ATTACHMENT 1

BALTIMORE CITY PLACEMENT REVIEW

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Prepared for the Maryland Department of Human Services, Social Services Administration, and the Baltimore City Department of Social Services

Prepared by:
Terry V. Shaw, PhD, MSW
Neil Mallon, MSW, LCSW-C
Caroline Harmon-Darrow, PhD, MSW, LMSW
Richard P. Barth, PhD, MSW
Carrie Gould-Kabler, MSW
Deborah S. Harburger, MSW

The Institute for Innovation & Implementation, University of Maryland, Baltimore

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Contents

Tables

Purpose

The Maryland Department of Human Services (DHS), Social Services Administration (SSA) contracted with The Institute for Innovation & Implementation (The Institute) at the University of Maryland, Baltimore to provide a comprehensive review of the case files of a sample of children[1] in state-supervised out-of-home placement services through the Baltimore City Department of Social Services (BCDSS).

The Institute conducted this review to assist DHS and BCDSS in ongoing continuous quality improvement activities and, specifically, to address requirements of the *L.J. v. Massinga* Modified Consent Decree (DHS, 2021). The consent decree requires that DHS/BCDSS complete a biennial "assessment of the range of placements and placement supports required to meet the needs of children in OHP by determining the placement resource needs of children in OHP, the availability of current placements to meet those needs, and the array of placement resources and services that DHS/BCDSS needs to develop to meet those needs in the least restrictive most appropriate setting…"(DHS, 2021, p.40).

This review examined the placement resource needs of children in out-of-home placement, as evidenced through administrative and case records, and assessed the consistency of the children's placements with those identified needs. This review was a point-in-time examination of children in out-of-home care, developed to better understand the placement needs of children served by BCDSS and how well children are matched with placement settings based on state policy and population needs. This report includes recommendations based on these findings to support BCDSS and its partners to meet the needs of all children in the least restrictive and most appropriate setting.

Background and History

Across the United States, communities are striving to serve children in their own homes without requiring an out-of-home placement. In Maryland, 8% of children who have been identified as experiencing maltreatment receive foster care services (U.S. Department of Health & Human Services, 2022). When an out-of-home placement does occur, the goal is to place children in relative (kin) placements or in a family setting within the child's community.

At the end of October 2021, there were 1,686 children in out-of-home placement in Baltimore City. Almost three-quarters of those children (1,234 or 73.2%) were placed in a family home, a setting that is inclusive of formal kinship care, restricted (relative) foster care, regular foster care, treatment foster care, trial home visits, and adoptive/pre-finalized adoptive homes. The other 26.8% of children were living in independent living, group home, residential treatment center, or other living situations, including college and correctional/detention/commitment facilities (DHS, 2022). This data compares favorably with Maryland's aggregate data: 69% (2,962) of all children in out-of-home placement (4,302) across Maryland at the end of October 2021 were living in family homes (DHS, 2022).

While the decision to remove a child in danger from the home has been intricately studied for more than a century, the level of care or service intensity among out-of-home placements has received less attention until recently. Attention to level of care decision-making has been driven by the larger effort to protect children's safety in the least restrictive environment, increase placement stability (Chor, 2013; Sunseri, 2005) and timeliness to permanence (Barth et al., 1994), and fit the placement level with the child's clinical, social, educational, and medical needs (Chor, 2013).

[1] The terms *child* and *children* are inclusive of all individuals aged 0-21.

Factors Impacting Placement Decision-Making

Ensuring that every child receives the right level of care is a complex matter for workers, supervisors, teams, and agencies, and numerous decision-making paradigms, instruments, processes, and programs have been used over the past several years to improve assignment of appropriate intensity of care, as well as accountability for those decisions. Since at least the 1970s, individual assessment instruments have been designed to ensure consistency in decision-making (Dukette et al., 1978), assisted by software programs since the 1980s (Mutschler, 1990; Schwab & Wilson, 1989; Shuerman & Vogel, 1986). Few studies have endeavored to determine how fair and effective these instruments are and what contributes to best placement decisions. In evaluations of out-of-home placement decision-making, worker factors are often viewed as central, due to broad discretion given to workers and the lack of consistency across workers (Britner & Mossler, 2002; Chateauneuf et al., 2021). Organizational factors, such as variance in agency centralization (Pösö & Laakso, 2015), worker support, workloads, and resources (Graham et al., 2015) have also been shown to present challenges for appropriate level of care decisions.

Challenges in identifying appropriate family homes in a timely fashion are one of the reasons why group home placements are over-utilized in Maryland and across the country (Lee, Hwang, Socha, Pau & Shaw, 2013). Many group homes provide important interventions and services and ensure that children have a safe place to live. However, the American Orthopsychiatric Association observes that "group care should be used only when it is the least detrimental alternative, when necessary therapeutic mental health services cannot be delivered in a less restrictive setting" (Dozier et al., 2014, p. 219). Most children residing in group homes are ages 13 and older, which poses particular concerns related to supporting healthy and normative adolescent brain development (National Academies of Sciences, Engineering, and Medicine, 2019).

Having an array of appropriate placement options for children and youth requires the presence of both services and resources. Individual factors such as the child's race as well as jurisdictional or community factors impact the decision-making process: being more urban, having more children of color on the caseload, higher poverty, and having more single-headed households are all factors associated with disparities in placements (Maguire-Jack et al., 2020). This suggests that these disparities may be structural, not just based on workers' biases (Maguire-Jack et al., 2020). Local policies intersect with racial disparity concerns in complex ways, with some studying whether racial disparities are more likely in jurisdictions without judicial review of out-of-home placements (Simon, 2018).

Maryland's Placement Process

A series of interviews, surveys, and large group discussions in 2018 and 2019 with State and local child welfare, juvenile justice, and health care leaders and provider organizations across Maryland identified that:

> [T]he child welfare group home placement process is highly variable. It relies heavily on the individual opinions and expertise of local department of social services (LDSS) staff members across 24 jurisdictions, as well as the availability of placements and the responsiveness of providers. Neither State, local, nor private agencies were able to describe the key characteristics and therapeutic needs of youth who require a non-family setting for the purpose of their own behavioral health treatment needs. Instead, they described youth placed in these settings because it was the most appropriate bed available at the time to meet particular needs (e.g., an older youth with some aggressive behaviors and a history of running away from placements). When asked whether the youth's clinical or behavioral needs could have been

> met in a family setting, with few exceptions,[2] the answer was "yes," had the necessary home- and community-based services been available (Harburger, Schober, Fields, Baxter, Manley, Lowther, Mutibwa, & Zabel, 2021, p. 2).

Children who are involved with both child welfare and juvenile services may experience placement decisions differently. One study found that that prior chronic justice system involvement predicted placement in residential facility or group home placements, while low justice system involvement predicted placement into foster homes (Kolivoski et al., 2017).

Maryland's public child- and family-serving agencies have embarked on a Quality Service Reform Initiative (QSRI) which, in conjunction with activities associated with implementation of the federal Family First Prevention Services Act (FFPSA), is designed to support a vision where all children live in committed, permanent homes; children receive individualized and trauma-responsive services; and residential interventions are short-term and designed to meet clinical and behavioral needs. The State of Maryland is working to improve care pathways to ensure that children access residential interventions—clinically necessary non-family settings—through a consistent process across the state that leverages strengths of the children and matches treatment interventions to identified needs (Harburger, Schober, Fields, et al., 2021).

This review provides insight into the current strengths within Baltimore City's placement services, identifies areas for improvement, and makes recommendations to continue to improve the ability of Baltimore City to appropriately place children who enter foster care.

Method

Stratified Sample and Oversample

The Institute conducted a *stratified random selection of children,* by placement type, from Maryland's Comprehensive Child Welfare Information System (CCWIS) known as CJAMS (Child, Juvenile & Adult Management System). A sample of 150 children was selected randomly from children whose cases were open on October 15, 2021. After the sample was drawn, an additional 15 children were included from the 'overstay list' in Baltimore City (referred to hereafter as the oversample). Children on the overstay list have either stayed in their current placement longer than allowed by policy (for instance, staying too long in a diagnostic treatment center) or stayed overnight in places that are not formal placements (such as in an office). In total, approximately 10% of the total population of children in out-of-home placement in October 2021 were included in the review, which is a sample size consistent with other research activities.

The table below shows how the case files of children included in the sample and oversample were consistent with the distribution of out-of-home placements of children placed by BCDSS. Most children, approximately 80%, were living in a family setting in both the sample/oversample and total BCDSS population of children.

[2] Most common exceptions noted were youth with significant attachment challenges that had not yet been addressed, youth with significant public safety risk factors and/or impulsive behaviors that were placing themselves or others at risk, and youth with intellectual/developmental disabilities and very impulsive behaviors. All these youth were identified as needing behavioral/treatment plans implemented before safely transitioning into a home setting.

Table 1: Sample Comparison by Placement Type

By Placement Type	Baltimore City on 10/15/2021		Sample and Oversample	
	n	%	n	%
Total Population	1,674	100.0%	165	100.0%
Family Home Settings	1,354	80.9%	133	80.6%
Group Homes/Shelters	155	9.3%	12	7.3%
Residential/Detention	31	1.9%	5	3.0%
All Other	134	8.0%	15	9.1%

Tables in Appendix A provide a comparison of the sample/oversample population to the BCDSS out-of-home placement population by race, sex, and age. The selected sample had proportionately similar numbers of Black children (77.6% compared to 80.2% in the Baltimore City caseload as a whole) and proportionally more White children (18.8% compared to 14.6% in the Baltimore City caseload as a whole). The selected sample was comparable by sex. The sample had slightly fewer very young and very old children. The remainder of the age groups were higher in the sample compared to Baltimore City as a whole; for example, 16- to 17-year-olds are 17% of the sample but only 9.3% of the Baltimore City caseload.

In prior research, the concept of children's behavior at the time of removal into out-of-home placement was seen to be predictive of the time to reunification and the likelihood of return to care after reunification (Shaw, 2006; Shaw & Ahn, 2015). The sample population was found to be similar to the Baltimore City caseload related to this factor, with 87.3% of the sample having an indication of child behavior as a factor at removal compared to 88.7% of the Baltimore City caseload as a whole. (See Appendix A, Table 17.)

Review Tool

A review tool was developed with input from BCDSS and used to examine the case files of each of the 165 children to understand if the child's placement was consistent with extant policy, regulations, and requirements. The review tool can be found in Appendix B. The tool included information on the child's demographic information, current placement (including whether a Family Involvement Meeting [FIM] was held), and existing documentation of strengths and needs (e.g., recent Child & Adolescent Needs and Strengths [CANS] assessment, psychiatric and psychosocial evaluations, MATCH documentation, and presence of educational and medical needs).

Review Process

The Institute's research staff drew the initial sample of 150 children in out-of-home placement on October 15, 2021, from CJAMS. DHS training staff provided training on accessing and interpreting information from CJAMS. Both BCDSS and DHS/SSA staff were available to answer questions and provide refresher trainings as requested.

The research team began the review process by having two members each review and code the tool for the same three case files. The files were coded individually and then the team members discussed any differences seen and the reason for the differences. This process helped the team to understand the different places that information could be in CJAMS. The preference was to use information that could be readily identified through flags or codes within the case record so that these might be developed into an administrative data tool for future examinations. However, the research team found that many of the items that were deemed to be important parts of the tool required an examination of documents that are stored in CJAMS (such as medical and diagnostic information) and a nuanced look at the various types of assessments that are available in CJAMS (such as the CANS, safety assessments, and risk assessments).

Once there was agreement on where information for the tool could be found, an additional 12 children's case records were reviewed. The research team then met to discuss any issues or concerns that came up related to the utility of the tool, the clarity of the information found, and the overall process. Minor changes to the data tool were made at that point and the records that had already been reviewed were re-reviewed to make sure that all the information was included. As noted, the final data collection tool can be found in Appendix B. At this point, the research team added contextual factors to the review tool. These factors were collected from narrative records from the child's case file, including Case Plans, Contact Notes, Family Team Decision Making (FTDM) reports, and MATCH documents. Factors included whether the child had an indication that their medication management was current, whether there was any indication that the child had engaged in violent behaviors, and if there were unmet needs, as suggested by any of these documents or the CANS. These factors were important for the reviewers to complete the analysis and were collected in a notes section of the tool.

As noted above, an additional 15 case records of children were sampled (i.e., the oversample). These children had four weeks on the overstay/waitlist reports from 10/15–11/3/21. The oversample included 7 children from the overstay report and 8 children from the waitlist report.

A series of chi-square tests were conducted to examine the association between variables and placement types to understand the association between the type of placement that children were experiencing, and other factors examined as part of the data collection process. When the p-value was less than 0.05, the research team concluded that there is likely some association (relationship) between the variables.

Categorization of Placements

Based on the information from the case record review tool, placements were categorized into both levels of service provision and need as a means for determining the overall appropriateness of placements and to determine if the placements align with the broader BCDSS and DHS policies.

NOTE: Most children with intensive needs can be safely and appropriately served in a family setting with the provision of necessary clinical and supportive services. However, such resources are not always available. BCDSS and DHS are working to improve the availability of clinically intensive and supportive home- and community-based services. For the purpose of this analysis, **the categorization makes assumptions about the intensity of services provided in more restrictive settings.** It assumes that services provided in a group home are more clinically and therapeutically intensive than those provided in a family setting and that the services provided in a residential treatment center or hospital are more clinically intensive than provided in a group home. It also assumes that the more restrictive settings can provide an appropriate level of 24/7 supervision and intervention to children who cannot get this need met in a family setting. **This is an imperfect set of assumptions but was necessary to complete the analysis.**

A three-part categorization of placement need[3] was determined to fit the structure of the placement array in Baltimore City: low, moderate, and high. When categorizing a placement type, the research team considered the documented presence of mental health needs, medical needs, and prescribed psychiatric medication. The CANS assessment data was the primary source of information when available. **If data were missing OR if the children did not meet the CANS criteria**, decisions were made based off other factors in the case review tool (number and type of prior placements, whether a FTDM occurred at time of placement, educational needs, medical or mental health needs identified

[3] See the Appendix for a definition of needs.

in the MATCH documentation, and the presence of psychotropic medication as identified in the MATCH documentation).

The Need/Restrictiveness of Placement Categories were categorized as follows:

- **Low Need/Restrictiveness:** Formal Kinship, Regular Foster Care, Relative/Fictive Kin Home, Restricted Relative Foster Care, Home w/Family or Relative, Independent Living
- **Moderate Need/Restrictiveness:** Treatment Foster Care, Intermediate Foster Care, Mother-Baby Treatment Foster Care or Group Home
- **High Need/Restrictiveness:** Regular Group Home, Therapeutic Group Home, Residential Group Home, Residential Treatment Center, In-Patient Psychiatric Facility, Detention, Medically Fragile Treatment Foster Care/Group Home

Children who were identified as "missing" were included in the category of high need/restrictiveness.

Findings

If the data described below do not have a corresponding data table, readers may find the data tables in the Appendices. Findings with a p-value less than 0.05—along with other key pieces of data and information—are bolded below.

Of the 165 children whose case records were sampled, **most were living in family-based placements.** Of those children, 43.6% were in relative placements, 28.4% in treatment foster care placements, and 10.9% in regular foster care placements. Group Homes (5.4%) and Residential Treatment placements (4.8%) were next, followed by Inpatient Psychiatric facilities and Hospitalization (3%), Independent Living, and any other placement type (each at 1.8%).

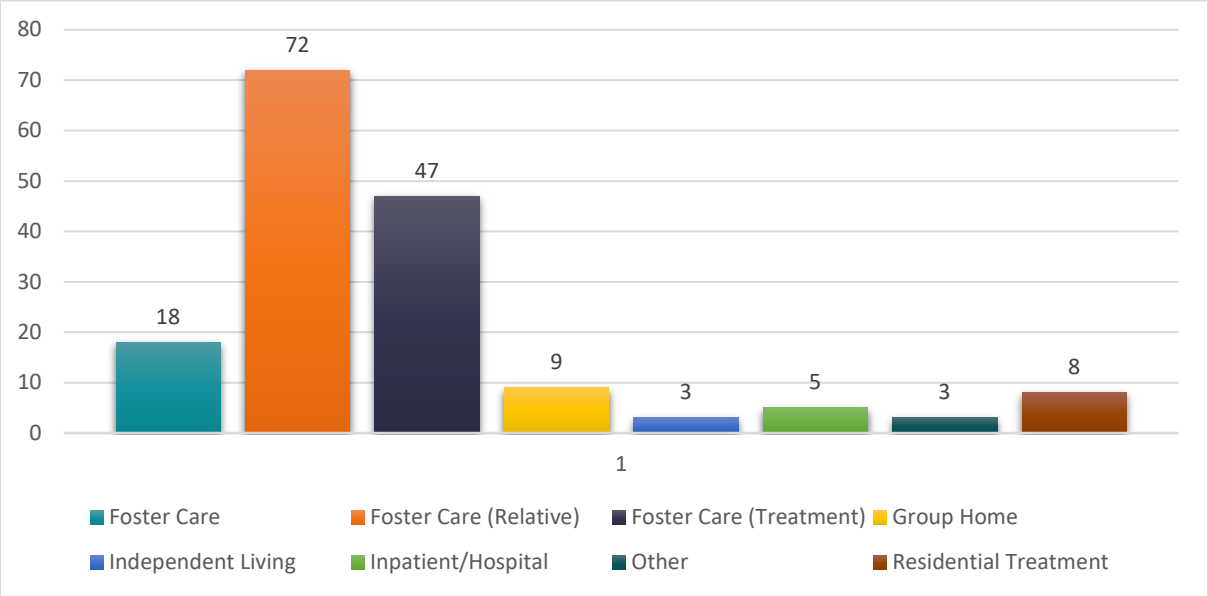

Figure 1: Placement Setting of Children in Sample

Permanency Plans

Children in out-of-home placements are expected to have concurrent permanency planning, meaning that multiple permanency plans often are worked on simultaneously. Additionally, it is generally discouraged in both federal and State policy to have APPLA as a permanency plan. Reunification

was the most common permanency plan (54.5%) followed by guardianship (24.8%), adoption (15.1%), Another Planned Permanent Living Arrangement (APPLA, 3.6%), and Unknown/Missing (3%).

The chi-squared test indicated a strong relationship or association between permanency plan and placement type. Although reunification was most common as a permanency plan for children in family settings, all children in residential treatment placements had a primary permanency plan of reunification. However, **children with a primary permanency plan of APPLA often were in group home and independent living placements, with some children in treatment foster care**. The guardianship permanency plan was the most dispersed of the placement types, present in each placement type except for Residential Treatment. Adoption was only associated with family-based settings (foster care, relative foster care, and Treatment Foster Care).

These associations do not indicate causality—a permanency plan of APPLA does not mean that children are always in group homes, nor does a group home placement indicate an APPLA permanency plan. However, there is a statistically significant relationship between these variables.

Demographic Factors

Just over half of the sample was female (52.1%) and just under half was male (47.2%). One child's case file indicated they were transgender. No association was found between sex/gender and placement type (X^2 (14) =17.2, p=0.25).

Almost 80% of the children in the sample were identified as non-Hispanic Black/African American (78.7%). Non-Hispanic white children comprised 16.9% of the children whose files were reviewed, with the remaining 4.2% of children identified as either Hispanic or any other race. No association was found between race/ethnicity and placement type (X^2 (14) =17.2, p=0.25).

The ages of the sampled children in placement on October 15, 2021, ranged from infants (age=0, 1.8%) to 19 years old (0.6%). No association was found between placement type and age at the individual sample level. However, when examining average age, there are differences between the average age and the type of placement, which would be expected based (i.e., younger children would not be expected to be placed in independent living, residential treatment or group care, so these average ages should be higher, as they are). Overall, the average age of the sample was 9.5 years. The average age by placement type ranged from 5.9 years for children placed in foster care to 18.3 years for children placed in Independent Living services. Generally, the average age of the children increased with the relative restrictiveness of the placement types.

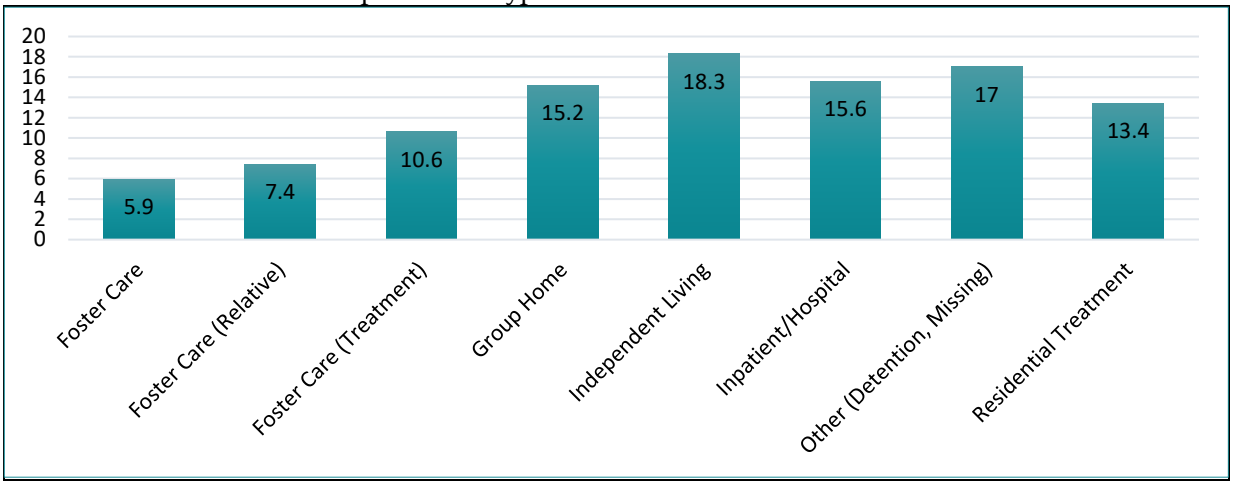

Figure 2: Average Age of Children in Sample, by Placement Type

Only two of the children in the sample were co-committed with the Department of Juvenile Services (1.2%). No association was found between placement type and whether a child was co-committed with DJS.

Siblings

Over half of the sample (n=90; 54.5%) had a sibling that was also in care at the same time and 74.4% of these children were placed with all or some of their siblings**. An association was found between whether a sibling was in care and placement type** (X^2 (7) =20.8, p < 0.01).

Table 2: Children Placed with Some or All Siblings

If Child Has Siblings in Care, is Child Placed with Those Siblings	**n**	**%**
Yes	67	74.4%
No	23	25.6%
Total Sample with Siblings	**90**	**100%**

A higher overall proportion of children in less restrictive types of care had an indication of a sibling also in care. Three-quarters (74.5%) of children in treatment foster care placements had siblings in out-of-home placement. The high proportion of children with siblings that are also in out-of-home placement suggests that children with siblings are represented across almost all of the placement types, with the overall trend skewed toward the less restrictive placement types.

Children who were placed with some or all of their siblings were almost always in family settings (65/67). See Appendix A, table 24, for a detailed break out of siblings and placement type. Six out of the 8 children in foster care were placed with all or some of their siblings; 36 out of 39 children in relative foster care placements were placed with all or some of their siblings; and 23 out of 35 children in Treatment Foster Care were placed with all or some of their siblings. There were two instances of children who were in the same residential treatment center or hospital setting.

Factors at Time of Removal

Workers can select factors in CJAMS that are present and are of special consideration, or characteristics that impacted the decision, at the time when children are removed from their homes and placed in out-of-home placement. There are 18 of these special factors, see Appendix A, table 27 for a table of special factors. Most of the children in the sample (87.8%) had at least one special factor noted at the time of removal. The number of considerations ranged from 1 item to 5 items with most cases having either 1 or 2 considerations listed. No association was found between the number of special considerations and placement type. The most common special considerations identified in CJAMS at the time of removal were parental substance abuse (28.5%), housing issues (23.6%), parental health/parental mental health (20.8%), and the inability to cope with the child/abandonment (18.2%). None of these four most common special considerations were significantly associated with placement type.

However, two of the special considerations were found to have an association with placement type individually, suggesting that there is variation in the association between these special considerations and placement type. **The presence of child behavior issues as a factor at removal (X^2 (7) =53.3, p < 0.001) and a history of running away (X^2 (7) =19.1, p < 0.05) were both found to have associations with placement type.**

Special Placement Decisions & Documentation

There were 7 instances (4.2%) where the child was in a placement type identified as an emergency placement at the time of the sample. These emergency placements were treatment foster care (n=2), residential treatment or group homes (n=2), and hospitalizations (n=3).

Six of the eight children placed in residential treatment centers, out of the full sample of 165 cases, had a documented Certificate of Need (CON) in CJAMS. The CON is the documentation required by Maryland Medical Assistance (Medicaid) and the Centers for Medicare & Medicaid Services for a child to be placed in a residential treatment center (also known as a psychiatric residential treatment facility) and receive Medicaid reimbursement. The CON documentation may be present with the Administrative Service Organization (Optum), the local behavioral health authority (Behavioral Health Systems Baltimore) or elsewhere in a paper or other record, but for two of the eight children placed in residential treatment centers, the CON was not found in CJAMS when completing the review.

Maryland child welfare policy requires a Family Involvement/Family Team Decision Making (FTDM) meeting to occur whenever a child is removed from the home or there is a change in placement type. Of the 165 children whose case files were sampled, fewer than half (42.4%) had documentation of a partial or complete meeting on record.

CANS

Maryland policy requires the completion of the Maryland CANS to assist with decision-making, communication, and care planning throughout a child's foster care experience. Current Maryland policy (SSA #12-14) requires the CANS to be completed within 30 days of a child over age 5 entering out-of-home placement. The CANS must be updated every 180 days, as well as when there is a change in placement, permanency plan, and prior to completing adoption and guardianship assistance agreements. Documentation that the CANS was completed was present in only 38.7% of all case records in CJAMS. However, policy does not require a CANS to be completed for children aged 5 and younger. There were 49 children who were age 5 or below at the time of the sample, 3 of whom had a completed CANS.

Out of the 119 children ages 6 and older in the sample, 52.6% (n=64) had documentation in their CJAMS records that a CANS had been completed within the past 12 months. There was no association found between the presence of a CANS assessment and placement type. This result was unexpected, so these variables were inspected in more detail. Except for the "other" placement category and the foster care placement category, all other placement types were evenly split between case files with and without a CANS assessment on file. Most of the 9 children over the age of 5 in a foster care setting did not have a documented CANS (7 out of 9 or 77.8%). All three children in "other" placements had a documented CANS (3 out of 3 or 100% with a CANS).

The research team examined the case files of the children with a documented CANS present, examining the number of identified needs and strengths to see if there was an association with the type of placement. **The number of needs documented in the CANS was found to have an association with placement type when examining all instances where a CANS should be documented** (X^2 (35) =54.7, $p < 0.05$) **and in instances where the CANS forms were present** (X^2 (35) =56.2, $p < 0.05$).

There was a high number of CANS forms that have no documented needs (n=37 out of 64 assessments, or 57.8%). It does appear that there is a pattern for a higher number of needs to be present for placements that are more restrictive. However, the high number of instances where there were no needs identified suggests that the CANS might not be being fully completed and, therefore, might be

challenging to use as a decision-making tool as it is intended.

Table 3: Number of Needs on Most Recent CANS for Children Ages 6 and Older in the Sample

Number of Needs on Most Recent CANS	**n**	**%**
No CANS Assessment	55	46.2%
0	37	31.1%
1	9	7.6%
2	7	5.9%
3	6	5.0%
4	2	1.7%
5 or more	3	2.5%
Total Sample	**119**	**100.0%**
Compared to placement type **($X^2(35) = 54.67, p < 0.05$)**		

Table 4: Needs on CANS by Placement Type

Placement Type	**Needs**	**n**	**%**
Foster Care	0	2	22.2%
	Missing	7	77.8%
Foster Care (Relative)	0	20	46.5%
	1	2	4.7%
	2	1	2.3%
	3	1	2.3%
	Missing	19	44.2%
Foster Care (Treatment)	0	12	30.8%
	1	3	7.7%
	2	3	7.7%
	3	1	2.6%
	4	1	2.6%
	Missing	19	48.7%
Group Home	1	2	22.2%
	3	1	11.1%
	5 or more	2	22.2%
	Missing	4	44.4%
Independent Living	3	1	33.3%
	5 or more	1	33.3%
	Missing	1	33.3%
Inpatient/Hospital	2	2	40.0%
	3	1	20.0%
	Missing	2	40.0%
Other	0	2	66.7%
	4	1	33.3%
Residential Treatment	0	1	12.5%
	1	2	25.0%
	2	1	12.5%
	3	1	12.5%
	Missing	3	37.5%

Unlike the needs, **most of the CANS forms present include at least one item listed as a strength** (n=58 out of 64 or 90.6%). Only 5% of the case files with a CANS present had no strengths identified. However, there was no association found between placement type and the number of strengths on the CANS.

SAFE-C Assessment

The Maryland Safety Assessment for Every Child (SAFE-C) is a federally required, state-enhanced, tool to assess the overall safety of a child receiving services from the Maryland Child Welfare System (SSA-CW #15-21). According to Maryland policy, the SAFE-C should be completed at several points during a child's experience in foster care. Most of the case files included in the sample had an indication that a safety assessment had been completed within the last 12 months (n=145, 87.8%). The presence of a SAFE-C was not found to be associated with placement type. According to results on the SAFE-C, children were found to be safe most of the time. The overall safety level of the child was not found to be associated with placement type.

Other Health, Psychological, and Medical Documentation

MATCH documentation was present in almost all the sample case files reviewed (96.9%), with 86.6% found to be current (i.e., within the last year). The MATCH records contained information on the presence of diagnoses; hospital and psychiatric professional visits; medication and psychotropic medication prescribed; and notes on how the child was doing and any changes seen between visits. The MATCH record is completed, scanned into CJAMS, and saved in a folder available to the caseworker and supervisor to inform overall practice and decision making. This means that while available for the worker and supervisor, this information was not consistently available to be utilized by a data analysis and decision-making tool. The presence of MATCH documentation was not found to be associated with placement type.

A small proportion of children in the sample had documentation of a psychological evaluation (n=19 or 11.5%), which was not found to be associated with placement type. In contrast**, use of psychotropic medication was highly associated with placement type**. More children had an indication of the prescribing of psychotropic medication when there was documentation of a psychiatric or psychological evaluation: 48 case files indicated that the child was prescribed at least one psychotropic medication while only 19 of the case files documented a psychiatric or psychological evaluation. These instances are inconsistent with Maryland policy (SSA-CW #15-8). The type of placement was associated with an indication that a child had been prescribed psychotropic medication.

Table 5: Psychotropic Medication (Sample)

Psychotropic Medication	**n**	**%**
Yes	48	29.1%
No	117	70.9%
Total Sample	**165**	**100%**
Compared to placement type (X2(7) = 49.9, p < 0.001)		

While there was an indication of psychotropic medication for one or more children at every level of placement, it was proportionally higher for children in more restrictive placement types. Children in treatment foster care, group homes, inpatient psychiatric/hospital, and residential treatment center settings had higher percentages of children with medication.

Table 6: Psychotropic Medication, by Placement Type

Placement Type	Psychotropic Medication	n	%
Foster Care	None	16	88.9%
	Present	2	11.1%
Foster Care (Relative)	None	63	88.7%
	Present	9	12.7%
Foster Care (Treatment)	None	31	66.0%
	Present	16	34.0%
Group Home	None	3	33.3%
	Present	6	66.7%
Independent Living	None	0	0.0%
	Present	3	100.0%
Inpatient/Hospital	None	2	40.0%
	Present	3	60.0%
Other	None	2	66.7%
	Present	1	33.3%
Residential Treatment	None	0	0.0%
	Present	8	100.0%

Educational Needs

Six of the children included in the sample had a 504 plan documented in their case files. A 504 plan is a plan requiring reasonable accommodations for children with disabilities and are often used for accommodations outside of an IEP (Individualized Education Program) (MDOD, 2022). **The presence of a 504 plan in the records was found to be associated with placement type (X^2 (7) =14.8, $p < 0.05$). These 504 plans were only present in the foster care (including relative and treatment) and independent living placement types.**

Just under 20% of the children included in the sample (18.7%, n=31) had documentation of an IEP in their CJAMS case record. **The presence of an IEP was found to be associated with placement type (X^2 (7) =42.6, $p < 0.001$).**[4]

IEPs were found in the records of children in every placement setting except "other." They were more commonly found in more restrictive placement types. However, while 77.8% of children in the sample placed in a group home had an IEP on record, only 37.5% of children in residential treatment centers had an IEP in the case record.

[4] There are multiple categories of disabilities that are accommodated through an IEP, including cognitive, sensory, and physical needs. There can be multiple needs identified in an IEP. See https://marylandpublicschools.org/programs/Documents/Special-Ed/IEP/MarylandIEPProcessGuide.pdf for more information.

Table 7: IEP, by Placement Type

Placement Type	Indication of an IEP	n	%
Foster Care	No	17	94.4%
	Yes	1	5.6%
Foster Care (Relative)	No	67	93.1%
	Yes	5	6.9%
Foster Care (Treatment)	No	38	80.9%
	Yes	9	19.1%
Group Home	No	2	22.2%
	Yes	7	77.8%
Independent Living	Yes	3	100.0%
Inpatient/Hospital	No	2	40.0%
	Yes	3	60.0%
Other	No	3	100.0%
Residential Treatment	No	5	62.5%
	Yes	3	37.5%

Overstay List

The BCDSS overstay list includes children who should no longer be in their current placement and children who are in an unallowable placement setting. These placements include hospital or diagnostic setting when the child no longer meets medical necessity criteria, as well as situations where a foster care provider has asked for a child to be moved to a different setting, but the child has not yet moved. Fifteen of the children in the case sample were identified from the overstay list.

The overstay list is broken into three categories:

1) Currently on the overstay list, which consists of children identified by BCDSS as being on the waitlist as of October 15, 2021;
2) Previously on the overstay list, which consists of children who had been on the overstay list prior to October 15, 2021 (September or the first part of October, 2021); and
3) On wait list, which consists of children on the overstay list identified as needing placement changes.

Children on the overstay list were included in the analysis in addition to the original 150 children sampled as part of the original stratified random sample. **Being on the overstay list was found to be associated with placement type (X^2 (21) =73.33, p < 0.001).**

Table 8: Children on Overstay List

Overstay List	n	%
Currently	3	1.8%
Previously	4	2.4%
On waitlist	8	4.8%
No	150	91.0%
Total Sample	**165**	**100%**
Compared to placement type (X2(21) = 73.33, p < 0.001)		

No children in regular or relative foster care were on the overstay list. One child in treatment foster care and two children in an independent living placement were included on the overstay list. The other children on the overstay list were in most restrictive settings.

Table 9: Children on Overstay List, by Placement Type

Placement	Overstay	n	%
Foster Care	No	18	100.0%
Foster Care (Relative)	No	72	100.0%
Foster Care (Treatment)	Yes	1	2.1%
	No	46	97.9%
Group Home	Yes	3	33.3%
	No	6	66.7%
Independent Living	Yes	2	66.7%
	No	1	33.3%
Inpatient/Hospital	Yes	4	80.0%
	No	1	20.0%
Other	Yes	1	33.3%
	No	2	66.7%
Residential Treatment	Yes	4	50.0%
	No	4	50.0%

Alignment of Placements with Policy and Identified Level of Need

Most placements were appropriately aligned with BCDSS and DHS policy and matched the level of intensity, restrictiveness, and service need of the children in the sample.[5] Overall, 87% of the children included in the full sample (92% of the random stratified sample and 33.3% of the oversample) were in placements consistent with policy, expectations, and documentation. The remaining 13% of children were either in placements that seemed inconsistent with policy (10% overall, 5% in the stratified sample, and 60% of the overstay over sample) or were questionable placements (3% overall, 3% of the stratified random sample, and 6.6% of the overstay oversample).

Table 10: Alignment of Placements with Policy

Results	n	%
Results of Random Sample	**150**	**100.0%**
Aligned with policy	138	92.0%
Not aligned with policy	8	5.3%
Questionable	4	2.7%
Results of Oversample	**15**	**100**
Aligned with policy	5*	33.3%
Not aligned with policy	9	60.1%
Questionable	1*	6.6%
Results of Combined Sample	**165**	**100**
Aligned with policy	143	86.7%
Not aligned with policy	17	10.3%
Questionable	5	3.0%

*Child was previously on the Overstay/Waitlist in a placement setting that **did not** align with policy, but at time of review had been placed in a setting that **did** align with policy or placement setting **is questionable** as to whether it aligns with policy.

[5] See note above about the assumptions regarding level of restrictiveness equating to intensity of service provision.

The Appendix includes detailed discussions around the reasoning used in determining why the cases that were determined to either be not aligned with policy or questionably aligned with policy were given those determinations. It is important to understand how well each placement type aligned with policy. Placements identified as not aligned with policy or questionable are highlighted in the table below.

Table 11: Alignment with Policy by Placement Categorization and Type (Sample)

Level of Restrictiveness/Care	Placement Type	Aligned with Policy?	n	%
Total Sample			150	100%
Low	All types		89	100.0%
	Formal Kinship Care	Yes	28	31.5%
	Own Apartment	No	1	1.1%
	Public Resource (Foster) Home	Yes	16	18.0%
	Relative/Fictive Kin Home	Yes	20	22.5%
	Restricted Relative Foster Care	Yes	24	27.0%
Moderate	All types		47	100.0%
	Intermediate Foster Care	Yes	2	4.3%
	Mother baby (TFC or Group)	Yes	1	2.1%
	Treatment Foster Care	Yes	37	78.7%
	Treatment Foster Care	No	4	8.5%
	Treatment Foster Care	Questionable	3	6.4%
High	All types		14	100.0%
	Missing/Unapproved Placement	No	1	7.1%
	Detention	Yes	1	7.1%
	In-Patient Psychiatric Facility	Yes	1	7.1%
	Medically Fragile TFC	Yes	1	7.1%
	Residential Treatment Center	Yes	2	14.3%
	Residential Treatment Center	No	1	7.1%
	Residential Treatment Center	Questionable	1	7.1%
	Therapeutic Group Home	Yes	5	35.7%
	Therapeutic Group Home	No	1	7.1%

In the low restrictiveness placement type, only one child's case record was found to be "not aligned with policy." The details are summarized in the Appendix but the reason for this misalignment relates to ongoing attempts to move the child to alternative placement settings to meet their needs.

Within the moderate restrictiveness placement types, four children living in treatment foster care placements were identified as having placements "not aligned with policy." These instances were found to be not aligned with policy as there was insufficient documentation justifying this restrictiveness and intensity of service and/or no history of the child receiving services in a regular foster home or other non-treatment setting. In addition, there are three instances of children whose placements were designated as questionable placements in the moderate restrictiveness placement type. This designation is related to lack of identified needs documented in the assessment tools.

Finally, in the high restrictiveness placement type category, there are three instances where the placements were determined to be not aligned with policy and one instance where the placement was questionable. The "missing" placement is considered not aligned with policy as all children should be in a safe and appropriate placement. There was a child in a therapeutic group home without any

documented identified needs who was placed in that setting as their first out-of-home placement. The child in a residential treatment center whose placement was considered not aligned with policy did not have documentation of a CON in the record. The child in a residential treatment center whose placement was considered questionable is due to the young age of the child and lack of identified needs documented in the CANS. However, the child did have a CON in the record and was placed with their siblings in that facility.

Overstay Specific Conversation

The same assessment framework and methodology was used to determine whether the children on the overstay list had a placement—at the time of review—that was aligned with policy. Three of the seven children initially identified on the **overstay report** were in placements that aligned with policy at time of review:

- Two children were placed in residential treatment centers (one out-of-state) with a CON. They had documented histories of violent behaviors and self-harm, multiple mental health diagnoses, and multiple prior placements (including inpatient psychiatric facilities).
- The third child had been placed in a group home for children identified as medically fragile. This was determined to be aligned with policy given the child's complex medical needs.

There was one child whose placement within a residential treatment center at time of review was determined to be questionable given the child's age and that the most recent CANS assessment indicated no needs. The other three children included on the overstay list were in medical or psychiatric hospital placements that were not aligned with policy.

Two of the eight children who were identified on the **waitlist report** were in placements that aligned with policy at time of review:

- One child had been placed in a diagnostic center following a return from an out-of-state residential treatment center. The child met the criteria for this level of care due to having a history of violent behavior, history of self-harm behavior, multiple mental health diagnoses, and multiple prior placements (including inpatient psychiatric facilities). Since the time of review, the diagnostic program has been reclassified in CJAMS as a high intensity group home, which confirms that the placement is consistent with policy and practice.
- The second child had been placed in a Mother/Baby program consistent with policy; she had been awaiting placement while pregnant.

Five of the other children previously identified on the waitlist report remained in placements that did not align with policy because they were still awaiting a more appropriate placement. This group included:

- One child in a therapeutic group home awaiting placement in a different group home;
- One child in an independent living program awaiting placement in an alternative placement setting;
- One child in an out-of-state residential treatment center awaiting placement in Maryland;
- One child in their own apartment awaiting placement in an independent living program, therapeutic family home, or a group home to meet their clinical needs; and
- One child who was experiencing homelessness and living in a hotel awaiting placement.

Additionally, there was one child, previously identified on the waitlist report, who was identified as missing at the time of the review. By including the children on the overstay/waitlist (the oversample) in the total sample, there is an increase in the number and percent of placements that are not aligned with policy or are identified as questionable. Placements identified as not aligned with policy or questionable are highlighted in the table below.

Table 12: Alignment with Policy by Placement Categorization and Type (Oversample)

Level of Restrictiveness/Care	Placement Type	Aligned with Policy?	n	%
Total Over Sample			15	
Low	All Types		1	100%
	Own Apartment	No	1	100%
Moderate	All Types		2	100%
	Independent Living	No	1	50.0%
	Mother baby (TFC or Group)	Yes	1	50.0%
High	All Types		12	100%
	Diagnostic	Yes	1	8.3%
	Homeless/Homeless Shelter	No	1	8.3%
	In-Patient Psychiatric Facility	No	2	16.6%
	Medical Hospital	No	1	8.3%
	Medically Fragile Group	Yes	1	8.3%
	Out-of-State Residential Treatment Center	Yes	1	8.3%
	Out-of-State Residential Treatment Center	No	1	8.3%
	Residential Treatment Center	Yes	1	8.3%
	Residential Treatment Center	Questionable	1	8.3%
	Missing	No	1	8.3%
	Therapeutic Group Home	No	1	8.3%

Discussion and Conclusions

The sample and oversample of the 165 children's casefiles revealed numerous strengths: **most children were placed in family settings** and **most siblings** in care **were placed with some or all of their siblings.** There were **no associations between race/ethnicity of children and their placement type, nor for sex/gender**. Most children had a primary permanency plan of reunification, guardianship, or adoption; plans of long-term foster care/APPLA were rare. **Few children were in emergency placements** and the SAFE-C was consistently completed and documented. Similarly, **MATCH documentation was present and current** in most of the files reviewed.

As discussed above**, 92% of the children whose casefiles were included in the random stratified sample were in placements consistent with policy, expectations, and documentation**. The other 8% of the children were identified as being in placements that seemed inconsistent with policy (5%) or in a placement that was questionable as to whether it was consistent with policy (3%).

The presence of an overstay/waitlist is problematic; it suggests that those children included on the list are not being served in the most appropriate setting to meet their needs. It is, however, an honest reflection of the challenges that exist in matching children with the most appropriate, least restrictive

setting that will meet their physical, social, emotional, behavioral, and developmental needs. Given that, it was unsurprising that only 33% of the children whose files were included in the overstay/waitlist oversample were in placements that appeared to be consistent with policy, expectations, and documentation. Most of these children were in placements that appeared inconsistent with (60%) or questionable (7%) in terms of alignment with policy, expectations, and documentation.

Consistent with the requirements of the *L.J. v Massinga* Modified Consent Decree, The Institute offers the following conclusions:

- Most children placed in out-of-home placements by BCDSS are in placements consistent with DHS and BCDSS policy and practice.
- Most children in out-of-home placement are living in family-based settings, which is the preferred placement setting to support normative child development and experiences.
- In Baltimore City and across Maryland, more family placements are needed for the children who do not have a clinical need to be in a non-family setting.
- A small number of children are placed in a treatment foster home as their first out-of-home placement; this intensive therapeutic intervention typically would not be expected for a child who has never been in out-of-home placement. While preferable to a group home or other congregate care setting, if this child were placed in a regular foster home with additional supports, if needed, the treatment foster home bed would be available to a child who is otherwise being placed in a more restrictive level of care.
- BCDSS should not develop additional residential treatment center or group home beds for children in the care of BCDSS. There are children in these settings who should be in family settings. Supporting these children to move to the most appropriate, least restrictive setting will make beds available for those children who have a clinical need for a residential intervention that cannot be met in the community due to the intensity of treatment and requirement for 24/7 supervision.

There is room for improvement: **fewer than half of the casefiles indicated there had been a Family Team Decision Making meeting (FTDM)** when there was a removal or a placement move. Similarly, **only 52.6% of all case files reviewed for children aged 6 and older included a completed CANS within the past 12 months** (while policy requires CANS to be completed at least every 180 days).

While the MATCH documentation was rich in information that was useful in the review process, this information was not always found in the CJAMS data system in areas where it might be expected to be present. Having the caseworker or health care provider translate the MATCH documents into the matching CJAMS fields would make it easier to use these administrative data to understand the prevalence of psychiatric medication and compliance with medical visits. Alternatively, having the documents available within CJAMS in a more readily accessible format would benefit workers and children.

As noted, there were a small number of children whose records suggest that their placements are not aligned with policy and practice; typically, this is due to either

1) a *lack* of documented needs while the child is in a restrictive placement *or*
2) a placement in an independent living or family setting when there was extensive documentation of need but no or little documentation of service and supports being provided.

If these are issues of *documentation*, BCDSS can address them through ongoing continuous quality improvement activities. However, if they are representative of worker, supervisor, or team decisions that are inconsistent with the most appropriate, least restrictive setting for the child's needs, BCDSS should implement a process that requires BCDSS oversight and approval—and meaningful input of

the children and family—prior to placement.[6]

Additionally, many children had special factors or considerations present at the time of their removal into foster care, including parental behavioral health problems and housing problems. These needs may prolong time in foster care and impact the success of reunification; they require intensive intervention by BCDSS when identified. Children who were identified as having behavioral health challenges or who had a history of being missing from a living situation often were placed in more restrictive settings. These children often can have their needs met in family settings with the appropriate clinical interventions and in-home supports and supervision. This is a population that could be supported through additional home- and community-based services, as recommended below.

The recommendations that follow are relevant to all populations of children in out-of-home placement across Baltimore City, inclusive of children with intellectual and developmental disabilities, behavioral health needs, and/or medical needs; sibling groups; older youth; and children in need of emergency placements.

The same strategies—tailored, individualized, evidence-based, or informed services; support for current and new foster parents; provision of one-on-one supports in homes when needed; access to quality and intensive care coordination; providing sufficient rates for services to meet the expectations of BCDSS; ensuring medically and clinically appropriate diagnoses; providing services that address complex trauma—apply to all the populations outlined.

The following recommendations reflect current best practices as seen across the United States, as well as best practices currently and previously in Maryland (e.g., Harburger, et al., in development; Engler, et al., 2022; Harburger, Schober, & Zabel, 2021; Lowther, et al., 2021; Harburger, Schober, Fields, et al., 2021; Gould-Kabler, et al., 2021; Substance Abuse and Mental Health Services Administration, 2019; Manley, et al., 2018; Fischer, et al., 2016; Mann & Hyde, 2013).

[6] The Institute recognizes that a review process could cause delays in placements, which might conflict with some of the standards in the consent decree. However, such a process could avoid children being in overly restrictive placements or experiencing multiple placement changes.

Table 13: Short-, Medium-, and Long-Term Recommendations

Short-Term (within the next year)
Children in the care of BCDSS or any local department of social services across Maryland who are at-risk of out-of-home placement or a non-family placement should have **comprehensive and frequent (*at least monthly*) FTDM** that encourage the use of flexible strategies and natural supports. All children in out-of-home placement should be having FTDM consistent with policy.
BCDSS should continue to engage **in recruitment and retention activities** to increase the number of foster homes to meet the placement needs of children who cannot remain safely in their own homes. DHS should support a comprehensive statewide recruitment and retention plan for resource homes, in collaboration with local departments of social services and child placing agencies, to support utilization of best practices and reduce duplication of efforts.
BCDSS should improve the **meaningful use of the CANS**, in partnership with DHS. CANS should be completed at a frequency consistent with policy and **needs and strengths** should be documented and consistent with placement and other decisions.
If children appear to be unable to remain in a family setting or move into a family setting due to concerns about behavior management or supervision, BCDSS should use **short-term (2-12 weeks) in-home supports**, such as a one-on-one or behavioral specialist, to provide supervision, structure, and/or supportive services, particularly during key periods during the day or night when increased supervision would enable the child to remain in the home.
BCDSS should conduct at least **quarterly reviews of all children in a non-family based out-of-home setting who have been in those placements for at least six months**. This review should be done collaboratively with the child, family, and team to include a review of the child's goals, transition plan, and steps needed to move into a family setting. It should be done in a manner consistent with the review process for Qualified Residential Treatment Programs (QRTP).
Children and families should be supported **to access and engage in evidence-based and promising practices** currently available in Baltimore City and across the state, including Functional Family Therapy (FFT), Multisystemic Therapy (MST), Parent Child Interactional Therapy (PCIT), Dialectical Behavioral Therapy (DBT), Aggression Replacement Training (ART), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).
Children who meet medical necessity criteria should be enrolled in the **1915(i) State Plan Amendment** to receive access to peer support, care coordination, and other services, in coordination with the child's team and, as needed, the local behavioral health authority.
BCDSS should continue to participate in Maryland's **Quality Service Reform Initiative (QSRI)** and be prepared to partner with providers, workers, and families on the implementation of **QRTP** and the new residential intervention structure and associated rates. In anticipation of these new structures, BCDSS should utilize the QRTP documentation and review process for any child recommended for a non-family setting to ensure the child's team identifies the prioritized treatment goals, confirms that the placement is necessary for the intensity of treatment and supervisory requirements, and has a plan for transitioning the child back to a family setting within 6-9 months. Every child placed in a residential treatment center should have a documented CON within CJAMS.
BCDSS should implement the revised DHS **Youth Transition Planning Process** to partner with transition aged youth in care in planning for their future. The Enhanced-Youth Transition Planning Model informed this process to support older youth in foster care, including those planning for or placed in semi-independent living or independent living.
All children who are receiving psychotropic **medication**s or other medications to address behavioral health needs should be reviewed to ensure that they are receiving medication management and that it is documented in their files. Children should be assessed for overutilization of one or more medications, off-label use, side effects, and the use of antipsychotic medications, particularly in young children.

BCDSS should continue to provide mobile response services and should explore opportunities to expand its use and its capacity to provide stabilization services. **BCDSS should connect and align this work with the mobile crisis work happening in other parts of the state** to meet the needs of children, youth, young adults, and families, including collecting continuous quality improvement and outcomes data. Mobile response should be provided when children and youth first enter an out-of-home placement or experience a placement change and be available ongoingly for any self- or family-defined crisis.

Medium-Term Recommendations (2-3 years)
DHS should modify CJAMS to enable **easier access to MATCH documents**, particularly regarding clinical histories and medication use.
BCDSS should **expand access to evidence-based and promising practices**, particularly those that can be provided in-home and within clinic or community-based settings, including FFT, MST, PCIT, DBT, ART, TF-CBT, and peer support. This should be done in partnership with the Maryland Department of Juvenile Services, local management boards, local behavioral health authorities, the local school system, and other local departments of social services.
BCDSS should be an active participant in **continuous quality improvement and implementation** activities associated with the new QSRI/residential intervention structures to ensure that contracted residential services meet the identified needs of children being served.
BCDSS should **replicate the needs assessment** to determine if strategies are effective and what needs should be prioritized.

Long-Term Recommendation (3-5 Years)
BCDSS and DHS should work with MDH and the other public child- and family-serving agencies to **develop, implement, and sustain intensive care coordination using High Fidelity Wraparound and moderate care coordination informed by Wraparound principles** to support children with moderate to intensive behavioral health needs.

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Appendices

Appendix A: Data Tables

Table 14: Sample Comparison (Race)

By Race	Baltimore City 10/15/2021		Sample + Oversample	
	n	%	n	%
Total Population	1,674	100.00%	165	100.00%
Black/African American	1,342	80.2%	128	77.6%
White	244	14.6%	31	18.8%
Multi-Racial	45	2.7%	3	1.8%
All Others	4	0.2%	.	.
Unknown/Not Provided	39	2.3%	3	1.8%

Table 15: Sample Comparison (Gender/Sex)

By Gender/Sex	Baltimore City 10/15/2021		Sample + Oversample	
	n	%	n	%
Total Population	1,674	100.0%	165	100.0%
Female	847	50.6%	87	52.7%
Male	825	49.3%	78	47.3%
All Other/Unknown	2	0.1%	.	

Table 16: Sample Comparison (Age Group)

By Age Group	Baltimore City 10/15/2021		Sample + Oversample	
	n	%	n	%
Total Population	1,674	100.00%	165	100.00%
Ages 0 to 4	499	29.8%	43	26.1%
Ages 5 to 11	446	26.6%	55	33.3%
Ages 12 to 15	274	16.4%	31	18.8%
Ages 16 to 17	156	9.3%	28	17.0%
Ages 18+	299	17.9%	8	4.8%

Table 17: Sample Comparison (Child Behavior at Removal)

Child Behavior identified as a factor at Removal	Baltimore City 10/15/2021		Sample + Oversample	
	n	%	n	%
Total Population	1,674	100.0%	165	100.0%
No	1485	88.71%	147	87.3%
Yes	189	11.29%	21	12.7%

Table 18: Placement Type in Sample

Placement Type	**n**	**%**
Foster Care	18	10.9%
Foster Care (Relative)	72	43.6%
Foster Care (Treatment)	47	28.4%
Group Home	9	5.4%
Independent Living	3	1.8%
Inpatient/Hospital	5	3.0%
Other	3	1.8%
Residential Treatment	8	4.8%
Total Sample	**165**	**100%**

Table 19: Primary Permanency Plan in Sample

Permanency Plan	**n**	**%**
APPLA	6	3.6%
Adoption	25	15.1%
Guardianship	41	24.8%
Missing	3	1.8%
Reunification	90	54.5%
Total Sample	**165**	**100%**
Compared to placement type ($X^2(28) = 62.6$, $p < .001$)		

Table 20: Permanency Plan by Placement Type for Sample

Placement Type	**Permanency Plan**	**n**	**%**
Foster Care	Adoption	8	44.4%
	Guardianship	3	16.7%
	Missing	2	11.1%
	Reunification	5	27.8%
Foster Care (Relative)	Adoption	10	13.9%
	Guardianship	22	30.6%
	Reunification	40	55.6%
Foster Care (Treatment)	APPLA	2	4.3%
	Adoption	7	14.9%
	Guardianship	9	19.1%
	Reunification	29	61.7%
Group Home	APPLA	1	11.1%
	Guardianship	2	22.2%
	Missing	1	11.1%
	Reunification	5	55.6%
Independent Living	APPLA	2	66.7%
	Guardianship	1	33.3%
Inpatient/Hospital	Guardianship	3	60.0%
	Reunification	2	40.0%
Other	APPLA	1	33.3%
	Guardianship	1	33.3%
	Reunification	1	33.3%
Residential Treatment	Reunification	8	100.0%

Table 21: Gender/Sex for Sample

Gender	**n**	**%**
Female	86	52.1%
Male	78	47.2%
Transgender	1	0.6%
Total Sample	**165**	**100%**
Compared to placement type ($X^2(14) = 17.2$, p= 0.25)		

Table 22: Race/Ethnicity for Sample

Race/Ethnicity	**n**	**%**
African American (Black)	130	78.7%
Caucasian (White)	28	16.9%
Hispanic or Latino(a)	5	3.0%
All Other	2	1.2%
Total Sample	**165**	**100%**
Compared to placement type ($X^2(21) = 18.7$, p= 0.60)		

Table 23: Siblings in Care

Does Child Have Siblings in Care?	**n**	**%**
Yes	90	54.5%
No	75	45.5%
Total Sample	**165**	**100%**
Compared to placement type ($X^2(7) = 20.8$, $p < 0.01$)		

Table 24: Siblings in Care by Placement Type

Placement Type	**Siblings in Care**	**n**	**%**
Foster Care	No	10	55.6%
	Yes	8	44.4%
Foster Care (Relative)	No	33	45.8%
	Yes	39	54.2%
Foster Care (Treatment)	No	12	25.5%
	Yes	35	74.5%
Group Home	No	7	77.8%
	Yes	2	22.2%
Independent Living	No	1	33.3%
	Yes	2	66.7%
Inpatient/Hospital	No	3	60.0%
	Yes	2	40.0%
Other	No	3	100.0 %
Residential Treatment	No	6	75.0%
	Yes	2	25.0%

Table 25: Special Considerations at Removal for Sample

Number of Special Considerations	**n**	**%**
0	20	12.2%
1	70	42.4%
2	55	33.3%
3	15	9.0%
4	4	2.4%
5	1	0.6%
Total Sample	**165**	**100%**
Compared to placement type ($X^2(35) = 39.8$, $p= 0.26$)		

Table 26: Count of Special Considerations

Special Considerations	**n**	**%**
Any Consideration	145	87.8%
Parental Substance Abuse	47	28.5%
Housing	39	23.6%
Parental Health/Mental Health	34	20.6%
Cannot Cope with child/Abandoned	30	18.2%
Child Behavior Issues	21	12.7%
Domestic Violence	11	0.7%
Missing	11	0.7%
Substance Exposed Newborns	11	0.7%
Developmental Delay	8	0.5%
Parental Death	6	0.4%
Medical Neglect	6	0.4%
Sexual Abuse	5	0.3%
Parental Incarceration	5	0.3%
Pregnant & Parenting	4	0.2%
Trafficking	2	0.1%
Medically Fragile	2	0.1%
Failed Adoption	2	0.1%
LGBTQ Youth	1	0.06%
Physical Health	1	0.06%
Total Sample	**165**	**100%**

Table 27: Placement Type & Age for Sample

Placement Type	**n**	**Age in Years**
Foster Care	18	5.9
Foster Care (Relative)	72	7.4
Foster Care (Treatment)	47	10.6
Group Home	9	15.2
Independent Living	3	18.3
Inpatient/Hospital	5	15.6
Other (Detention, Missing)	3	17.0
Residential Treatment	8	13.4
Total Sample	**165**	**9.5**

Table 28: Co-commitment with DJS

Co-Committed with DJS	**n**	**%**
Yes	2	1.2%
No	163	98.7%
Total Sample	**165**	**100%**
Compared to placement type ($X^2(7) = 11.8$, p= 0.11)		

Table 29: Certificate of Need (CON) Documentation

If Placed in an RTC, is there a Certificate of Need on File?	**n**	**%**
Yes	6	75.0%
No	2	25.0%
Total Sample	**8**	**100%**

Table 30: FTDM Completion

FTDM completed in conjunction with the change to the current placement?	**n**	**%**
Yes	70	42.4%
No	93	56.3%
Partial	2	1.2%
Total Sample	**165**	**100%**
Compared to placement type ($X^2(14) = 13.5$, p= 0.49)		

Table 31: CANS Completion (Last 12 months)

Has a CANS Assessment been completed in the last 12 months?	**n**	**%**
Yes	64	38.7%
No	101	61.2%
Total Sample	**165**	**100%**

Table 32: CANS Completion Compared to Placement

Has a CANS Assessment been completed in the last 12 months?	**n**	**%**
Yes	61	52.6%
No	55	47.4%
Total Sample	**116**	**100%**
Compared to placement type ($X^2(7) = 8.17$, p=.33)		

Table 33: Strengths on CANS

Number of Strengths on Most Recent CANS	**n**	**%**
No CANS Assessment	55	46.2%
0	6	5.0%
1	18	15.1%
2 or more	40	33.6%
Total Sample	119	100.0%
Compared to placement type ($X^2(21) = 30.4$, p=0.09)		

Table 34: SAFE-C Completion

Safety Assessment (SAFE-C) completed in the past 12 months?	**n**	**%**
Yes	145	87.8%
No	20	12.1%
Total Sample	**165**	**100%**
Compared to placement type ($X^2(7) = 10.1$, p= 0.18)		

Table 35: SAFE-C Safety Level & Placement

What was the safety level indicated on that assessment?	**n**	**%**
Child is Safe	143	86.6%
Child is Unsafe	2	1.2%
N/A- No Safety Assessment	20	12.1%
Total Sample	**165**	**100%**
Compared to placement type ($X^2(14) = 21.4$, p= 0.09)		

Table 36: MATCH Documentation

MATCH Documentation	**n**	**%**
Found	143	86.6%
None Found	5	3.0%
Not Current	7	10.3%
Total Sample	**165**	**100%**
Compared to placement type ($X^2(14) = 15.7$, p= 0.33)		

Table 37: Psychological Evaluation Documentation

Documentation of Psychological Evaluation	**n**	**%**
Yes	19	11.5%
No	146	88.4%
Total Sample	**165**	**100%**
Compared to placement type ($X^2(7) = 7.02$, p= 0.43)		

Table 38: 504 Plan Documentation

Educational Needs- 504	**n**	**%**
Yes	6	3.6%
No	159	96.3%
Total Sample	**165**	**100%**
Compared to placement type ($X^2(7) = 14.8$, $p < 0.05$)		

Table 39: IEP Documentation

Educational Needs- IEP	**n**	**%**
Yes	31	18.7%
No	134	81.2%
Total Sample	**165**	**100%**
Compared to placement type ($X^2(7) = 42.6$, $p < 0.001$)		

Appendix B: Casefile Review Tool

CHILD INFORMATION					
1. Child's Initials: Click here to enter text.			**2. CJAMS ID#:** Click here to enter text.	**3. DOB:** Click here to enter a date.	
4. Gender: ○ Male ○ Female ○ Non-Binary ◉ Transgender Male ○ Transgender Female			**5. Permanency Goal (both primary and secondary):** Enter Permanency Goal		
6. English as a second Language: **Yes ☐ No ☐**	**7. Legal Status**:		**8. Race/Ethnicity** Choose an item.		
9a. Does the Child have siblings in care? **Yes ☐ No ☐**	**9b. If yes, number of siblings:**		**9c. Placed with Siblings:**		
10. Immigration Status:	Choose an item.				
11. Special Considerations:	11a. Child Behavior a factor at removal ☐	11b. Prior Runaway/ Missing ☐	11c. Abandoned ☐	11d. DV: ☐	11e. Criminal Record ☐
11f. Deaf & HOH: ☐	11g. LGBTQ: ☐	11h. DD/IQ ☐	11i Substance Abuse: ☐	11j. Pregnant & Parenting: ☐	11k. Trafficking Victim ☐
11l. Sexual Abuse Victim: ☐	11m. Sexual Abuse Offender: ☐	11n. Other issues: Click here to enter text.			

Current Placement Information	
12. Current or most recent placement type:	**13.Date Placement Began:**
	14. Emergency Placement: Yes ☐ No ☐
15. Co-committed with DJS? **Yes ☐ No ☐**	**16. If this is a Residential Placement, is there a** **Certificate of Need: Yes ☐ No ☐**
17a. List all prior placement types	**17b.Dates of prior placements**
18. Was a FIM Completed in conjunction with the change to the current placement? **Yes ☐ No ☐ Partial ☐**	**19.Date of last FIM:** Click here to enter text.

Are the following documents present for child		
☐	**20. Child and Adolescent Needs and Strengths**	
	List Needs and Strengths Identified with Level:	
	CANS Area	**Level of Need/Strength**
☐	**21. Safety Assessment**	
	List Service Plans	
☐	**22. MATCH documentation**	
	List Plans	
☐	**23. Psychological Evaluations (most recent) – if one has been done**	
	List diagnosis(es) and dates:	
☐	**24. Prescribed Psychotropic Medications (most recent) – if present**	
	List medication(s) and dates:	
☐	**25. Identified Medical Needs (if applicable)**	

	List needs and dates identified:
☐	**26. Identified Educational Needs (if applicable)**
	26a. Special Education (IEP) Yes ☐ No ☐ **26b. 504 Plan Present Yes ☐ No ☐** **List needs and dates identified:**
☐	**27. Is there an 818 form for this child?**
☐	**28. This child on the overstay list?** **☐ Currently** **☐ Previously** **☐ Previously, but not now**
☐	**Court orders / hearings (list all)**
	Summary judgement of the reviewer

PLACEMENT REQUEST FORM - KEY

PLACEMENT TYPE:
Formal Kinship Care
Restrictive Kinship Care
Public Resource (Foster) Home
Treatment Foster Care
Medically Fragile TFC
*Mother baby (TFC or Group)
Diagnostic
Respite
Regular Group Home
Therapeutic Group Home
Medically Fragile Group
Residential Treatment Center
Alternative Living Unit
Independent Living

RACE/ETHNICITY:
African American (Black)
American Indian or Alaskan Native, specify tribe
Asian or Asian-American
Caucasian (White)
Hispanic or Latino(a) American
Native Hawaiian or Other Pacific Islander
Other
Need

Appendix C: Definitions Used in Categorizing Placements

Categories of Needs:

- **Mental Health Needs:** Child has a documented mental health diagnosis indicated within the child's case record (i.e., within health folder, recent mental health evaluation, Annual MATCH Care Plan, Treatment Plan, etc.)
- **Medical Needs**: Child has a documented acute or chronic medical condition (including physical disability) that requires support or one or more interventions. This information is indicated within the child's case record (i.e., within health folder, recent mental health evaluation, Annual MATCH Care Plan, Treatment Plan, etc.)
- **Psychotropic Medication**: Child is prescribed psychotropic medication, as evident by documentation within the child's case record (i.e., within health folder, recent mental health evaluation, Annual MATCH Care Plan, Treatment Plan, etc.)
- **CANS Needs**: Child has a CANS assessment that was completed within the past 12 months and has an item rated 2 or greater on any of the following domains: Life Functioning, Emotional Behavioral Needs, Child Risk Behaviors

Based on the needs documented in the child's case record, the child was identified as requiring a low, moderate, or high level of intensity of care, typically provided through a more restrictive setting. As discussed above, the authors recognize that high intensities of care can be provided within family-based settings; however, **few children in Maryland have access to or receive very intensive in-home services.** Most children in Maryland receive more services, at times with more intensity, in more restrictive settings. Therefore, **the assumption was made for the purpose of this analysis that higher needs require a more restrictive placement based on availability of services and supports.**

- **Low Need:** Child's case record included documentation of one or no mental health needs, medical needs, or psychotropic medication. The child's case record indicates the child has 1-3 needs identified on the CANS.
- **Moderate Need:** Child's case record included documentation of one or more mental health needs, medical needs, and/or use of psychotropic medications and 4-6 needs on the CANS.
- **High Need:** Child's case record included documentation of two or more mental health needs, medical needs, and/or use of psychotropic medications and 7 or more needs on the CANS.

These groupings were used to help assess alignment between the level of need and the type of placement.

Appendix D: Reasons for Determinations Where Placements Were Determined Out of Alignment with Policy

Not Aligned with Policy

Children included in the Random Sample

13-year-old placed in a High Level of Care Therapeutic Group Home following removal. This placement is not aligned with policy because there were no prior placements in lower levels of care, a Family Team Decision Meeting was not conducted prior to placement, and the child had low levels of needs on their most recent CANS assessment.

18-year-old living in their own apartment. This placement is not aligned with policy because it is not an approved placement, as well as the fact that the child has a documented mental health diagnosis, is prescribed psychotropic medication, has a history of self injury and inpatient hospitalization for suicide attempts, and SAFE-C indicated that placement was not safe.

13-year-old placed in Moderate Level of Care Treatment Foster Care home following removal. This placement is not aligned with policy because there were no prior placements in lower levels of care and the child had no identified needs on their most recent CANS assessment.

14-year-old placed in Moderate Level of Care Treatment Foster Care home following removal. This placement is not aligned with policy because there were no prior placements in lower levels of care, there was no CANS assessment completed in the past 12 months, no record of a mental health evaluation/mental health diagnosis or behavioral health or medical needs, and no record of a Family Team Decision Meeting.

10-year-old placed in Moderate Level of Care Treatment Foster Care home following removal. This placement is not aligned with policy because there were no prior placements in lower levels of care, there was no CANS assessment completed in the past 12 months, no record of a mental health evaluation/mental health diagnosis or behavioral health or medical needs, and no record of a Family Team Decision Meeting.

18-year-old living in unapproved placement with family member. This placement is not aligned with policy because it is not an approved placement, as well as the fact that the child has documented mental health needs and moderate level of need on their most recent CANS assessment.

5-year-old child placed in Moderate Level of Care Treatment Foster Care since he was 1.5 years old. This placement is not aligned with policy because there are no documented mental health diagnosis, behavioral health or medical needs, and there were no identified needs on child's most recent CANS assessment.

14-year-old child placed in a High Level of Care Residential Treatment Center following voluntary placement into care. This placement is not aligned with policy because there is no certificate of need on file, as well as no prior placements in lower levels of care and low level of needs on child's most recent CANS assessment.

Children included in the Oversample

17-year-old placed at state psychiatric hospital and currently on the overstay list. This placement is not aligned with policy because the child has overstayed the necessary length of care for this placement setting.

17-year-old child placed at an inpatient psychiatric facility and currently on the overstay list. This placement is not aligned with policy because the child has overstayed the necessary length of care for this placement setting.

16-year-old with medically fragile and developmental disabilities placed in a pediatric rehabilitation hospital and currently on the overstay list. This placement is not aligned with policy because the child has overstayed the necessary length of care for this placement setting.

18-year-old currently placed in therapeutic group home currently on the waitlist awaiting placement at another group home placement. This placement is not aligned with policy because the child needs an alternative placement setting to meet their needs.

17-year-old currently placed in Independent Living Program currently on the waitlist awaiting alternative placement. Child has been denied 37 times by providers while awaiting a placement that can meet her needs. This placement is not aligned with policy due to the fact the child needs an alternative placement setting, such as a treatment foster care home or therapeutic group home.

16-year-old placed in out-of-state Residential Treatment Center on waitlist for placement in Maryland because current placement is no longer able to meet their needs. Child was placed in this setting following removal from family. There is no certificate of need on file and no other prior placements in lower levels of care. This placement is not aligned with policy due to the fact the child needs alternative placement setting to meet their needs.

20-year-old placed in her own apartment and currently on the waitlist awaiting placement in an Independent Living Program. Child has a history of going missing and experiencing episodes of homelessness, as well as having documented mental health needs, prescriptions for multiple psychotropic medications, and a history of multiple inpatient psychiatric placements. This placement is not aligned with policy because the child needs an alternative placement setting to meet their needs.

17-year-old who is experiencing homelessness and living in a hotel, is currently on the waitlist for alternative placement. Child has a significant history of disruptions in placements, including Treatment Foster Care, Residential Group Homes, Diagnostic Centers, Residential Treatment Centers, and In-Patient Psychiatric Facilities. Child has a recent history of incarceration for assault on caregiver and was missing after leaving detention and then living out of hotels. Child has significant mental health needs, has been prescribed psychotropic medication, and was identified to have very high needs on their most recent CANS assessment. This placement is not aligned with policy because the child needs an alternative placement setting to meet their needs.

16-year-old who recently gave birth to a child is currently living with boyfriend in an unapproved placement and is identified as missing. Child was previously on the waitlist for placement in a Mother/Baby TFC/Group Home while placed in a Public Resource Home. This placement is not aligned with policy because the child needs an alternative placement setting to meet their needs.

Questionable

Children included in the Random Sample

17-year-old placed in Moderate Level of Care Treatment Foster Care Home. This placement is questionable because the child has no identified needs on their most recent CANS, as well as the fact that the child's permanency plan is Reunification with Concurrent Plan of Guardianship by Relative,

yet there has been no documentation of Family Team Decision Meetings conducted during child's time in care and only one prior placement in Kinship.

17-year-old placed in Moderate Level of Care Treatment Foster Care Home. This placement is questionable because there have been no prior placements with relatives/kin, even though the child's permanency plan is Reunification with Concurrent Plan of Guardianship by Relative. Additionally, a Family Team Decision Meeting was not conducted in conjunction with the change to their current placement and the child had low needs on their most recent CANS assessment.

9-year-old placed in High Level of Care Residential Treatment Center along with sibling. This placement is questionable due to the child's age and the fact that the child has low needs on their most recent CANS assessment. There is a certificate of need on file, but there has been no documentation of Family Team Decision Meetings conducted during the child's time in care, even though the child's permanency plan is Reunification with Concurrent Plan of Guardianship by Relative.

7-year-old placed in Moderate Level of Care Treatment Foster Care Home. This placement is questionable because the child has only had one prior placement in Regular Foster Care for a few months. The child's most recent mental health evaluation indicates a mild language disorder and a history of ADHD, but no other mental health or behavioral health needs. The child has four other siblings in care but was not placed with any of them.

Child included in the Oversample

10-year-old placed in a High Level of Care Residential Treatment Center. The child was previously on the overstay list following placement in an in-patient psychiatric facility for over 1 month. This placement is questionable due to the child's age and the fact that the child had no needs on their most recent CANS assessment. A Certificate of Need was documented and indicated that congregate care was therapeutically necessary. The child has multiple mental health diagnoses, a history of aggressive behavior and self harm, an IEP for emotional disability, and has been prescribed psychotropic medication.