almost all the cases that were reviewed, they actually did list what the child's preference for placement was, which I think was a real strength. But, unfortunately, there wasn't a single one where the child's desires for where they would like to live, that there seemed to be any work [that was done]*

Case Reviewers' Recommendations	Select Examples of Illustrative Case Reviewer Comments
	there. It [the placement form] stated, "this is what the child desires, and this is why this can't happen. And I know that's the reality of foster care sometimes, and it's a real strength that they captured that [the youth's preference] sometimes. But a pattern seemed to be that, those kinds of desires were met with, "that's not possible." And it didn't seem like there was a path forward to some of those, at least in the cases that I reviewed." *"I only reviewed a small handful [of cases], but in the majority of them, there was a lack of – I couldn't find it anywhere-whether there had been efforts to preserve, you know, the placements they had been in before. Like, it felt like a really missing part of the story. There was so, so, so little there about, you know, trying to save where the kid had been before. And preserve the relationship that they had had. It was striking."*
Create a real time dashboard or give access to a provider census showing information about providers' profiles, and placement capacity/openings	*"My wish list would be that we would have a dashboard with provider's availability – you know, why refer to a place that doesn't have any openings? So, if we could see that in real time, it would begin to change this culture of spamming everybody and really know that, when you get a referral, that it's intentional. Let's look at it."* *"We used to get, like, census updates – daily, if not weekly, from all the providers. So, we could say, 'Oh, hearts and homes, I see you have three placements. But you said yesterday you're full.' So, like, we're working with very limited information, and CJAMS doesn't provide the same level of information that we used to be able to get from CHESSIE, to some degree, in terms of provider census."*

Case Reviewers' Recommendations	Select Examples of Illustrative Case Reviewer Comments
Make targeted placement referrals	*"It felt like we're just spamming all providers, and it's, at best, just horribly inefficient. At worst, it's actually a sign that we have lost the ability to kind of connect kids with the places we know they would benefit from. So, I think, in those forms alone - those lists of providers after providers with denials or the absence of any response at all – that speaks volumes to an area for potential process improvement."*
Train workforce to be better story tellers	*"We need to train our workforce to be better storytellers about the kids' needs."* *"The story sometimes just resides in the case notes. And one of the problems with that is, when you're trying to pull out summaries of things, those summaries, at least the ones I read, weren't what I expected – they weren't as thorough."*
Update placement forms to include youth's prior placement history, number of times caseworkers changed, and their strengths and coping skills	*"I don't think forms are the answer, but it would be important to know how many times caseworkers change. Because that's probably a part of this too."* *"On the placement sheet, most of the information that was given was truthful [about the youth]. But it wasn't much positive about them. It was mainly everything that's going wrong but not really talking about anything that was positive about the youth."* *"…the placement sheet just indicates what the youth behaviors are, but some of the youth have really good coping skills. They are able to say what their triggers are. They could say how they have managed it in the past. I think that that needs to be included and explored with case managers. You know, how they [the youth] are able to manage [their behaviors].*
Explore provider related factors and/or dynamics that may be implicated in the occurrence of	*"We're all part of the system. So, neither party – LDSS' or providers – are totally doing everything right. But it should be*

Case Reviewers' Recommendations	Select Examples of Illustrative Case Reviewer Comments
index events and not just caseworkers' case management or case documentation practices, i.e., require accountability from both sides	*balanced. We should be looking at both sets of this system and how we can improve."* *"So, you know, the focus is always on the locals and the social workers or case managers, and I don't see as much engagement on the provider side, to hold folks accountable for accepting the kids that are in their provider profile."* *"We no longer have access to the provider profile. So, we can't say, 'Hey, you say you accept this type of kid with this type of behaviors, but you're [now] you're saying that you don't. So, I hope that part of this process is expanding the emphasis, the priority, the need, to not only focus on the LDSS' but also the providers."*
Place youth behaviors into developmental context	*"It seems like, maybe in a lot of places there's kind of a lack of, I would say, kind of like specialized knowledge and serving that population and kind of being able to speak to their needs. You know, normalizing older youth developmental needs."* *"If you had a specialized workforce, that really understood and enjoyed working with this population, what they could do to gather more information and make this process work more for them, for older youth in particular is what I'm talking about, that would be really impactful."*

Appendix J – Summary of Key Qualitative Case Review Findings and Relevant Recommendations

Key Findings of the Thematic Analysis	*Recommendations*

The primary takeaway from the qualitative portion of the case review is that the occurrence of index events among children in Maryland's foster care system is not simply due lack of sufficient placement availability and/or resources. Instead, the factors below are also **implicated, including some events and/or circumstances that can be fully addressed with more strategic planning, creative problem-solving, and increased interagency coordination**.

Theme 1: Administrative and Documentation Challenges

- Widespread data discrepancies and the unavailability of sufficient information about children and their needs captured in CJAMS hinders the ability to match children to appropriate placement settings.
- Placement forms are not currently being completed, submitted, or utilized in a standardized or consistent way by caseworkers or jurisdictions in Maryland and are not an effective tool for capturing child needs with any level of confidence or accuracy.
- Lack of responses from providers to placement referrals, and the lack of information provided to agencies as to reasons for placement denials by providers, are additional obstacles for understanding the story behind the occurrence or duration of index events.

✓ *Make relevant changes to CJAMS to better capture child needs information and increase the analyzability of available child needs data.*

✓ *Update placement forms to include youth's prior placements, caseworker changes, strengths, and coping skills to help match children to appropriate settings.*

✓ *Implement a system for monitoring the consistent and accurate use of placement forms and gather feedback to continuously improve their effectiveness.*

✓ *Tie the renewal of provider contracts or reimbursements to certain standards of communication, such as placement referral response rates of a given percent.*

Theme 2: Complex Child Needs

- Hospital overstays, office, and hotel stays sometimes happen because there aren't enough placements to meet the needs of these children.
- Some children have significant, oftentimes comorbid, behavioral, mental, or physical

✓ *Establish a coordinated care system with mental health, public health, and other allied professionals to share resources and better meet children's complex needs.*

Key Findings of the Thematic Analysis	*Recommendations*
health challenges and need specialized placement settings.	
Theme 3: Crises Incidents	
• Conflicts between children and placement providers are sometimes a precipitating factor in the occurrence of some index events. • In some cases, hospital, office, or hotel stays result from a series of prior crises, such as consecutive placement disruptions or behavioral incidents, rather than a single crisis. • 72-hour discharge notices do not always provide sufficient time for caseworkers to identify alternative, more appropriate placements.	✓ *Hold placement providers accountable for training staff to understand youth behavior in a developmental context and provide trauma-informed care.* ✓ *Quickly identify and stabilize children experiencing multiple sequential crises.* ✓ *Extend the buffer period for placement discharges beyond 72 hours when safety permits, allowing caseworkers more time to find alternative placements.*
Theme 4: Provider Issues	
• Caseworkers lack access to providers' profiles and real-time capacity information, hindering their ability to find suitable placements and make targeted referrals. • Lack of sufficient knowledge about provider-related factors or dynamics related to placements limits Maryland's ability to prevent the occurrence of index events.	✓ *Create a real-time provider dashboard with capacity and eligibility details and ensure consistent access for caseworkers.* ✓ *Conduct a follow-up mixed-methods study to better understand the role of provider-related factors in the occurrence of index events.*
Theme 5: Poor Casework Planning	
• Hospital overstays, office stays, or hotel stays sometimes occur due to inadequate case management practices, such as insufficient planning for transitions like aging out of a group home. • Insufficient efforts are being made to preserve youths' existing placements when child and staff safety allow.	✓ *Plan sufficiently in advance of expected periods of transition, ideally in conjunction with the youth.* ✓ *Consider instituting a policy requiring placement providers to hold youth's current placements for 30 days to give providers and youth a chance to defuse conflicts and/or*

Key Findings of the Thematic Analysis	*Recommendations*
• Even when placement changes are unavoidable, some caseworkers are not initiating placement finding efforts in a timely manner.	*crises, or to allow caseworkers more time to identify alternative placements.* ✓ *Initiate placement finding in a timely manner.*
Theme 6: Lack of Agency Resources	
• Some hospital overstays, office stays, and hotel stays occur due to insufficient agency placement resources, even for youth without critical or complex health challenges. • Subgroups of children, such as siblings, are also harder to place together due to lack of available placements that could accommodate them. • Placements are also hard to identify on a short-term emergency basis, adding to the occurrence of hospital overstays, office stays, and hotel stays.	✓ *Contract with more placement providers and/or foster parents who are willing to accommodate siblings.* ✓ *Identify more placement options for children who need short-term or emergency housing.* ✓ *Establish a coordinated system of care, consisting of partnerships with mental health, public health, and other allied professionals, to share limited resources and identify more placements for children.*
Theme 7: Child Preferences	
• Hospital overstays, office stays, and hotel stays are sometimes directly precipitated by children running away from their placements. • Youth placement preferences are not sufficiently considered or incorporated into placement decision-making processes. • Current placement forms and assessments fail to adequately address older youths' needs for self-determination and gradual independence.	✓ *Provide more training to providers, caseworkers, and caregivers on how to prevent youth from running away.* ✓ *Address and honor youth placement preferences, whenever it does not risk child, staff, or caregiver safety.* ✓ *Monitor family team decision meetings to ensure youth consistently attend and advocate for their placement preferences.* ✓ *Update Maryland's placement decision-making forms and processes to address the developmental needs and perspectives of older youth.*
Theme 8: Caregiver Inability to Cope with Child Needs	
• Some hospital overstays, office stays, and hotel stays coincide with the presence of	✓ *Increase the utilization of resources such as mobile crises units to help stabilize children in*

Key Findings of the Thematic Analysis	*Recommendations*
strained or fractured familial relationships between children and their biological families, or of instances of maltreatment. ● Hospital overstays, office stays, or hotel stays sometimes occur when biological parents or caregivers can't cope with the stress of managing significant mental or behavioral health needs. ● Placement disruptions could sometimes have been prevented if stressed and depleted caregivers were able to receive much needed respite, or other forms of support, from child welfare agencies.	*their homes whenever possible and to prevent the occurrence of hospital overstays, office stays, or hotel stays.* ✓ *Coordinate with mental health, public health, and other allied professionals, to share limited resources and to meet the needs of vulnerable families and their children more effectively.* ✓ *Establish more respite care options for caregivers of children in foster care.*
Theme 9: Case Reviewers' Recommendations	
● Maryland's child welfare workforce has the potential to be its strongest and most effective ally in preventing the occurrence of index events. ● Maryland's caseworkers who served as case reviewers in this study had thoughtful and valuable recommendations for improving Maryland's ability to meet the needs of its foster children.	✓ *Respond to LDSS' concerns about the lack of information about providers' real time bed capacity and profiles.* ✓ *Address LDSS' concerns about the lack of balance in the current inquiry into the occurrence of index events by also examining the potential role of provider-related factors.* ✓ *Consider implementing the recommendations made by the case reviewers during the debriefing session (see Table 31 of this report for a comprehensive list of those recommendations).*

Appendix K – Latent Class Analysis: Strengths and Needs of Youth in Maryland's Out-of-Home Care by Placement Type (2019-2023)

Latent Class Analysis: Strengths and Needs of Youth in Maryland's Out-of-Home Care by Placement Type (2019-2023)

Prepared for the Maryland Department of Human Services, Social Services Administration as part of the 2023-2024 Placement Needs Assessment

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February 2024

Introduction

Maryland's use of the Child and Adolescent Needs and Strengths (CANS) assessment creates an opportunity to inform decisions with person-centered data regarding placement, interventions, and case closure. Within systems of care, the CANS (Praed Foundation, 2021) has been useful in variety of machine-learning applications to create decision-support models and other system-planning recommendations (Troy et al., 2021, Shimshock et al., 2022, Chor et al., 2015, Cordell et al., 2016). Peer-reviewed literature demonstrates the reliability of the CANS (Kisiel et al., 2018, Anderson et al., 2003) and the validity of the CANS (Kisiel et al., 2018, Chor et al., 2012, Lardner, 2015, Dilley et al., 2007) in multiple system-of-care settings.

For this report, we conducted a Latent Class Analysis (LCA). An LCA is a popular, unsupervised method of identifying subgroups of children and youth in care (Petersen et al., 2019). Latent Class Analysis is a model-based clustering method for improving research on child development, (Lanza & Cooper, 2016), differential early education outcomes (Cooper et al., 2014), behavioral health constructs (Petersen et al, 2019), and treatment foster care populations (Chor et al, 2015).

A CANS-based LCA uses CANS item predictors rated on a Communimetric scale to identify probable patterns of heterogeneity in the population (Chor et al., 2018). CANS scores of 0, 1, 2, 3 are dichotomized into "non-actionable" versus "actionable" status, where the former is defined as a score of 0 or 1 (i.e., no action required for the child in regard to an item), and the latter as a higher score of 2 or 3 (i.e., action required). Dichotomous CANS scores from core domains (Life Functioning, Risk Factors, Behavioral/Emotional Needs, and Youth Strengths) (Praed Foundation, 2021) are typically used as predictors.

Methods

Latent Class Analysis

The LCA modeling was completed in R using the "Polytomous Variable Latent Class Analysis" (poLCA) package (Haughton et al., 2009). The 65 items from all of the core domains of the Maryland CANS (Life Functioning, Child Behavioral Emotional Needs, Child Risk Behaviors, Cultural Factors, Trauma Stress Symptoms, and Child and Environmental Strengths) were included in the analysis. A cross-sectional sample of unduplicated youth assessments completed from January 2019 through October 2023 was selected. Assessments with unusual rating patterns and suspected accuracy issues were removed from the analysis.[58] The remaining sample of 2,630 youth were included in the LCA. The sample demographics are included below in Table 1.

Table 1. Sample Demographics

Gender	N	%
Female	1317	50%
Male	1293	49%
Transgender/Other	20	1%
Age	**N**	**%**
5 and below	404	15%
6 to 10	526	20%
11 to 13	484	18%
14 to 17	820	31%
18+	396	15%

Placement Type	N	%
FC (non-rel)	842	32%
FC (rel)	507	19%
TFC	489	19%
Group	280	11%
Group (Ther)	130	5%
RTC	121	5%
Psych	76	3%
Other*	185	7%

Race	N	%
Black	1267	48%
White	1018	39%
Multiracial	191	7%
Unknown	113	4%
Asian	27	1%
Other**	14	1%

[58] 1,416 cases were excluded for reasons that included the following: only contained '0' ratings, only contained '3' ratings, had all strengths rated 0, had all needs rated 0, had all needs rated 3.

*The "Other" category for Placement Type includes the following categories: Adult Correctional Institution, College, Homeless, Homeless Shelter, Runaway, Secure Juvenile Detention, and Unknown Whereabouts.

** The "Other" category for Race includes the following categories: American Indian or Alaskan Native, Pacific Islander, Declined, and Other.

The method for developing the LCA model followed Guttman's (1954) method which utilizes two lower bounds for common factor analysis. The details of how the 17-class solution was reached are included the tables of eigenvalues found in Appendix A.[59]

Based on the LCA "Lower Bound" analysis, we found a lower bound on a 17-class solution for the Maryland data cohort. The Estimated Response Tables provide probability scores for all items across all classes 1-17. Each score is the probability of an item being actionable for a youth in that class. These tables can be found in Appendix B. Each of the classes was ordered by mean total actionable items, such that Class 1 and 2 have the lowest intensity of needs and robust strengths, and Class 17 has very few strengths and a high intensity of need on the CANS. Table 2 provides a comparison of the characteristics of each of the 20 classes. The "Mean # of Actionable items" is the sum of both actionable needs and strengths to be built or developed (all items rated with a '2' or '3'). These classes represent specific subpopulations of youth profiles within Maryland's system that could be used to understand differential outcomes for youth in Out of Home care or the impact of supports/ services /interventions. These types of analyses are beyond the current scope of this placement assessment but could be pursued in future.

[59]By dichotomizing the CANS items, then calculating the correlation matrix R to compute S1, within the resulting matrix S1, we count the number of eigenvalues greater than one. This count represents the lower bound on the number of classes for our LCA, which for this data set resulted in a 17-class solution.

Table 2. LCA Class Characteristics

Class	Number of Cases	Percent of Total Population	Mean Age	Percentage Male	Mean # Total Actionable Items
1	661	25%	12	48%	2
2	126	5%	10	44%	5.3
3	362	14%	10	50%	5.8
4	117	4%	15	44%	6
5	110	4%	13	48%	8.6
6	71	3%	13	68%	9.3
7	224	9%	14	52%	9.9
8	313	12%	8	51%	12.4
9	100	4%	12	47%	14.5
10	71	3%	12	32%	14.7
11	72	3%	10	51%	15.1
12	84	3%	13	49%	16.9
13	65	2%	11	52%	17.3
14	71	3%	15	59%	17.9
15	96	4%	12	47%	21.6
16	21	1%	14	71%	27.6
17	66	3%	14	44%	29.6

Hierarchical Agglomerate Clustering

The 17-class solution creates challenges for easily translating the classes into a decision support model for placement decisions, as opposed to a decision support model whose output is a

service/support/intervention referral pathway.[60] To address this, hierarchical agglomerate clustering was performed based again on 65 actionable items and the original 17-class LCA categories. After testing several clustering options, the 7-cluster solution was found to be the most parsimonious option. Classes of similar levels of acuity as defined by actionable items were able to be successfully organized within clusters. The "Class Description by Cluster" table in Appendix C details the organization of the classes within clusters, with brief clinical descriptions for each of the 17 classes.

A breakdown of the prevalence of "actionable" needs (needs rated '2' and '3') and "useful" strengths (strengths rated '0' and '1') for each of the items within the 7 clusters is included in the Item Prevalence Tables (Appendix D). These prevalence tables were used to order and label each of clusters into the following with a graph of their relative size included below:

High Need /Externalizing

Family-Focused Trauma & Internalizing

Moderate Functioning Needs /High Strengths

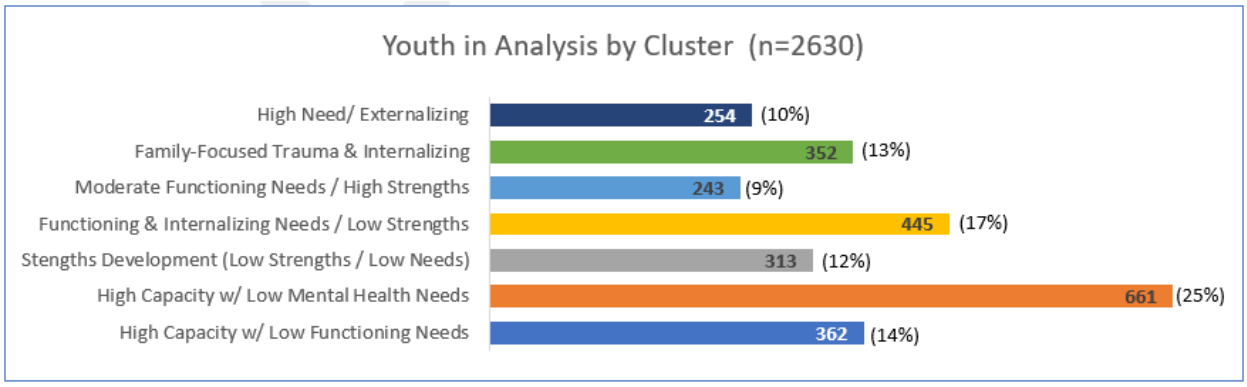
Functioning & Internalizing Needs /Low Strengths

Strengths Development (Low Strengths /Low Needs)

High Capacity w/ Low Mental Health Needs

High Capacity w/ Low Functioning Needs

Figure 1. Number of Youth by Cluster



[60] As noted earlier, the 17 classes can be revisited in future analysis as they may be useful in defining service/supports/intervention referral pathways for specific subpopulations or for identifying variations in the impact of services/supports/interventions for those same subpopulations.

the placement types noted in CJAMS were consolidated eight categories in descending order of intensity:

Psychiatric Hospital	Therapeutic Group Home	Foster Care (Non-Relative)
Residential Treatment Center (RTC)	Group Home	Foster Care (Relative)
	Treatment Foster Care	Other

The "Other" category consists of the following placement types that did not naturally fit with any of the existing placement types:

Adult Correctional Institution	Homeless Shelter	Unknown Whereabouts
College	Runaway	
Homeless	Secure Juvenile Detention	

The results of the placement mapping can be seen in Figures 2 and 3 below. As expected, youth in the two highest need clusters ("High Need /Externalizing" and the "Family Focused Trauma and Internalizing") had the highest percentages of youth placed in congregate care settings. Likewise, youth in the three "Low Need" clusters (Strengths Development (Low Strengths /Low Needs), High Capacity w/ Low Mental Health Needs, and High Capacity w/ Low Functioning Needs) had the highest percentages of family-based placements.

Figure 2. Placement Type by Cluster

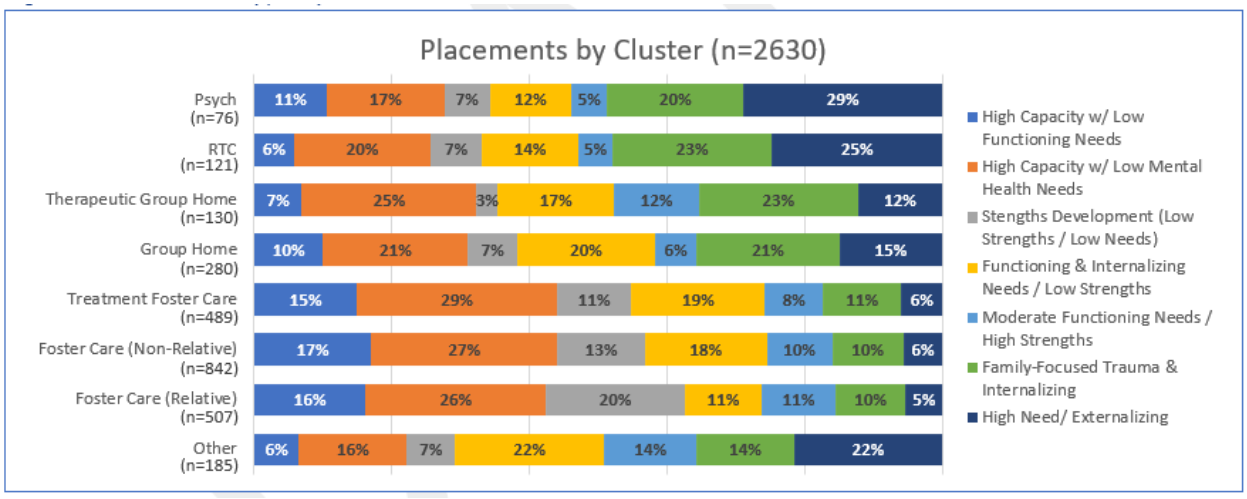
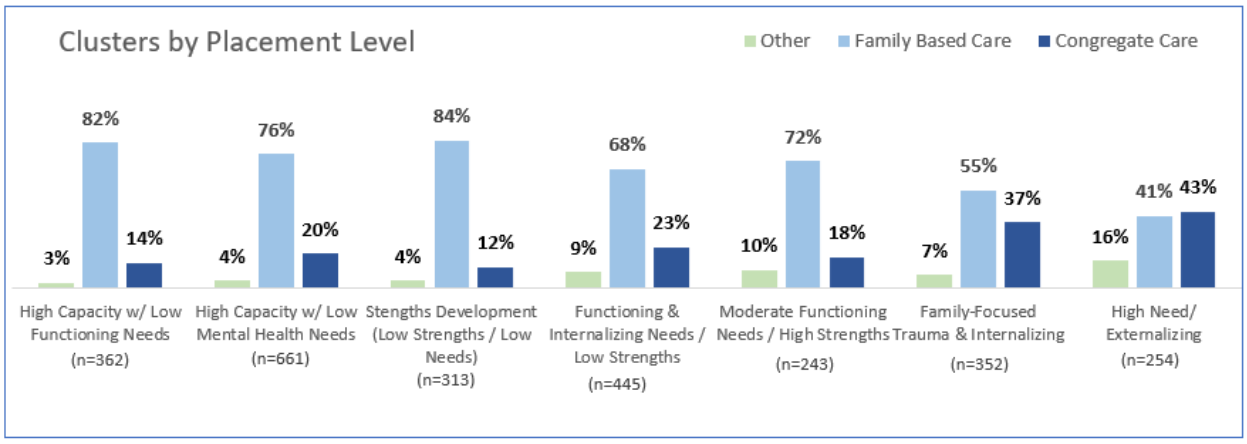


Figure 3. Percent of Youth in Congregate Care by Cluster



Discussion

The analysis demonstrated a connection between the intensity of youth needs and placement in higher 'levels of care' that is consistent with other states. As an example, 43 percent of youth in the highest need category, as expected, were being served in congregate care setting (Figure 3). Additionally, very small percentages of youth placed in family-based placements fall into the highest need cluster (High Need /Externalizing) (Figure 2: TFC, 6%; Foster Care Non-Relative, 6%; Foster Care Relative, 5%).

Alternatively, almost a third of the youth in each of the highest level of care setting (Psychiatric Hospitalization, Residential Treatment Centers, Therapeutic Group Homes, and Group Homes) are youth in the lowest need clusters. While the data set used was selected for its utility in model building, a more refined data set that includes assessments for a representative sample of youth currently placed in Out-of-Home care might suggest that higher intensity services could be reduced by around a third as part of efforts to optimize the State's use of congregate care settings.

While this analysis has demonstrated the potential for using Maryland CANS data to support and evaluate placement decisions, it is recommended that some current data limitations be addressed to take advantage of the placement decision support potential of the current model. Taking steps towards increasing the completion of CANS assessments for all youth, especially at the point of placement decision-making making would help increase the effectiveness of a placement decision support model. Engaging supervisors/coaches in the support of timely and accurate assessments has proven effective in other State systems using the CANS assessment. Finally, enhancing the practice of collaborative assessment across private placement provider agencies and county caseworkers will be useful in establishing trust in the implementation of placement decision support models.

Potential Next Steps

Although the LCA is person-centered and model-based, the translation to readable, transparent, and programmable Decision Support Model (DSM) would include additional steps. To determine the optimal actionable item counts for each class and cluster, building a "decision tree" to map current placements through supervised machine learning is necessary. Decision trees split the cohort based on a subset of predictors to create easily interpretable "trees" that still include interactions. The resulting DSM would need to be empirically tested to ensure that the clinical criteria for placement decisions is

consistent with the unsupervised learning model (LCA). Best practice would dictate that these models are monitored at regular intervals to ensure effectiveness.

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Appendices

Appendix A - LCA “Lower Bound" Analysis

After calculating a correlation matrix, S1 = R-Identity, of which the eigenvalue decomposition provides the lower bound on classes. In the correlation matrix, R, we find that the diagonal is all 1s, which we replace with 0s. Our resulting matrix S1 will have a number of eigenvalues >= 1 equal to the common elements explaining sameness, i.e. the minimal number of common elements for our LCA.

By dichotomizing the CANS items, then calculating the correlation matrix and replacing 1s with 0s, we remove the diagonals. Then, we count the number of eigenvalues greater than one. This count represents the lower bound on the number of classes for our LCA (Guttman, 1954).

[1]	8.875886	5.690156	2.455461	2.224601	1.822847	1.656933	1.546384
[8]	1.490598	1.353072	1.278041	1.27149	1.163018	1.15644	1.13073
[15]	1.112866	1.066135	1.017073	0.993088	0.941976	0.885815	0.863934
[22]	0.857203	0.828884	0.80994	0.79059	0.788301	0.782283	0.752264
[29]	0.743689	0.738766	0.727646	0.708992	0.703174	0.693869	0.654391
[36]	0.640485	0.633679	0.623808	0.604105	0.59942	0.574041	0.563161
[43]	0.557146	0.55129	0.535331	0.533542	0.518738	0.514453	0.50395
[50]	0.490413	0.481703	0.465681	0.453328	0.450502	0.441157	0.421412
[57]	0.41508	0.406654	0.39123	0.386479	0.377635	0.353269	0.3398
[64]	0.328575	0.267405					

Using eigenvalues of R > 1, there is a lower bound of 17

[1]	7.875886	4.690156	1.455461	1.224601	0.822847
[6]	0.656933	0.546384	0.490598	0.353072	0.278041
[11]	0.27149	0.163018	0.15644	0.13073	0.112866
[16]	0.066134	0.017073	-0.00691	-0.05802	-0.11418
[21]	-0.13607	-0.1428	-0.17112	-0.19006	-0.20941
[26]	-0.2117	-0.21772	-0.24774	-0.25631	-0.26123
[31]	-0.27235	-0.29101	-0.29683	-0.30613	-0.34561
[36]	-0.35952	-0.36632	-0.37619	-0.3959	-0.40058
[41]	-0.42596	-0.43684	-0.44285	-0.44871	-0.46467
[46]	-0.46646	-0.48126	-0.48555	-0.49605	-0.50959
[51]	-0.5183	-0.53432	-0.54667	-0.5495	-0.55884
[56]	-0.57859	-0.58492	-0.59335	-0.60877	-0.61352
[61]	-0.62237	-0.64673	-0.6602	-0.67142	-0.73259

Using eigenvalues S1 > 0, there is a lower bound of 17

Appendix B - Estimated Probability Tables

Classes 1 through 9 – Child Behavioral Emotional Needs

Item	class 1	class 2	class 3	class 4	class 5	class 6	class 7	class 8	class 9
Adjustment to Trauma	0.03	0.14	0.01	0.07	0.38	0.03	0.07	0.00	0.38
Anger Control	0.02	0.00	0.01	0.04	0.23	0.07	0.03	0.00	0.54
Anxiety	0.03	0.09	0.02	0.03	0.44	0.07	0.08	0.00	0.50
Attachment Difficulties	0.00	0.02	0.00	0.02	0.18	0.01	0.03	0.00	0.22
Conduct/Antisocial Behavior	0.00	0.00	0.01	0.00	0.06	0.00	0.00	0.00	0.26
Eating Disturbance	0.00	0.00	0.00	0.00	0.03	0.06	0.02	0.00	0.02
Attn Deficit/Impulse Control	0.08	0.11	0.04	0.04	0.51	0.17	0.11	0.03	0.62
Depression/Mood Disorder	0.03	0.17	0.02	0.13	0.59	0.00	0.11	0.00	0.56
Oppositional Behavior	0.02	0.02	0.00	0.01	0.19	0.03	0.02	0.00	0.52
Psychosis	0.00	0.04	0.01	0.03	0.02	0.07	0.00	0.00	0.14
Substance Abuse	0.02	0.00	0.01	0.15	0.07	0.01	0.06	0.00	0.16

Classes 10 through 17 – Child Behavioral Emotional Needs

Item	class 10	class 11	class 12	class 13	class 14	class 15	class 16	class 17
Adjustment to Trauma	0.75	0.37	0.05	0.08	0.22	0.37	0.29	0.89
Anger Control	0.17	0.22	0.00	0.06	0.38	0.73	0.43	0.77
Anxiety	0.33	0.36	0.05	0.03	0.09	0.42	0.43	0.53
Attachment Difficulties	0.37	0.23	0.04	0.05	0.13	0.18	0.28	0.62
Conduct/Antisocial Behavior	0.05	0.00	0.01	0.01	0.24	0.22	0.28	0.53
Eating Disturbance	0.05	0.02	0.00	0.06	0.03	0.03	0.19	0.17
Attn Deficit/Impulse Control	0.27	0.55	0.00	0.27	0.40	0.60	0.67	0.79
Depression/Mood Disorder	0.40	0.41	0.14	0.00	0.22	0.59	0.42	0.77
Oppositional Behavior	0.21	0.20	0.02	0.05	0.44	0.61	0.48	0.75
Psychosis	0.00	0.01	0.00	0.00	0.00	0.06	0.09	0.25
Substance Abuse	0.01	0.01	0.06	0.00	0.35	0.18	0.24	0.34

Estimated Probability Tables (cont.)

Classes 1 through 9 – Life Functioning

Item	class 1	class 2	class 3	class 4	class 5	class 6	class 7	class 8	class 9
Autism Spectrum/PDD	0.01	0.00	0.01	0.00	0.03	0.62	0.01	0.01	0.05
Enuresis/Encopresis	0.01	0.01	0.02	0.00	0.08	0.24	0.02	0.01	0.07
Family	0.09	0.90	0.07	0.28	0.22	0.31	0.30	0.08	0.55
Intellectual (IQ only)	0.02	0.00	0.01	0.00	0.10	0.76	0.02	0.00	0.11
Job Functioning	0.01	0.02	0.01	0.16	0.06	0.19	0.06	0.00	0.05
Judgment/Decision Making	0.02	0.06	0.00	0.16	0.25	0.56	0.11	0.00	0.41
Legal (DJS/criminal court)	0.01	0.02	0.00	0.05	0.05	0.00	0.04	0.00	0.13
Living Situation	0.03	0.40	0.03	0.25	0.07	0.20	0.17	0.02	0.48
Medical/Physical	0.03	0.14	0.05	0.13	0.04	0.31	0.08	0.04	0.18
Recreational	0.00	0.00	0.00	0.01	0.05	0.06	0.03	0.00	0.00
School Achievement	0.02	0.02	0.03	0.68	0.12	0.12	0.16	0.00	0.36
School Attendance	0.01	0.01	0.02	0.70	0.09	0.06	0.14	0.00	0.28
School Behavior	0.02	0.04	0.00	0.28	0.07	0.08	0.04	0.01	0.46
Sexual Development	0.01	0.04	0.00	0.00	0.05	0.04	0.01	0.00	0.17
Sleeping	0.01	0.05	0.00	0.01	0.07	0.07	0.02	0.00	0.08
Social Functioning - Adult	0.00	0.05	0.01	0.05	0.09	0.27	0.07	0.00	0.52
Social Functioning - Peer	0.01	0.05	0.02	0.06	0.12	0.31	0.09	0.00	0.55

Estimated Probability Tables (cont.)

Classes 10 through 17 – Life Functioning

Item	class 10	class 11	class 12	class 13	class 14	class 15	class 16	class 17
Autism Spectrum/PDD	0.00	0.03	0.00	0.43	0.02	0.04	0.48	0.08
Enuresis/Encopresis	0.00	0.07	0.00	0.19	0.00	0.03	0.38	0.08
Family	0.74	0.25	0.37	0.36	0.46	0.50	0.48	0.65
Intellectual (IQ only)	0.03	0.03	0.05	0.35	0.10	0.04	0.48	0.23
Job Functioning	0.10	0.02	0.06	0.07	0.21	0.03	0.43	0.09
Judgment/Decision Making	0.00	0.13	0.25	0.40	0.72	0.51	0.95	0.78
Legal (DJS/criminal court)	0.00	0.00	0.11	0.02	0.41	0.16	0.33	0.17
Living Situation	0.44	0.06	0.20	0.32	0.43	0.33	0.66	0.47
Medical/Physical	0.11	0.08	0.18	0.31	0.18	0.09	0.57	0.39
Recreational	0.04	0.01	0.03	0.01	0.14	0.04	0.66	0.15
School Achievement	0.12	0.00	0.52	0.10	0.62	0.26	0.85	0.50
School Attendance	0.00	0.00	0.51	0.07	0.67	0.17	0.57	0.43
School Behavior	0.08	0.00	0.21	0.13	0.43	0.33	0.62	0.53
Sexual Development	0.05	0.00	0.08	0.03	0.27	0.06	0.33	0.32
Sleeping	0.04	0.10	0.02	0.05	0.10	0.03	0.47	0.12
Social Functioning - Adult	0.18	0.00	0.13	0.34	0.31	0.55	1.00	0.75
Social Functioning - Peer	0.16	0.02	0.18	0.39	0.32	0.57	0.91	0.79

Estimated Probability Tables (cont.)

Classes 1 through 9 – Risk Behaviors

Item	class 1	class 2	class 3	class 4	class 5	class 6	class 7	class 8	class 9
Bullying	0.00	0.00	0.00	0.00	0.04	0.00	0.00	0.00	0.10
Danger to Others	0.01	0.00	0.00	0.01	0.02	0.01	0.01	0.00	0.24
Delinquent Behavior	0.00	0.00	0.00	0.04	0.04	0.00	0.01	0.00	0.15
Exploited	0.00	0.02	0.00	0.02	0.03	0.06	0.00	0.00	0.07
Fire-Setting	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.03
Intentional Misbehavior	0.00	0.00	0.00	0.00	0.07	0.00	0.00	0.00	0.18
Reckless Behavior	0.00	0.01	0.00	0.03	0.06	0.04	0.00	0.00	0.48
Runaway	0.01	0.00	0.00	0.15	0.06	0.04	0.04	0.01	0.29
Self-Injurious Behavior	0.01	0.02	0.00	0.01	0.06	0.07	0.01	0.00	0.19
Sexual Aggression	0.00	0.00	0.01	0.00	0.01	0.00	0.00	0.00	0.09
Sexually Reactive Behaviors	0.00	0.00	0.00	0.00	0.10	0.00	0.02	0.00	0.06
Suicide Risk	0.00	0.02	0.00	0.04	0.04	0.03	0.00	0.00	0.17

Classes 10 through 17 – Risk Behaviors

Item	class 10	class 11	class 12	class 13	class 14	class 15	class 16	class 17
Bullying	0.08	0.00	0.01	0.00	0.00	0.12	0.05	0.26
Danger to Others	0.04	0.01	0.00	0.05	0.07	0.25	0.09	0.46
Delinquent Behavior	0.00	0.00	0.00	0.01	0.29	0.10	0.19	0.43
Exploited	0.05	0.00	0.00	0.03	0.07	0.03	0.29	0.24
Fire-Setting	0.00	0.04	0.00	0.00	0.00	0.03	0.00	0.02
Intentional Misbehavior	0.05	0.05	0.00	0.00	0.20	0.26	0.05	0.61
Reckless Behavior	0.07	0.03	0.06	0.00	0.45	0.31	0.71	0.70
Runaway	0.07	0.00	0.06	0.05	0.43	0.20	0.38	0.34
Self-Injurious Behavior	0.10	0.07	0.01	0.04	0.00	0.24	0.38	0.33
Sexual Aggression	0.04	0.00	0.02	0.00	0.07	0.01	0.05	0.18
Sexually Reactive Behaviors	0.05	0.00	0.04	0.00	0.20	0.04	0.14	0.26
Suicide Risk	0.06	0.04	0.04	0.00	0.00	0.20	0.00	0.31

Estimated Probability Tables (cont.)

Classes 1 through 9 – Cultural Factors & Trauma Stress Symptoms

Item	class 1	class 2	class 3	class 4	class 5	class 6	class 7	class 8	class 9
Culture Stress	0.00	0.06	0.00	0.02	0.00	0.00	0.01	0.00	0.06
Gender / Sexual Identity	0.00	0.00	0.01	0.01	0.02	0.01	0.00	0.00	0.06
Language	0.02	0.06	0.01	0.01	0.02	0.14	0.02	0.00	0.04
Ritual	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.03
Avoidance	0.00	0.04	0.02	0.01	0.25	0.00	0.00	0.00	0.10
Dissociation	0.00	0.00	0.00	0.02	0.07	0.00	0.00	0.00	0.04
Affect Dysregulation	0.00	0.01	0.00	0.00	0.18	0.01	0.01	0.00	0.02
Numbing	0.00	0.00	0.00	0.01	0.16	0.00	0.00	0.00	0.02
Re-experiencing	0.00	0.01	0.01	0.00	0.23	0.02	0.00	0.00	0.10
Traumatic Grief/Separation	0.05	0.31	0.03	0.01	0.40	0.09	0.06	0.02	0.35

Classes 10 through 17 – Cultural Factors & Trauma Stress Symptoms

Item	class 10	class 11	class 12	class 13	class 14	class 15	class 16	class 17
Culture Stress	0.00	0.00	0.00	0.03	0.00	0.04	0.00	0.05
Gender / Sexual Identity	0.06	0.01	0.00	0.00	0.01	0.03	0.00	0.11
Language	0.00	0.01	0.03	0.19	0.01	0.01	0.10	0.02
Ritual	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00
Avoidance	0.33	0.04	0.08	0.00	0.10	0.11	0.00	0.72
Dissociation	0.06	0.00	0.00	0.00	0.00	0.09	0.00	0.25
Affect Dysregulation	0.20	0.07	0.01	0.03	0.10	0.20	0.10	0.62
Numbing	0.15	0.00	0.02	0.00	0.03	0.00	0.00	0.50
Re-experiencing	0.16	0.08	0.00	0.01	0.02	0.02	0.00	0.45
Traumatic Grief/Separation	0.78	0.31	0.16	0.10	0.10	0.19	0.00	0.58

Estimated Probability Tables (cont.)

Classes 1 through 9 – Child and Environmental Strengths*

Item	class 1	class 2	class 3	class 4	class 5	class 6	class 7	class 8	class 9
Youth Involvement w/ Care Planning	0.04	0.09	0.45	0.15	0.09	0.48	0.26	0.84	0.15
Community Life	0.10	0.16	0.42	0.15	0.20	0.24	0.82	0.92	0.25
Cultural Identity	0.04	0.09	0.63	0.00	0.25	0.26	0.50	0.93	0.09
Educational Environment	0.12	0.08	0.17	0.57	0.19	0.12	0.52	0.57	0.34
Family Environment	0.27	0.63	0.12	0.32	0.13	0.21	0.64	0.42	0.61
Interpersonal Skills – Peer	0.04	0.08	0.14	0.06	0.14	0.37	0.55	0.87	0.38
Interpersonal Skills –Non-caregiver Adult	0.05	0.04	0.14	0.01	0.08	0.31	0.51	0.88	0.27
Natural Supports (i.e., unpaid)	0.07	0.13	0.20	0.09	0.07	0.17	0.67	0.69	0.24
Optimism	0.02	0.05	0.18	0.12	0.10	0.15	0.33	0.87	0.07
Spiritual/Religious	0.38	0.22	0.83	0.29	0.47	0.41	0.82	0.96	0.25
Relationship Permanence	0.09	0.25	0.13	0.05	0.05	0.08	0.65	0.68	0.42
Resiliency (History)	0.01	0.04	0.17	0.06	0.08	0.19	0.11	0.75	0.05
Resourcefulness (History)	0.01	0.02	0.49	0.05	0.10	0.37	0.29	0.95	0.04
Talents/Interests	0.02	0.00	0.30	0.09	0.06	0.14	0.38	0.81	0.05
Vocational Preferences & Skills	0.11	0.10	0.82	0.22	0.30	0.40	0.55	0.98	0.06

** Scores represent the probability of being a "Strength in Need of Development/Building" or "No Strength"*

Estimated Probability Tables (cont.)

Classes 10 through 17 – Child and Environmental Strengths *

Item	class 10	class 11	class 12	class 13	class 14	class 15	class 16	class 17
Youth Involvement w/ Care Planning	0.45	0.68	0.73	1.00	0.39	0.75	0.90	0.54
Community Life	0.54	0.78	0.92	0.86	0.67	0.88	0.71	0.72
Cultural Identity	0.51	0.90	0.77	0.93	0.45	0.80	0.81	0.52
Educational Environment	0.32	0.49	0.89	0.38	0.55	0.57	0.62	0.54
Family Environment	0.61	0.22	0.73	0.51	0.56	0.59	0.67	0.70
Interpersonal Skills – Peer	0.46	0.83	0.90	1.00	0.59	0.93	1.00	0.89
Interpersonal Skills –Non-caregiver Adult	0.37	0.84	0.92	0.95	0.49	0.92	0.82	0.79
Natural Supports (i.e., unpaid)	0.56	0.62	0.83	0.75	0.56	0.61	0.77	0.58
Optimism	0.69	0.84	0.93	0.89	0.48	0.78	0.57	0.62
Spiritual/Religious	0.73	0.92	0.95	0.95	0.71	0.92	0.85	0.64
Relationship Permanence	0.59	0.49	0.91	0.58	0.57	0.65	0.52	0.61
Resiliency (History)	0.40	0.73	0.76	0.82	0.15	0.70	0.51	0.50
Resourcefulness (History)	0.56	1.00	0.92	1.00	0.26	0.83	0.76	0.62
Talents/Interests	0.22	0.75	0.77	0.76	0.42	0.55	0.61	0.32
Vocational Preferences & Skills	0.64	0.94	0.91	0.99	0.54	0.91	0.95	0.73

** Scores represent the probability of being a "Strength in Need of Development/Building" or "No Strength"*

Appendix C - Classes Descriptions Organized by Cluster

Hierarchical Agglomerated Clusters	Latent Classes
High Need /Externalizing	Class 14 - 3% of total pop – High Family, School, Judgement Needs. Oppositional Behaviors and Low Strengths
	Class 15 - 4% of total pop – High Externalizing Behaviors (Anger, Oppositional and Impulse); Low Strengths
	Class 16 - 1% of total pop – Very High Social Skills, School and Judgement Needs, Low Strengths, Impulsivity and Recklessness
	Class 17- 3% of total pop – Very High Trauma, Impulse, Mood, Anger, Oppositional and Recklessness Needs, Low Strengths
Family-Focused Trauma & Internalizing	Class 5 - 4% of total pop, High Internalizing MH Needs (Depression, Impulse, Anxiety) w/ Trauma
	Class 6 - 3% of total pop, DD population, High Functioning Needs (with Intellectual, ASD, Judgement)
	Class 9 - 4% of total pop, High MH Needs (Depression, Impulse, Anger) w/ Family, School, and Social Skills Needs
	Class 10 - 3% of total pop, High Trauma and Family needs, Low Strengths, Moderate MH Needs (Mood, Attachment, Anxiety)
Moderate Functioning Needs /High Strengths	Class 2 - 4% of total pop – High Family Needs with Trauma, High strengths with the exception of Family
	Class 4 - 5% of total pop – High School Needs, with Moderate family needs, High Internal Strengths

Hierarchical Agglomerated Clusters	Latent Classes
Functioning & Internalizing Needs /Low Strengths	Class 7 - 9% of total pop - Low Internal Strengths, with some Family/ Living situation /Mood/ Impulse Control needs
	Class 11 -3% of total pop –Internal Strengths, with Adjustment to trauma, Mood, Impulse Control and Anxiety Needs
	Class 12 - 3% of total pop – Very Low Strengths, High School and Family Needs
	Class 13 - 3% of total pop – Low Strengths w ASD, Social Skills, Judgement Needs and functioning Needs.
Strengths Development (Low Strengths /Low Needs)	Class 8 - 12% of total pop, Very Low Needs and Very Low Strengths (Family and School environment are present in roughly half the class.)
High Capacity w/ Low Mental Health Needs	Class 1 - 25% of total pop, Low Needs with some MH, High Internal strengths (Resiliency, Resourcefulness, Talents, Optimism)
High Capacity w/ Low Functioning Needs	Class 3 - 14% of total pop; Very low needs; High Family & Internal strengths (Social Skills, Resiliency)

Appendix D - Item Prevalence Tables

Item	High Capacity w/ Low Functioning Needs	High Capacity w/ Low Mental Health Needs	Stengths Development (Low Strengths / Low Needs)	Functioning & Internalizing Needs / Low Strengths	Moderate Functioning Needs / High Strengths	Family-Focused Trauma & Internalizing	High Need/ Externalizing
Psychosis	1%	0%	0%	0%	3%	6%	10%
Attn Deficit/Impulse Control	5%	8%	3%	19%	8%	43%	60%
Depression/Mood Disorder	2%	3%	0%	15%	16%	43%	53%
Anxiety	2%	4%	0%	11%	7%	36%	36%
Oppositional Behavior	0%	2%	0%	6%	2%	26%	59%
Conduct/Antisocial Behavior	1%	0%	0%	0%	0%	10%	32%
Substance Abuse	1%	2%	0%	4%	7%	7%	28%
Eating Disturbance	0%	0%	0%	2%	0%	4%	8%
Anger Control	1%	3%	0%	6%	2%	27%	63%
Attachment Difficulties	0%	0%	0%	7%	2%	20%	29%
Adjustment to Trauma	1%	3%	1%	12%	12%	39%	46%

7 Clusters – Child Behavioral Emotional Needs

7 Clusters – Life Functioning

Item	High Capacity w/ Low Functioning Needs	High Capacity w/ Low Mental Health Needs	Stengths Development (Low Strengths / Low Needs)	Functioning & Internalizing Needs / Low Strengths	Moderate Functioning Needs / High Strengths	Family-Focused Trauma & Internalizing	High Need/ Externalizing
Family	7%	9%	8%	31%	64%	44%	53%
Living Situation	2%	3%	2%	19%	34%	29%	42%
Social Functioning - Peer	2%	1%	0%	15%	5%	29%	59%
Social Functioning - Adult	1%	0%	1%	12%	5%	27%	58%
Medical/Physical	5%	3%	4%	14%	14%	14%	24%
Enuresis/Encopresis	2%	1%	1%	5%	1%	9%	6%
Sleeping	1%	1%	0%	3%	3%	7%	11%
Intellectual (IQ only)	1%	2%	0%	8%	0%	23%	14%
Autism Spectrum/PDD	1%	1%	1%	7%	0%	15%	8%
Recreational	0%	0%	0%	2%	0%	4%	15%
Legal (DJS/criminal court)	0%	1%	0%	5%	4%	6%	25%
Judgment/Decision Making	0%	2%	0%	20%	12%	31%	68%
Sexual Development	1%	1%	0%	3%	2%	9%	21%
Job Functioning	1%	1%	0%	6%	10%	9%	13%
School Achievement	3%	1%	0%	20%	35%	18%	47%
School Attendance	2%	1%	0%	19%	36%	12%	41%
School Behavior	0%	1%	1%	9%	16%	19%	43%

Item Prevalence Tables (cont.)

7 Clusters – Risk Behaviors

Item	High Capacity w/ Low Functioning Needs	High Capacity w/ Low Mental Health Needs	Stengths Development (Low Strengths / Low Needs)	Functioning & Internalizing Needs / Low Strengths	Moderate Functioning Needs / High Strengths	Family-Focused Trauma & Internalizing	High Need/ Externalizing
Suicide Risk	0%	0%	0%	2%	3%	8%	16%
Self-Injurious Behavior	0%	1%	0%	3%	2%	11%	21%
Reckless Behavior	0%	0%	0%	2%	2%	18%	49%
Danger to Others	0%	1%	0%	2%	0%	8%	25%
Sexually Reactive Behaviors	0%	0%	0%	2%	0%	6%	15%
Sexual Aggression	1%	0%	0%	0%	0%	4%	7%
Runaway	0%	1%	1%	4%	7%	13%	32%
Delinquent Behavior	0%	0%	0%	1%	2%	6%	24%
Fire-Setting	0%	0%	0%	1%	0%	1%	2%
Intentional Misbehavior	0%	0%	0%	1%	0%	8%	32%
Bullying	0%	0%	0%	0%	0%	6%	12%
Exploited	0%	0%	0%	1%	2%	5%	12%

7 Clusters – Cultural Factors & Trauma Stress Symptoms

Item	High Capacity w/ Low Functioning Needs	High Capacity w/ Low Mental Health Needs	Stengths Development (Low Strengths / Low Needs)	Functioning & Internalizing Needs / Low Strengths	Moderate Functioning Needs / High Strengths	Family-Focused Trauma & Internalizing	High Need/ Externalizing
Language	1%	2%	0%	5%	4%	5%	2%
Ritual	0%	0%	0%	0%	0%	1%	0%
Culture Stress	0%	0%	0%	1%	4%	2%	3%
Gender / Sexual Identity	1%	0%	0%	0%	0%	4%	4%
Traumatic Grief/Separation	3%	6%	2%	13%	17%	41%	25%
Re-experiencing	1%	0%	0%	2%	0%	14%	13%
Avoidance	2%	0%	0%	2%	3%	17%	26%
Numbing	0%	0%	0%	1%	0%	9%	14%
Affect Dysregulation	0%	0%	0%	2%	0%	11%	28%
Dissociation	0%	0%	0%	0%	1%	5%	10%

Item Prevalence Tables (cont.)

7 Clusters – Child and Environmental Strengths*

Item	High Capacity w/ Low Functioning Needs	High Capacity w/ Low Mental Health Needs	Stengths Development (Low Strengths / Low Needs)	Functioning & Internalizing Needs / Low Strengths	Moderate Functioning Needs / High Strengths	Family-Focused Trauma & Internalizing	High Need/ Externalizing
Family Environment	88%	73%	58%	42%	51%	63%	38%
Educational Environment	83%	88%	42%	42%	68%	76%	44%
Spiritual/Religious	16%	62%	4%	12%	74%	55%	22%
Community Life	56%	91%	8%	16%	84%	71%	23%
Relationship Permanence	87%	91%	31%	32%	84%	73%	39%
Natural Supports (i.e., unpaid)	80%	93%	32%	28%	88%	76%	40%
Interpersonal Skills – Peer	86%	97%	12%	25%	93%	68%	17%
Interpersonal Skills –Non-caregiver Adult	86%	95%	12%	29%	97%	76%	24%
Optimism	82%	98%	12%	40%	91%	78%	35%
Talents/Interests	69%	98%	18%	43%	96%	90%	54%
Cultural Identity	36%	96%	8%	32%	94%	74%	36%
Youth Involvement w/ Care Planning	54%	96%	15%	48%	88%	74%	39%
Resiliency (History)	83%	99%	25%	56%	95%	84%	52%
Vocational Preferences & Skills	15%	89%	1%	27%	85%	67%	24%
Resourcefulness (History)	49%	99%	4%	37%	97%	77%	39%

** This table reports the percentage of "Useful Strengths" in each cluster.*