L. J. v. Massinga Independent Verification Agent CERTIFICATION REPORT FOR DEFENDANTS' 60th SIX-MONTHS COMPLIANCE REPORT

Rhonda Lipkin
Independent Verification Agent

Lisa Mathias
Assistant to Independent Verification Agent

rhonda.lipkin@gmail.com
410.499.3752

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III. SPECIAL CASE REVIEW: CHILDREN UNDER 13 WITH SIGNIFICANT PLACEMENT INSTABILITY

Pursuant to the MCD, "where the Independent Verification Agent determines that the Defendants have not provided sufficiently reliable and accurate information to measure Defendants' performance on the requirements of this Decree, the Independent Verification Agent may conduct additional information-gathering activities to obtain information to measure performance" (Part One, II., C., p. 4). For this 60th report, the IVA has undertaken this additional review regarding the cases of 36 children under the age of 13 who have experienced significant placement instability, lack of appropriate placements and waiting lists for treatment programs. One of the first young children with frequent moves that came to the attention of the IVA was DJ.

> *DJ, ten-years-old at the time, entered foster care in April 2016 and spent six months placed with a long-time caregiver before she became unable to handle his behaviors. From November 2016 through August 2017, DJ experienced at least 35 placement disruptions. During that time, D.J. was transferred between 6 different Treatment Foster Care agencies, 9 different BCDSS foster homes, spent at least one night on runaway at least 8 times, and stayed overnight at the Gay Street office at least 5 nights. He was enrolled in at least 5 schools during that time but attended almost no school days due to his constant moves. In August 2017, DJ was placed at St. Vincent's diagnostic treatment center and then at St. Vincent's Villa RTC in November 2017.*

Although DJ had stabilized prior to the 60th Report period by his entry into Villa RTC in late 2017, his was only one of the first of the frequently moved children under 13 that have come to the attention of the IVA in the last couple of years.

Data Sources

The cases of these very young children with frequent placement disruptions have come to the IVA's attention through a few different sources including Gay Street overstay reports, maltreatment reports against a foster parent that required a child's move, review of requests for placement of children under 13 in congregate care, information about psychiatric hospitalizations and information from a child's CINA attorney. For the last few years, Defendants have failed to provide regular reports on placement moves, leading to a lack of attention to the "big picture" of frequent moves for these younger children. Until this month, the Intensive Case Management Unit, required by the MCD Preservation and Permanency Additional Commitment 5 (MCD, p. 17), only accepted youth 14 years and older, and, therefore, reports of children moving frequently were not tracked and acted upon for children under 14.

Findings

Through the various sources listed above, the IVA has compiled a list of 36 children (including DJ) who entered OHP prior to January 1, 2019, and were no older than 12 as of January 1, 2018. Besides date of birth and date of entry (DOE) into OHP, the following data was collected from CHESSIE, Quest (Baltimore City Juvenile Court database) and Gay Street overstay reports:

1. Reason for entry into OHP.
2. Prior removals.
3. All placements since the most recent date of entry into OHP.[8]

[8] Although all of this information should be in the placement and living arrangements' sections in CHESSIE, caseworkers frequently do not document regular placement disruptions such as hospitalizations, respite placements, runaway periods or stays at Gay Street, as well as fail to list each individual treatment foster home in which a child may be placed within a treatment foster care agency. For example, it may appear that a child remained in one home for 6 months under X Treatment Foster Care program, when, in fact, review of the CHESSIE contacts, Extended

4. Whether the child had a "one-to-one" while in OHP.

5. All school placements documented in CHESSIE and Quest.[9]

Based upon this review, the following information emerged:

Of these 36 children, 17, or almost half of the children, entered OHP in 2018; 10 entered OHP in 2017; 8 entered OHP in 2015 or 2016; and 1 entered in 2013. The average number of months in OHP through April 2019 for the 36 children was 19.8 months. During that time, those 36 children experienced an average of 11.7 placements per child. This would include moves between foster and kin homes (including regular, TFC, unlicensed kin and licensed respite homes), hospitals, unlicensed placements such as the BCDSS office building on Gay Street, trial visits home, and runaway episodes.

The results of this review follow.

36 children DOE prior to 1/1/2019; under 13 as of 1/1/2018.	**# of Months in OHP**	**# of documented (doc.) placements**	**# of doc. school placements (This is the data most likely to be significantly undercounted.)**	**# of doc. Treatment Foster Care agencies with which child placed**	**# of doc. BCDSS foster homes**	**# of doc. Kin Place-ments**
Average per child	19.8	11.7 (placement change every 51 days)	3.8 (school change every 5 months)	3.1	2	.47

Hours non-CPS reports, and Quest reveals that the child was in 3 different homes under X TFC program during those 6 months.

[9] School placements and placement changes are often not documented so reports of school placement changes often are undercounted.

Hospitalizations

Between January 1, 2018 and April 30, 2019, a 16-month period, at least 25 of the 36 children had documented psychiatric hospitalizations. Eighteen of those children had at least 1 or 2 hospitalizations; 6 had at least 3 or 4 hospitalizations; and one child, a 10-year-old, had at least 7 hospitalizations in those 16 months.

Impact on Education

Reviewing contact notes as well as the "education" section of CHESSIE reveals that nearly two-thirds of the children, over an average 20 month length of stay in OHP, had 3-7 school changes, and one child had at least 10 school changes. Because of poor documentation of school and other education information by caseworkers, it is highly likely that this is a serious undercount. There is no data in CHESSIE about school attendance. However, because many of these children changed placements so often, they also often missed large number of school days. In addition, needed testing or IEP meetings for special education services failed to occur, and school placements would be delayed until the school system determined the "right" school for the children or, when the children were in school, they were not placed in appropriate settings. Most of the children who remained stable in school were children enrolled in the non-public schools such as Villa Maria, which children who qualify may attend wherever they live (within a reasonable transportation distance).

Kin Caregivers are not being Sought

In 21 of the 36 cases, there was no placement with a kinship caregiver during this time. Few of the 36 children had a trial home visit with a parent or guardian. In some cases, there may well have been no parent or relative available, but, in reading over the contact notes, in most of

these cases, there does not appear to have been an attempt to find relatives who might be willing, with sufficient supports, to allow the child to be placed in their care.

Overuse of One-on-Ones

In the case of these 36 children, at least two-thirds - 22 children ages 7 to 13 - have had one-on-ones for varying lengths of time, including while placed in TFCs and in residential group homes. Besides the expense, the IVA is concerned about the unknown impact to these children of having random young adults with minimal training and education about mental health and other needs of young children being, essentially, their primary companions and caregivers.

Increased Use of Congregate Care for Children Under 13

Fourteen, more than one-third of the children reviewed, were placed at some time in the last three years at St. Vincent's Diagnostic Center and/or St. Vincent's Villa RTC, the state's only diagnostic group home and residential treatment center for children under 13. For a growing number of the rest of the children, the failure to provide sufficient, appropriate supports to care for these children in family homes and the waiting lists for available beds at St. Vincent's has resulted in BCDSS having to place them in group homes not licensed to house and, therefore, not focused on the needs of younger children.[10] In just the past three months, 4 children under the age of 13 have been placed in 3 different group homes (other than the diagnostic facility mentioned above).

In at least 3 of the cases, a decision was made to place the children in those group homes because the agency had exhausted the currently-available placements, and the children were in danger of having to have multiple overnight stays at Gay Street or placement in any number of temporary foster homes which, most likely, was going to be for only a night or two.

[10] The facilities involved would have to obtain a waiver from DHS to accept the children.

The case of NF illustrates how one of these children ended up in this situation.

> *NF first entered foster care in August 2016 at age 9. She remained in foster care for 6 months at which point she was reunified with her mother under an Order of Protective Supervision. Her mother had a long history of mental illness and substance abuse, transiency and allegations of neglect and abuse of her children. During the 6 months NF spent in OHP, due to foster parents' inability to cope with her suicidal and aggressive behaviors, NF was placed in at least 5 different foster homes and had 2 psychiatric hospitalizations as well as being enrolled in at least 4 different schools.*
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> *In July 2018, NF was once again removed from her mother and placed in BCDSS care. The mother had been leaving NF and her brother alone for long periods of time, was not addressing her own or NF's mental health needs, and was physically abusing NF's brother. NF was taken directly by the police to the University of Maryland Hospital for psychiatric care. For the next 9 months until the end of April 2019, NF, now 11, had at least 12 foster home placements, at least 7 hospitalizations and 1 trial home visit (lasting 3 weeks). NF had a total of at least 20 disruptions in placement in those 9 months at a rate of more than 2 disruptions a month. This was despite the fact that while she was in the last (at least) 4 foster homes, from January through April, 2019, she had a one-on-one with her at all times. She was also enrolled in at least 4 different schools and spent a significant amount of time not in school at all.*
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> *Unable to find another foster home to take her, and with no available beds at St. Vincent's Diagnostic or Villa RTC, BCDSS obtained a waiver to place her, with a one-on-one, at a group home licensed for youth 13 and older, in April. After at least 20 placement disruptions, it is hoped that NF can be stabilized, obtain consistent therapy and be assessed for appropriate educational services.*

While the IVA understands the clinical justification of the decisions to place some of these children under 13 in group homes, the fact remains that the vast majority of available research and professional opinion supports the conclusion that congregate care is not good for any child, especially at a young age. See, for example, Att. 2, Dozier et al., "Consensus Statement on Group Care for Children and Adolescents: A Statement of Policy of the American Orthopsychiatric Association," (American Journal of Orthopsychiatry, 2014).

Lack of Meaningful Clinical and Trauma-Informed Placement Processes

It appears that there is no process in place for thoughtful, child-centered placement decision-making when children are entering OHP, even when the child already is known to BCDSS. The data shows that at least 21 children, nearly two-thirds of these 36 children, had had prior entries into OHP, and at least 17, nearly half of the children, came into OHP explicitly due to problems with the children's behavior and mental health challenges. In some cases, the children entered OHP because a parent or guardian refused to pick the child up from a psychiatric hospitalization because of fear for their own safety or of the safety of other children in the home. Others had worked with BCDSS family preservation in attempts to obtain sufficient help in the community to keep the children in their homes but were unsuccessful in doing so.

Despite this foreknowledge of their challenges, BCDSS has failed to plan for appropriate placements when the children entered into foster care. Even if the first placement may not have been able to be the "right" placement, certainly the agency had enough information at its disposal to work to find more appropriate placements within a short time. These placements should have had the necessary services to avoid the, literally, dozens of placements that some of these children have suffered and some continue to suffer. DC's case illustrates this problem.

> *DC, who will be 8 in June 2019, entered foster care in June 2017 at the age of 6 due to neglect by his mother, a drug addict. By the time he entered OHP, he was well known to BCDSS because Family Preservation had been serving the family and helping the mother get treatment for herself and for DC who was diagnosed with ADHD, OCD and mood disorder and had been expelled from school due to stabbing another child with a pencil. Despite foreknowledge of his significant mental health and behavioral issues, BCDSS evidenced no thoughtful planning for his placement and needed services.*

During the 22 months in BCDSS custody from June 2017 through April 2019, DC had at least 28 disruptions in placement, including at least 2 hospitalizations, 3 trial visits home, 3 BCDSS foster parents, and multiple foster parents from 6 different treatment foster care agencies. With the presence of a one-on-one, he has had increased stability since January 2019 and has remained with the same foster parents except for a respite period in April. Unfortunately, DC will soon have to move again. The foster parents have asked for his removal at the end of this school year.

What is Needed?

There are waiting lists for St. Vincent's RTC and diagnostic programs, and children are staying in the diagnostic center over the licensing 90-day limit while awaiting a bed in the RTC. However, a solution is not to precipitously remove any children from those programs or necessarily to add more inpatient diagnostic and RTC placements. Defendants need to find more appropriate interventions that can be provided before young children get to the point where they seem unable to stabilize in any foster home, and the only option left seems to be inpatient diagnostic and RTC or, even, as happening lately, placement in group homes designed and licensed for older children.

Experts have suggested having mobile treatment programs which include both psychiatric and therapeutic providers so that children who are moving often can at least have consistency in mental health care. In addition, there need to be more outpatient day diagnostic and treatment programs with supplemental supports for families on weekends as necessary.[11] Wraparound mental health support needs to be available earlier and more quickly. Most importantly, perhaps, foster parents and kinship caregivers need to have significantly more training, guidance and

[11] Recently, a caseworker was told that there was a two-year waiting list for a day treatment program at Kennedy Krieger Institute.

support to care for children with difficult-to-manage behaviors. There are therapies developed specifically for this purpose, for example, Trust-Based Relational Intervention (TBRI).[12]

All of this is expensive, certainly, but certainly no more money than has been spent moving these 36 children from home to home, hospital to hospital, RTC to RTC or group home, often with months of 24/7 "one-on-one" supervision. Incalculable is the future cost of failing to help these children heal from early trauma and, even more devastating, contributing to deterioration in their capacity to function within a family setting, thus precluding finding a permanent home – or worse.

[12] Karyn B. Purviss, David R. Cross, Donald F. Dansereau,& Sheri R. Parris (2013) Trust-Based Relationsl Intervention (TBRI): A Systemic Approach to Complex Developmental Trauma, Child and Youth Services, 34:4, 360-386, DOI: 10.1080/0145935X.2013.859906. A copy is attached as Att. 3.