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Maryland Social Services Administration Placement Needs Assessment

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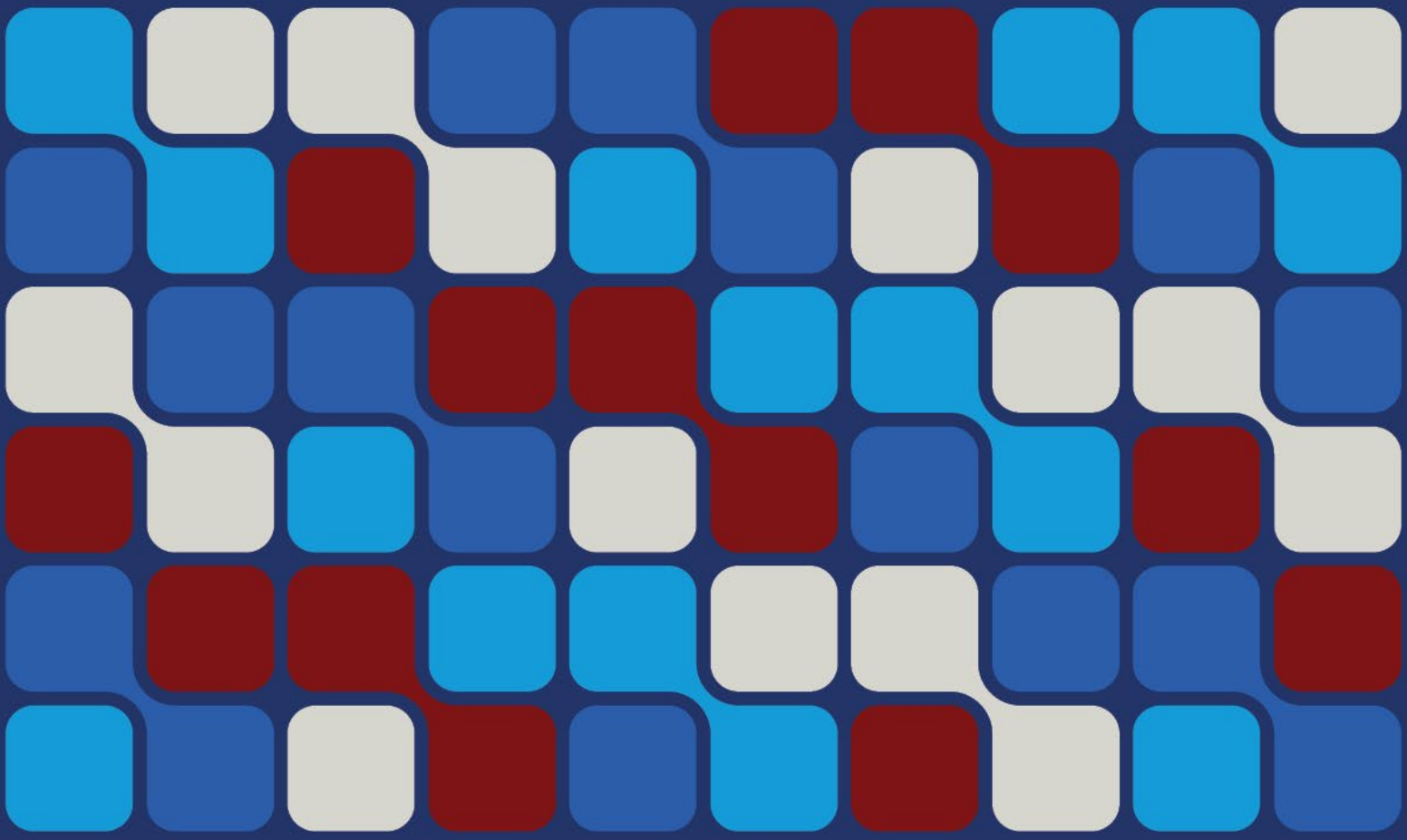
Executive Summary to the Final Report



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

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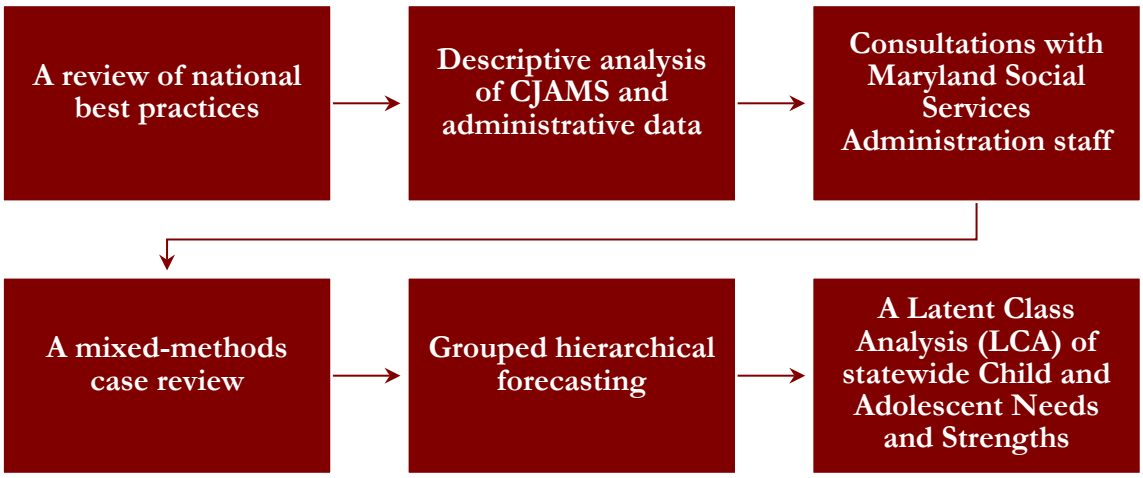
EXECUTIVE SUMMARY

In FY2024, Chapin Hall conducted a placement needs assessment aimed to describe the foster care experiences and placement needs of children in Maryland's foster care system across four populations: (1) children served from SFY 2020 to 2024, (2) children experiencing hospital overstays, (3) children experiencing hotel stays, and (4) children experiencing office stays (for Baltimore City only). Two additional objectives involved forecasting future placements for SFY 2025 based on historical patterns and developing needs profiles to guide future planning. Analyzing the service array itself (e.g. number, type, and capacity of providers) was not part of the scope of this assessment. Assessment activities included:



Our comprehensive approach enabled a meaningful analysis of youths' needs based on the administrative data, despite several noted limitations. The key findings of this placement assessment are as follows:

Population 1 – Children Served (SFY 2020 – 2024)

- Maryland has the 2nd lowest foster care entry rate in the nation (0.91 entries per 1,000 children) and its entries into care continue to decline.
- Within Maryland, entry rates vary widely by region and range from a low of 0.3 entries per 1,000 children in the Southern Region (Charles, Calvert, and St. Mary's) and a high of 4.0 entries per 1,000 children in Baltimore City.
- There are significant regional variations in the age, racial, and ethnic composition of children entering care, with Black or African American children disproportionality represented. The largest age groups entering care are children aged 5 to 10 (24%) and youth aged 14 – 17 (23%).
- Most children enter foster care due to neglect (71%) or caregiver substance use), emphasizing the need for primary prevention and specialized services for families struggling with substance use. Circumstances vary significantly by age at entry: compared to other age groups, children under one year of age are more likely to have needs related to caregiver substance use (35%) and older youth (14 – 17) are more likely to have needs related to child drug or alcohol use (66%), child behavior (61%), and abandonment (41%).
- 72% of children who enter care in Maryland have their first placement in a family home setting, including 38% placed in non-relative foster care and 34% placed in relative foster care. The remainder (28%) have

congregate care as their first placement. This distribution has remained relatively stable over the past five state fiscal years.

- For children who entered care in SFY 2024 in Maryland, there were 4.0 moves per 1,000 days of care. Four regions had placement rates higher than the state rate, including Montgomery (6.5), Western region (6.4), Central region (4.6), and Southern region (4.2). Frederick and Baltimore County had the lowest number of moves per 1,000 days (2.5 and 2.8, respectively). 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.
- Data quality issues, including missing data or inaccurate documentation, impacted the ability to accurately identify children with developmental disabilities, those deemed medically fragile, and pregnant and parenting youth, complicating efforts to examine their specific needs.

Population 2 – Children with Hospital Overstays

- 9% of the children who entered care in SFY 2023 had at least one hospitalization (121 out of 1,337 unique children). 33 (27%) of the 121 children with at least one hospitalization in SFY 2023 had at least one overstay of 10 or more days past the anticipated discharge.
- 15% of hospitalizations resulted in overstays of 10 or more days past the anticipated discharge date; 27% of children with hospital overstays experienced more than one overstay.
- 76% of hospital overstays involved older youth (age 14+), particularly those with significant behavioral or psychological health issues. 88% of the children with hospital overstays were psychiatric admissions. These overstays are more common among females (57%) and in regions like Baltimore City (28%) and Baltimore County (22%).
- 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%).
- The median length of stay (LOS) for children with overstays (from admission to discharge) was 47 days, with a median overstay of 37 days beyond the expected discharge, highlighting challenges in securing timely and appropriate placements.
- 78% of these children had discharge recommendations for residential treatment centers (RTCs), group homes, and treatment foster care.
- To address hospital overstays it is critical to expand specialized placement options. In addition, increased coordination among hospitals, child welfare workers, and foster care providers is needed to communicate changes in the child's prognosis during the hospitalization and ensure discharge plans and needs are thoroughly understood by everyone involved in the child's care.

Population 3 – Children with Hotel Stays

- 4% of the children who entered care in SFY 2023 had at least one hotel stay (49 out of 1,337) according to the hotel file.
- Hotel stays are more common among youth aged 14 or older (81%) and Black or African American children (64%).
- Most children in hotels had workers recommending a group home (74%), treatment foster care (32%), or RTCs (16%), indicating that these children have significant needs that require specialized care.
- 25% of children placed in hotels entered the custody of MDHHS at the same time their stay in the hotel began (i.e., their custody start date matched their hotel start date); 27% were previously in non-relative foster care, 16% in a group home, and 15% on a runaway, homeless, or in secure juvenile detention.

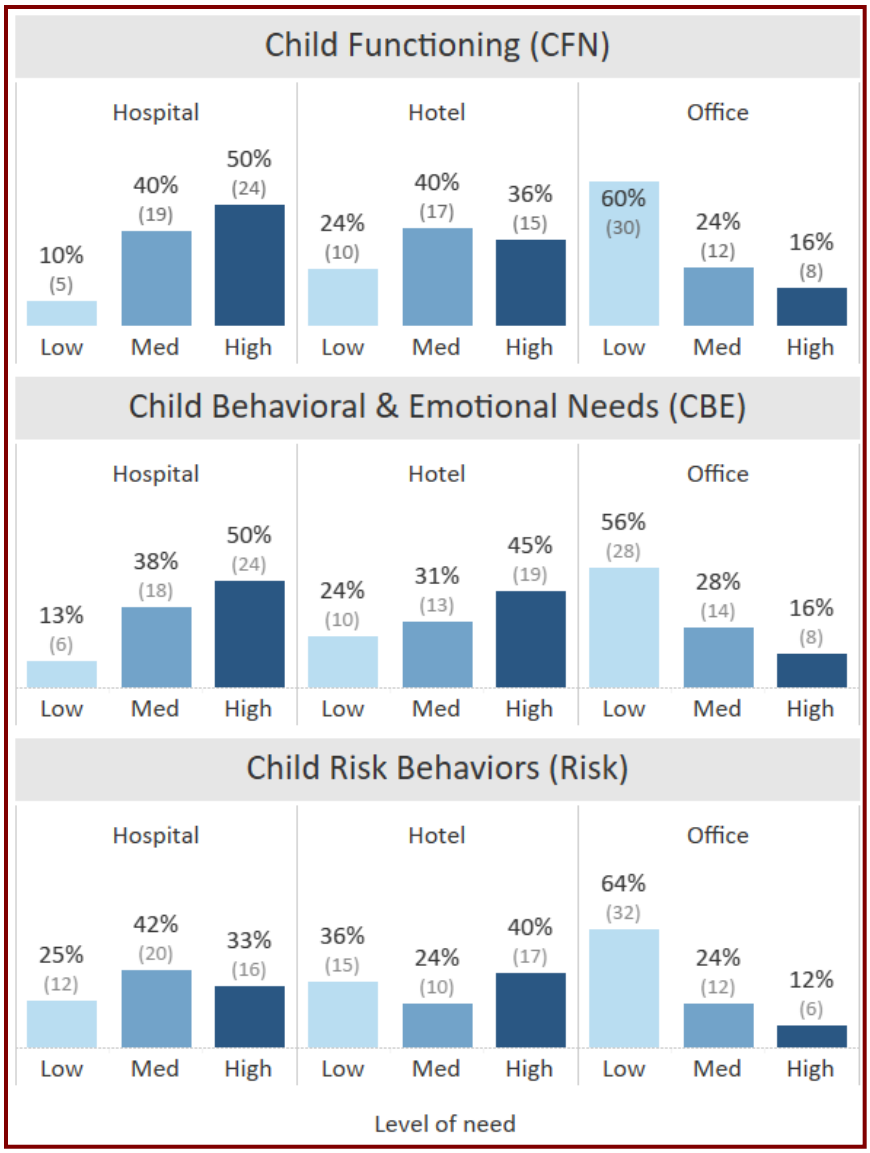
- The median LOS for male children in hotel stays was nearly twice that of females (35 days).

Population 4 – Children with Office Stays (Baltimore City only)

- 7% of the children who entered care in Baltimore City in SFY 2023 had at least one office stay (30 out of 439) according to the office file. An office stay was defined as any stay in the office that lasted more than four hours.
- 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.
- Demographically, 53% of youth with office stays were aged 14-17; 53% were female; and 89% were Black or African American.
- 33% (11 out of 33) of children with office stays had five or more prior moves during the same foster care episode.
- Improving the accuracy of office logs and expanding the types of information collected would contribute to understanding the nature of office stays and ultimately reduce their use.

Case Review Results (*Quantitative*)

- Children who experience hospital overstays in Maryland exhibit the highest needs in both child functioning and child behavioral/emotional needs (see chart below).
- Children who experience hotel stays exhibit the highest needs in both child behavioral/emotional needs and risk behaviors.
- Children who experience office stays have the lowest needs across all three domains, which suggests comparatively fewer challenges and stay factors related to child functioning needs, managing emotions and behaviors, and risk behaviors.
- Children experiencing stays at hospitals and hotels face more severe challenges and may require more intensive support and interventions. For example, 88% of hospital overstays involved psychiatric admissions, suggesting these children face substantial challenges in functioning and managing their emotions and behavior.



Case Review Results (*Qualitative*)

- 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 children in the hotel, office, or hospital overstays had significant placement challenges or instability, or significant behavioral, mental, or physical health challenges, according to their case review documentation.
- 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.

Forecasting Results

- Assuming no significant changes in policy and practice, Maryland should anticipate approximately 4,369 placements in SFY 2025 across various settings including non-relative foster care, kinship care, group homes, residential treatment centers, and treatment foster care. (See Table 43 for a breakdown of estimated placement by setting.) This estimate represents a slight decline from the 4,388 placements that occurred in SFY 2024. The estimate is based on a technique called grouped hierarchical forecasting which

used placement counts for SFY 2019 to 2024 to estimate placement counts in SFY 2025. See the corresponding Methods section for further details on this technique.

Latent Class Analysis (LCA) Results

- There is a significant connection between the intensity of youth needs and their placement in higher levels of care (i.e. 43% of youth in the highest need category are placed in congregate care). This is consistent with trends in other states.
- Development of a placement decision support model based on the LCA could help significantly reduce Maryland's reliance on high-intensity placements. An analysis of data from 2019-2023 revealed that one-third of the youth in high-level care settings (e.g. therapeutic group homes, group homes, psychiatric hospitals, and residential treatment centers) were in the lowest need clusters.
- Very small percentages of youth in family-based placements fall into the highest need cluster, suggesting appropriate use of family-based placements across the state.

Overall Findings Discussion

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. Within Maryland, entry rates vary widely by region and range from a low of 0.3 entries per 1,000 children in the Southern Region (Charles, Calvert, and St. Mary's) and a high of 4.0 entries per 1,000 children in Baltimore City. The wide range in entry rates across regions suggests potential systemic issues or unique factors in certain regions 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. This trend underscores the need for targeted interventions and support services tailored to the unique needs of these younger children and their families, such as caregiver drug abuse and parental inability to cope.

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.

About 9% of the children who entered care in SFY 2023 had at least one hospitalization (121 out of 1,337 unique children). Twenty-seven percent of these children (33 out of 121) had at least one overstay of 10 or more days past the anticipated discharge. Hospital overstay episodes predominantly affect older children (ages 11-18) and occur primarily due to behavioral/psychiatric issues (25%), self-harm/suicide attempts (25%), or

aggressive behavior (21%). Eight-eight percent of the children with hospital overstays were psychiatric admissions, and these overstays are more common among females (57%) and in regions like Baltimore City (28%) and Baltimore County (22%). These findings underscore the importance of tailored interventions and comprehensive support services to address the complex needs of children experiencing prolonged hospital stays.

About 4% of the children who entered care in SFY 2023 had at least one hotel stay (49 out of 1,337 unique children) according to the hotel file. Hotel stays are also more common among older youth, particularly Black or African American children. A notable 25% of children with a hotel stay entered MDHHS custody on the same day they started their hotel stay, with others transitioning from non-relative foster care, group homes, or situations involving runaway or homeless status. The reliance on hotels underscores the need for more placements that serve youth with complex behavioral and emotional needs, the most frequent of which were related to social functioning among adults (93%), judgment/decision making (87%), and social functioning among peers (87%).

About 7% of the children who entered care in Baltimore City in SFY 2023 had at least one office stay (30 out of 439) according to the office file. An office stay was defined as any stay in the office that lasted more than four hours. 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. 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 children with hotel, office, or hospital overstays had significant placement challenges and instability, or significant behavioral, mental, or physical health challenges based on the case review findings. Challenges related to complex child needs, crisis incidents, and caregiver inability to cope with child needs all contribute to these kinds of stays. Strategic planning, increased interagency coordination, an emphasis on caseworker practices, and additional research could improve caseworker responses to 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:

a. 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.

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

c. 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:

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

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

   c. 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.

   d. 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.[1]
8. Increase Caseworker Training: Train caseworkers to:
    a. identify and respond to early warning signs of placement instability;
    b. incorporate trauma-informed care, cultural competence, and developmentally appropriate approaches to improve their understanding of youth behavior and needs;
    c. 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 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.

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

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.