Maryland Department of Human Services

2024 Annual Progress and Services Report

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Appendices:

Section 1: Collaboration and Feedback Loops

The Maryland Department of Human Services, Social Services Administration (DHS/SSA) continued to engage families, children, youth, tribes, as well as legal and court partners in meaningful and substantial collaboration through its established Implementation Structure that includes an array of Implementation Teams, Networks, Workgroups, and connections to a number of advisory boards (i.e., Provider Advisory Council, SSA Advisory Board, Youth Advisory Board) and Local Department of Social Services (LDSS) Director and Assistant Director groups. It is through this structure that DHS/SSA regularly reviews current data performance, assesses agency strengths and areas for improvement, and develops strategic plans to increase safety, permanency, and well-being. DHS/SSA has continued its partnership with Maryland Coalition of Families (MCF) to assist with bringing family voices to the various teams within its implementation structure using a variety of strategies to recruit additional families from across the state that represent a variety of populations. MCF recruits individuals with varied backgrounds and lived experience within the child welfare system. This allows for representation across races and economic status. Additionally, each of the SSA Implementation Team members have a wide variety of state, local and community agencies that are represented and contribute to the objectives of the team. Implementation Team members represent the diverse backgrounds and the children and families they serve, many who have a history of being underserved. SSA utilizes these perspectives to inform the agency's strategies and approach to our work.

DHS/SSA began engaging in bi-monthly meetings with the Governor's Office of Community Initiative in September 2022 where a review of the policy, past collaboration, and sharing of data regarding youth identifying as American Indian has taken place. There will be presentations in 2023 by the Maryland Commission on Indian Affairs (MCIA) representative in Permanency hosted meetings as well as, SSA staff will present in MCIA meetings regarding our current work and collaboration.

In addition to meaningfully collaborating with key stakeholders, DHS/SSA continued to utilize feedback loops and the DHS/SSA Continuous Quality Improvement (CQI) cycle within the Implementation Structure to:

- Assess strengths and areas needing improvement,
- Review and modify goals, objectives, and interventions, and
- Monitor progress in implementing DHS/SSA's strategic vision.

During 2022 most of the teams met regularly (meeting frequency of each group listed below), explored opportunities to strengthen and expand membership to ensure representation from key stakeholder groups, and utilized feedback loops to assess performance as well as monitor and adapt key strategies. Below are DHS/SSA workgroups that demonstrate meaningful collaboration and utilization of feedback loops that occurred over the past reporting period.

Outcome Improvement Steering Committee (OISC) (Meeting Frequency: Monthly)

In 2022, the OISC was facilitated by the Deputy Executive Director of Programs, Deputy Executive Director of Operations, and the Director of the Office of Adult Services. The priorities for 2022 were monitored by the OISC and associated subgroups with input and decision points addressed through status presentations. The participants were charged with reviewing the

program goals, strategies, and data to evaluate success of the planned priorities and identifying ideas to address barriers and gaps. Clarification around presentation content was also reviewed and these presentations regarding the work being carried out by each team or group became more robust and detailed. Representatives from MCF, LDSS, federal partners, University of Maryland School of Social Work (UMSSW)/Innovations Institute, Chapin Hall attended the meetings along with SSA. Presentations by stakeholders included Supervision Matters training from Child Welfare Academy at UMSSW; Tools for Youth Engagement by the Foster Care Youth Ombuds; and some items were shared for feedback, such as Safe Sleep material which was reviewed by MCF to ensure it was accessible. Data was regularly shared by different groups along with the updated Headline Indicators Dashboard which included storyline data concerning race/ethnicity, age, and circumstances of removal for all of the Permanency Indicators and Placement Stability. This additional data allowed for disproportionality and disparity around these measures to also be evaluated. Planning session with the Implementation and Network leads is planned for January 2023 to review the relevancy of all implementation teams and Network groups to determine which are still needed and which need to have their content area integrated into remaining implementation teams and network groups and create more time for content specific dialogue.

Kinship Navigation Workgroups (Meeting Frequency: Monthly)
In 2022 SSA engaged representation from LDSS Kinship Navigators (KN) and MCF Kinship Navigators who also shared lived expertise to identify barriers and trends across the state affecting system coordination and service delivery to underserved kinship families. Family Investment Administration (FIA) staff were trained in several counties to strengthen coordination of services to underserved and unidentified kinship caregivers by focusing on targeted outreach, identifying language and terminology barriers, and facilitating warm handoffs. Through screening of the application for the Food Supplement Program/ SNAP benefits and TCA program, additional families were then referred to their local Kinship Navigator for supplemental assistance and access to resources. The process aims to provide comprehensive support to families in need and allows them to be linked to customized services, including legal assistance, support groups, and various community resources to enhance their well-being. The Enhanced Kinship Navigator Pilot Program fully launched and technical assistance was provided to key staff identified in each pilot jurisdiction to engage and facilitate participation in the study program. SSA Kinship Navigation Program Administrator held a collaboration meeting with the Director of Family Connections in Baltimore to discuss the unique needs of kinship families, ways to support the Kinship Navigation Program in Maryland and develop a single point of contact to streamline services for caregivers.

- **Kinship Navigator Family First Workgroup (Meeting Frequency: Monthly)**
  LDSS Kinship Navigators, technical assistance partners, the MCF, kinship caregivers, and LDSS leadership contributed to the revamping of the Kinship Plan Builder Assessment tool for the Enhanced Kinship Navigator model to be more efficient and strength based for strategic planning with families. The business process map was simplified for the Enhanced Kinship Navigation model. Strength, challenges, and barriers to Maryland's current KN program were discussed, and feedback was solicited from stakeholders to combat barriers and strategically plan opportunities for engagement.

- **Kinship Navigator Peer Support Meeting (Meeting Frequency: Monthly)**

SSA along with University of Maryland, Baltimore, Institute for Innovation and Implementation (The Institute), Kinship Navigator Training Specialist provided Kinship Navigator's with targeted, specialized training relevant to topics affecting kinship caregivers. This regularly occurring support group was utilized as a forum for ongoing knowledge acquisition, skill building, and peer support to discuss practice issues, advocate for families, plan engagement activities and supportive events and share ideas about how to best address the needs of kinship families. Resources were shared with KN to enhance support and services to kinship families being served and strengthen partnerships with community agencies and programs while also exchanging information to address gaps in services and address practice challenges and emerging trends in Maryland.

Child Protective Services and Family Preservation Implementation Team (Meeting Frequency: Monthly)

In February 2022 the team reconvened with new membership. New membership was sought to provide representation of several new LDSS, Maryland Family Network, new SSA staff – Kinship Specialist, Education Specialist and Family Engagement Specialist – to bring in more lived experience to the team. The Child Protective Services and Family Preservation Implementation Team developed a smaller safe sleep workgroup that met for two months. This workgroup included community partners that work with families that have lost children from sleep related deaths. Videos from those with lived experience were included in the safe sleep guidance that was released to staff in May.

In July of 2022 Child Protective Services (CPS) and Family Preservation Implementation Team worked with the Out-of-Home (OOH) Team to select a new trafficking screening tool. During the trafficking policy development, a validated tool was selected and shared with the youth advisory board for feedback on the best ways to educate workers around engaging youth in utilizing the screening tool. The feedback provided by youth was incorporated into the Trafficking Guidance draft. The Child Protective Services and Family Preservation Implementation Team developed a workgroup to work on the Trafficking Policy and Guidance that included frontline staff. After receiving feedback from frontline staff DHS/SSA partnered with community partners that directly serve individuals with lived experience to gather more feedback on the Trafficking Guidance. As policy and guidance were being drafted the Child Protective Services and Family Preservation Implementation Team partnered with SSA to provide feedback.

June 2022 through July 2022 a workgroup met to discuss CPS appeals that included frontline staff. The workgroup developed long term strategies including creating a google drive to share research with staff. Another workgroup, that included frontline staff, met from June through August to plan the first Screening Summit. The Screening Summit agenda development was based on utilizing feedback and concerns received from constituents such as families with lived experience and community partners.

The Family Preservation Team engaged in Integrated Practice Model (IPM) activities that included coaching and technical assistance with many LDSS, and work related to Family Team Decision Making Meetings. This team also developed, organized, and executed the training for the legal and court partners on DHS/SSA's teaming policy in June.

Birth match work in 2022 included some Child, Juvenile and Adult Management System (CJAMS) enhancements in June and then, in August new practice guidance was shared with the LDSSs that included a fillable summary. All 24 jurisdictions are reporting on lethality assessments. The Lethality Assessment Program Overview was presented at the Protection, Preservation, and Prevention (PPP) Implementation meeting in November and a workgroup convened in December to work on updates. The Parent Partner Program was relaunched in Washington County after a hiring difficulty with SSA's partner agency (MCF). SSA is piloting this program in Washington County to determine benefits to families receiving peer support while working with the child welfare agency. Capacity Building Center for States was very supportive in helping Maryland start this pilot (see Section 4: Goal 1 for more information).

Family First Prevention Services implementation has been continuing in 2022. A service plan refresher was developed with Family Preservation and CJAMS experts and offered 3 times in September. As a follow-up to this training, the Program Manager offered Google Meet drop-ins for three weeks on Tuesday mornings in November in which LDSS staff were able to come in and ask questions about Family First and get walkthroughs of documentation in real time if needed.

Several tipsheets have been released to help caseworkers with identified barriers to Implementation of Family First:

1. Talking with Families about Prevention Services tipsheet disseminated in October
2. Two tipsheets on how to document and how to update a child specific plan
3. Checklist for eligibility in FFPSA

In December, the new Family First Prevention Services Act (FFPSA) work plan design was accepted by the Family First Leads Team, and they began development. Training began for Cohort III of FFPSA on December 20 (final seven counties) and four more training sessions are scheduled in January and February 2023.

Code of Maryland Regulation (COMAR) 07.02.01, the Family Preservation regulation, was rewritten with input from local jurisdictions, SSA leadership, the Attorney General's Office, and other SSA partners including individuals with lived experience. The rewrite has more family friendly language, more updated approaches to practice, and will allow more clinical work to help families in better, more efficient, and effective ways. It will be submitted for approval during the February 2023 session.

Maryland faced challenges with the claiming process for Title IV-E reimbursable prevention services in calendar year 2022 due to a range of obstacles. Monthly meetings were held with the jurisdictions implementing Family First Prevention Services Act (FFPSA) to identify some of the problems. Many of the problems were related to incomplete service plans within CJAMS. There were also technical problems within CJAMS, and it was discovered that more items were necessary for processing Title IV-E claims than initially developed. Reviewing the outcomes in partnership with local departments, Title IV-E staff, FFPSA leads, data and finance staff SSA formulated a new claiming process. These meetings are continuing into 2023 to evaluate and finalize the claiming process, which includes retroactively claiming funds for children who were eligible for prevention services in CY2022.

Service Array Implementation Team (Meeting Frequency: Every Other Month)
In 2022, The Service Array Implementation Team was able to retain its membership which include members of various units at SSA, the LDSS, private provider agencies, Maryland State Department of Education, Court Appointed Special Advocates (CASA), Local Behavioral Health Authorities, Community Based Agencies such as Maryland Coalition of Families as well as expand membership by including family voice of a resource parent and members of the Governor's Office of Crime Prevention, Youth, and Victim Services and Maryland Family Network; Maryland's Community-Based Child Abuse Prevention (CBCAP) provider.

The implementation team members focused on the objectives such as increasing awareness or availability of behavioral health services, supporting coordination with sister agencies, and identifying lessons learned from partnership success identified in Community Partnership Survey. Each team member was assigned to one of three smaller workgroups to provide feedback on. The group developed a toolkit for the LDSS to utilize to enhance partnership and coordination of services. The team identified several tools and activities to raise awareness regarding existing behavioral health services and where to house this information. The Service Array Team members weighed in on ideas of how to include more bio parent and youth voices into Service Array Needs in real time, and strategies will need to be developed and implemented in the coming year.

Throughout this reporting period, SSA was able to utilize the Service Array Team to provide feedback and input related to ideas to address/meet individualization of service needs and how LDSS are currently using funding to support individual needs. As in previous years, the team reviewed CFSR performance data quarterly for Needs and Services of Child, Parents, and Foster Parents (Item 12) and Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-Entry into Foster Care (Item 2) and contributed to ideas to improve performance and identify strategies to address barriers.

The latter portion of 2022, the Service Array Implementation Team was discontinued. While the agency goals and objectives related to services have not changed, the structure in which the agency focuses on this effort has changed. Service Array is now a theme throughout each of the other existing implementation teams to focus on.

Integrated Practice Implementation Team (Meeting Frequency: Monthly Through September)
Membership of this team includes local department staff and leadership, parents with lived experience, kinship caregivers, community partners and providers, SSA staff and University of Maryland and Chapin Hall staff as well as a foster parent. In January 2022, the IPM Team worked together with LDSS staff and leadership to develop annual technical assistance days for each local department that incorporated support for staff to become certified in use of the CANS and CANS-F tool and to develop practice sessions that focused on collaboration to promote collaborative assessment with families. The sessions were launched in March and incorporated a parent with lived experience in designing the technical assistance (TA) and assisting with the sessions. Evaluations were completed by staff and feedback was used to inform further peer to peer learning opportunities and coaching in the coming year as a result. Coaching planning and evaluation sessions were inclusive of the family engagement specialist who has lived experience to lend this perspective in the planning and evaluation of each agency's goals.

The IPM Implementation Team evaluated the IPM Coaching Intensives and growing opportunities to infuse the Coach Approach learning circle concept in their work based on evaluation feedback. The team looked at evaluation results and noted the responses often called out the need to increase opportunities to grow the professional development opportunities for staff to learn and grow their coaching skills. As a result, additional slots for staff to join existing sessions in 2022 were added and additional sessions were added for early 2023. A plan to be able to further recruit coach mentors was also built into this plan. Learning circle concepts have also been expanded as a result of the evaluation and feedback process of this group. SSA staff learning circles were expanded to address a variety of topics in which technical assistance could help address such as diversity, equity, and inclusion in our work with local departments and secondary trauma. Learning circles were also incorporated later in the year to complement technical assistance to local staff around screening decisions in CPS, collaborative assessment, and family engagement.

The Court Outreach Workgroup of the IPM Implementation Team formed a task group to develop a Webinar to introduce the new family teaming policy to our court partners across the State. The team consisted of an agency attorney, a youth transition planning trainer from the Child Welfare Academy, a parent with lived experience, a public defender, a retired judge, the executive director of CASA, and SSA staff. The training was delivered in June and July and the link has been made available across the State to continue to make this information accessible to our court partners. The training sessions were well-attended by CASAs, attorneys, and judges. There was strong interest among the Department of Juvenile Services (DJS) staff and the links to the training recording were made available for them as well since the virtual training sessions were at full capacity. FAQ sheets were also developed to address questions.

The Court Outreach Workgroup began discussions on supporting the Placement and Permanency Implementation Team with some root cause analysis and discussion about barriers to guardianship as a permanency plan. Attorneys noted that it is particularly difficult for some relatives to let go of the support of the local department and the court and to navigate relationships with the parents of the children in their care beyond agency involvement. Model court orders that support giving instructions to guardians and opportunities for support beyond agency involvement was a suggestion that was made. There was also some discussion about concurrent planning and the attorneys and CASAs noting that they felt staff needed to understand that concurrent planning means working on two plans simultaneously not having a primary and secondary plan. Concurrent planning training is being planned for staff and attorneys in 2023 to address this concern.

From July to September 2022, the IPM Implementation Team focused on embedding IPM practices, principles, and core values to the on-going work of the CPS/Family Preservation Implementation Team, Service Array Team and the Placement and Permanency Implementation (PPI) Team. Integrating and sustaining the IPM in these teams seemed to be a natural evolution since IPM implementation has been completed. The last meeting of the IPM Implementation Team took place in September. The team has dissolved into other implementation teams.

SSA Advisory Board (Meeting Frequency: Semi-Annually)
DHS/SSA provided a review of the different areas of work currently being undertaken by the different areas and to share performance and goals for the upcoming year. One area of concern related to the Program Improvement Plan (PIP)- Non-Overlapping Period (NOP) is the CFSR performance measures of Timeliness of Investigations and Achieving Permanency, with greater attention paid to the latter. In addition, the following information was shared and discussed: strategies regarding planning of meetings with each local department and collaboration with Foster Care Court Improvement Program (FCCIP); progress on the audit findings with 3 of 6 being deemed complete and significant progress on the remaining items; Implementation of the Child Maltreatment Fatality Review (CMFR) as well as benefits to the state through real time feedback; challenges with hospital overstays along with seeking feedback regarding creative problem solving; and information regarding additional Qualified Residential Treatment Programs (QRTPs) being sought in 2023.

The Provider Advisory Council (Meeting Frequency: Quarterly)
This team reconvened in August 2022 after revising its charter and establishing a format to improve overall communication and feedback from the provider community. It was originally planned that the Providers Advisory Council (PAC) would meet quarterly. But due to the need and request for more frequent communication opportunities from providers, the council will begin meeting monthly in 2023. The team consists of providers and local department staff and is attempting to recruit youth and parents with lived experience as well as foster parents. Though the official membership represents about 10 providers, a request was made to include all providers. All providers are invited to attend in order to improve communication and over half of the 150 providers in the State usually attend. An emphasis in the coming year is to ensure that provider representation is improved among the implementation teams at SSA.

Workforce Development Network (WDN) (Meeting Frequency: Monthly)
Beginning in August 2022 the WDN moved from a bi-monthly to monthly meeting cadence to achieve several time-sensitive goals. These included continued enhancement of pre-service training activities, completion of the training system evaluation plan, and redesign of the Supervision Matters Training Series (all discussed in more detail in subsequent training sections). The WDN includes a diverse and devoted membership of SSA, Child Welfare Academy (CWA), LDSS Managers and Caseworkers, University of Maryland and Morgan State University Title IV-E Faculty, DHS Learning Office staff and members with "lived experience." The members with lived experience include an adult mother of three, who was previously in foster care and a mother with a special needs son with autism. The WDN does not have court represented membership at this time despite rigorous recruitment efforts. However, lawyers and court personnel are actively involved in our pre-training activities. Initial discussions with SSA Emerging Staff have also occurred to discuss the appropriateness and subsequent recruitment of youth to the WDN.

The Workforce Development Unit (WDU) is also a member of the Title IV-E Consortium (Maryland Universities who offer Title IV-E Social Work Programs). This group meets monthly. Active work with this group has included on-going recruitment and placement of macro-level social work student interns to support various SSA programs and operations, and continued work of the IPM into Maryland Social Work curricula. The WDU also participated in the DHS

Employment Services Seminar held in December 2022. WDU spoke to approximately 300 potential students about current SSA priorities (IPM, Family First Prevention Services) to recruit students to the Title IV-E Program who once they finish school will join the DHS workforce. The WDU also has a standing agenda time at monthly LDSS Assistant Directors (Affiliates) to collaborate on any child welfare training and professional development matters.

Substance Use Disorder (SUD) Workgroup (Meeting Frequency: Monthly)
The Substance Use Disorder (SUD) Workgroup is composed of a diverse group of professionals and individuals representing key stakeholders such as birthing hospitals, families, substance use treatment providers, state agencies, local health departments, LDSS program staff, and other community service providers. With their experience and expertise, workgroup members provide input and recommendation to support implementation of evidence-based practice models related to SUD, SEN related policies, best practice interventions, SUD service array and workforce development opportunities. The University of Maryland Institute for Innovation and Implementation and Chapin Hall provide TA to the workgroup. DHS/SSA will continue to utilize the SUD Workgroup as a structure and opportunity to collaborate with stakeholders to identify service barriers and address the needs of SEN. The SUD Workgroup is also addressed in Section 6 "Population at Greatest Risk of Maltreatment."

Placement and Permanency Implementation Team (Meeting Frequency: Monthly)
The PPI Team met in January 2022, and restarted meeting monthly. The team includes staff from SSA, LDSS, providers, ombuds, MCF, Court Improvement, Legal Aid. While the PPI Team is a racially diverse group that includes members with lived experience and youth voice is incorporated through subgroups, all aspects of equity may not be represented. In the future we will poll the team participants for these demographics. If there is a lack of representation of individuals who are considered to be historically underserved, marginalized, adversely affected by poverty and inequality in the child welfare system we will make efforts to ensure that we are appropriately recruiting them to engage in the team.

Child and Family Services Reviews (CFSR) data and root cause analysis of length of stay, and placement stability have been reviewed, and an emphasis on achieving permanency will continue in the coming year. QRTP implementation was also a placement focus, and four Maryland jurisdictions were pilot sites for QRTP and Qualified Individual (QI) assessments. Those pilot jurisdictions are Baltimore City, Frederick County, Montgomery County, and Wicomico County. There are currently six designated QRTP, with one of the six a DJS-only provider.

The PPI Team consists of SSA staff from various units, community members, providers, local departments of social services, resource parents, court/legal partners, and youth and family representatives including the Maryland Coalition of Families. A primary purpose of the PPI is to enhance collaboration and garner a diverse review of the work done within the Placement and Permanency Units. This multidisciplinary group of stakeholders provide feedback to the Permanency Unit with respect to SSA policies, initiatives, programming, COMAR, and relevant aspects of issues that affect youth in care. Priorities are driven by SSA's headlines and the CFSR, pertaining to improving outcomes related to placement stability, timely permanency, and successful planning and discharge for older youth exiting care.

In May 2022, the team started with new SSA leaders. In June, the workgroup focused on the revision of various policies that needed to be updated, the Emerging Adults (EA) Workgroup, and developing a Concurrent Planning Workgroup. The August meeting focused on policy and CFSR Permanency Item 6 as well as other Placement and Permanency areas in need of attention. Data was shared with the team during the September meeting in order to: identify jurisdictions that are doing well; dive deeper to determine their efforts to improve their permanency numbers; and to begin identifying strategies to address low CFSR Item 6 numbers.

In the October meeting, the focus was on the improvement of permanency through guardianship, beginning with a review of the data to ascertain barriers and identify strengths in efforts to expedite permanency through guardianship. There was also discussion of the partners who needed to be added to the dialogue surrounding the achievement of permanency for youth in care for future meetings as well as, other workgroups needing to hear this information surrounding permanency. In October 2022 the Concurrent Planning Work group met to discuss engaging with team members to review LDSS practices related to concurrent planning. This workgroup will continue to meet to brainstorm ideas and increase concurrent planning efforts across the state. The November and December meetings were combined, and the December meeting focused on improving relative and non-relative guardianship numbers by coordination with the Foster Care Court Improvement Team to develop an action plan to strengthen efforts on Item 6.

There was also work done with respect to the Emerging Adults Workgroup that meets monthly and provides feedback for the team. Members were convened to seek input related to surrounding changes to COMAR, youth transition planning, program feedback and coordination from the State Youth Advisory Board (SYAB) monthly meeting, eligibility of social security benefits through Maximus, and feedback on the Educational Toolkit. The diverse perspectives of this team allow for varied considerations to be given to the work being implemented by the Permanency Unit to provide more informed programs, policies, etc. to support children and families.

Emerging Adults Workgroup (Meeting Frequency: Monthly)
It is intended that the EA Workgroup leverages the experiences, expertise, and insight of key individuals to improve outcomes for youth ages 14-21. The purpose of the EA Workgroup is to communicate, advise, and serve as a formal stakeholder in the development and enhancement of the strategic vision for Maryland's children and families. The EA Workgroup consists of local DSS staff, including supervisors and independent living coordinators. There are community partners who are members, but there needs to be increased diversity of members. Efforts will be made to recruit new members who represent marginalized and underrepresented groups such as LGBTQIA and racial minority groups. Efforts also will be made to recruit members from various professional, community, and academic affiliations such as legal/law enforcement, foster youth alumni, homeless services providers, colleges, landlords/property managers, and civic organizations.

The charge of the EA Workgroup is to develop strategies that improve outcomes for older youth while in care and after they leave care. The EA Workgroup will also examine the current service array available to older youth and make recommendations to assist local jurisdictions in providing effective programs and services. The EA Workgroup reports and provides recommendations to the Placement & Permanency Team.

Health Workgroup (Meeting Frequency: Monthly)
The Health Workgroup is composed of a diverse group of professionals and individuals representing key stakeholders such as local health departments, LDSS program staff, state agencies (including Medicaid contractors for health, dental and behavioral health), and other community service providers. Workgroup member experience, expertise and insight provides leadership and guidance on strategies to improve health services (including dental and behavioral health) for children, youth, and young adults. The charge of the Well-being Workgroup is to communicate, manage, advise, and serve as a formal stakeholder in the development and enhancement of the strategic vision for Maryland's children and families. Chapin Hall provides TA to the Workgroup. DHS/SSA will continue to utilize the Health Workgroup as a structure and opportunity to collaborate with stakeholders to identify service barriers and address health care needs and services for children, youth, and young adults in foster care. The Health Workgroup is addressed in Section 2 Well-Being Outcome 3.

Quality Service Reform Initiative (QSRI) Workgroup (Meeting Frequency: Bi-Weekly)
The DHS and the QSRI Workgroup have continued to focus on the key activities necessary to implement this new rate structure, including a proposed Medicaid State Plan Amendment. Over the past year, this has included delineating proposed clinical and direct care classes of services; updating the draft medical necessity criteria for the clinical services; refining staffing qualifications; developing a logic model and continuous quality improvement process in partnership with provider organizations; aligning the activities to implement Qualified Residential Treatment Programs (QRTP) with the QSRI, including providing training on a transition tool to support discharge planning; and mapping referral and care pathways for youth to enroll in residential interventions. The work of DHS and the QSRI Workgroup has remained focused and on-track, enabling a smooth onboarding of the vendor for actuarial services.

DHS initiated the process of developing a Request for Proposals (RFP) for a vendor for the actuarial services. The procurement process was completed in August 2021. The RFP was submitted to the Office of State Procurement for approval in September 2021. The RFP was issued in October 2021. The contract for the vendor was fully executed on July 1, 2022.

Continuous Quality Improvement (CQI) Network (Meeting Frequency: Monthly)
The CQI Network leverages the experiences and expertise of key stakeholders, SSA leadership, and the local departments to provide guidance on the development, implementation, and adjustment of CQI processes within the child welfare system. At the start of 2022, the CQI Network reviewed and revised the CQI Network Charter to reestablish the priorities for the calendar year 2022 and outline key members whose insights will support the achievement of the identified goals. In June and July of 2022, the CQI Network reviewed the work done thus far towards the identified priorities and determined a need to establish a more action-based orientation to reinvigorate the CQI Network's efforts to support the function of the CQI throughout SSA. As result, CQI Network membership was expanded to include representation from more local departments and programs within SSA. The role and function of the SSA CQI unit, SSA programs, and CQI Network were reemphasized.

In January 2022 and February 2022, the CQI Network supported the development of the Adult Service local review process and reviewed the integration of Family First with the CQI cycle in

accordance with the identified priorities for that year. Additionally, the CQI Network supported the integration of the CFSR focus group results, which captured the voices of youth, biological parents, resource parents, child welfare staff, court personnel, and service providers, into overall CQI processes and provided a space to strategize ways to improve focus group recruitment, participation, and implementation alongside partners at the University of Maryland School of Social Work and Chapin Hall. To support continuous improvement plans and provide coordinated technical assistance to the local departments, the CQI Network primarily focused on improving the State's compliance with Item 1 (timeliness of initiating investigations) and Item 6 (timeliness of achieving permanency), per the CFSR and Maryland's PIP. The CQI Network examined Headline Indicator data and qualitative CFSR data for the State and the local jurisdictions to evaluate progress towards meeting the identified PIP targets for these items and determine areas of practice that can be strengthened to move the needle and achieve compliance by the conclusion of Period 11 in September 2023. Through collaborating with the local departments, partners at Chapin Hall and the University of Maryland School of Social Work, and the SSA Permanency unit, the CQI Network was able to have ongoing dialogue regarding the barriers to achieving strength ratings for Items 1 and Item 6. The multiple perspectives and voices shared through the CQI network allowed for a root cause analysis of Item 6, which supported the CQI Network in identifying practices to support the timely achievement of permanency, leveraging the IPM to promote permanency, and determining practical assistance SSA can provide to the LDSS that will improve their capacity to achieve Item 6. For example, a pervasive theme that emerged from these conversations was the need for improved collaboration between child welfare staff and the courts. To strengthen the communication and relationship between the local departments and the courts, the CQI Network Meeting intends to create opportunities and provide tangible support, such as connecting the local departments with their permanency liaisons, in order to bridge this gap in the coming year.

Communications Network (Meeting Frequency: Bi-Monthly Through September)
The communications network was composed of SSA staff, parents with lived experience (MCF), local department leadership, and providers. The network focused during the first quarter of the year (January – March) on developing one-pager descriptions of Family First programs aimed at internal and external customers, including parents, community stakeholders and providers as well as local department staff. Marketing materials for the kinship caregiver texting application were also developed collaboratively with the input of this group. In conjunction with the communications office, a communications strategy retreat was held in May and a strategic plan was developed for launching a website redesign, on-boarding materials for staff on families first, dissemination of one-pagers, and talking points around Family First. In October, this work was temporarily paused due to changing leadership.

Section 2: Update to the Assessment of Current Performance in Improving Outcomes

Safety Outcome 1

Table 1: Safety Outcome 1 CY2019 - 2022

Safety Outcomes	*Time Period*	*Overall Determination*	*State Performance*
Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect	January-December 2022	Not in Substantial Conformity	86% Substantially Achieved
	January-December 2021	Not in Substantial Conformity	79% Substantially Achieved
	January-December 2020	Not in Substantial Conformity	75% Substantially Achieved
	January-December 2019	Not in Substantial Conformity	67% Substantially Achieved
Data Source: Online Monitoring System (OMS)			

Table 2: Timeliness of CPS Responses CY2019 - 2022

Timeliness of CPS Response with Alleged Victim(s) (Target: 90% or greater for abuse and neglect contacts.)				
Calendar Year	**% Within the first day**	**% Within the first 5 days**	***Corrected Data* % Within the first day**	***Corrected Data* % Within the first 5 days**
2022	81%	83%		
2021	91%	97%	67%	82%
2020	90%	97%	61%	81%
2019	74%	79%	51%	84%
Data Source: Child, Juvenile and Adult Management System (CJAMS) -for CY21, 20, and 19 milestone report and for CY22 HB1248 as this report was developed in 2022 to capture more details surrounding initial contact.				

Assessment of Performance:
As noted in Table 1, from January to December 2022, Maryland's performance on Safety Outcome 1 did not meet the standard for substantial conformity as 86% of the cases reviewed received a substantially achieved rating. The data trend shows that Maryland is closing the gap between contacts that require a 24-hour response versus those requiring a 5-day response.

As discussed below, in 2022, the Department of Human Services (DHS), Social Services Administration (SSA) made substantial improvements to the CJAMS to provide a more accurate representation of the actual compliance rate regarding this Outcome. These improvements addressed significant data defects and now enable CJAMS to capture data around timeliness of

Child Protective Services (CPS) responses that includes information related to contact with a broader array of individuals (i.e., additional caregivers, other children in the home). This allowed for accurate data regarding face-to-face contact with alleged victims to be separated from initial contacts with other members of the household. This has allowed DHS/SSA to better understand and track performance related to Safety Outcome 1. Table 2 above reflects corrected data for 2019 – 2021, which aligns with enhancements made to the milestone report; the data from 2019-2021 was updated to accurately reflect this measurement. The corrected data are noted in the corrected data columns. For 2022 data, there was a 14% improvement in Maryland's required initial contact within the first day when compared to the corrected timeliness from 2021 and prior.

Strengths:
Using a multi-pronged approach, DHS continues to improve performance on Safety Outcome 1. The trend is moving in a positive direction with a 7% increase from last year's (CY2021) Child and Family Services Review (CFSR) performance of 79%. The data provides evidence that this multi-pronged approach is effective. This multi-pronged approach is outlined below under activities to improve performance.

Concerns:
During 2022 defects were discovered that caused the CJAMS system to inaccurately identify some initial contacts as untimely. This led to significant revisions to the CJAMS and data reports. More details regarding revisions can be found below under activities to improve performance.

Staff challenges, which have an impact on timely CPS responses, were a prominent theme throughout the CFSR focus groups. Although staff challenges are not systemic areas measured through the CFSR process, they were a consistent theme in the focus group summaries. Community partners and resource parents noted the high turnover rate. Groups noted that staff were working very hard to meet mandates but that staff turnover, as well as the time it takes staff to develop new partnerships between families and community partners, makes it difficult to keep up with the workload.

Implementation of the 2022 amendments to Family Law Article §5-706 brought to light the reasons why some cases fall in the "not-achieved" category for timely initial contact. Some of the situations that result in delays are outside a local department's control. As an example, when Maryland is required to investigate maltreatment that occurred to a victim who lives in another state, it must wait for and rely on information from the other state. If the other state has more lenient timeframes for contacting a victim after a report, the local department cannot insist that the other state comply with Maryland's mandates and, as a result, the local department must report an untimely initial contact. As implementation of this law went into effect in October 2022, DHS/SSA only has 3 months' worth of data that shows approximately 2-3% of cases in the last quarter of 2022 fall into this category. During technical assistance (TA) sessions Local Departments of Social Services (LDSS) report this occurring frequently in counties that border other states. SSA expects this percentage to increase as staff become more familiar with the reason for delay in initial contact selections in CJAMS. At times local department staff may have selected the alleged victim being unavailable instead of the alleged victim being out of the jurisdiction, appropriately 7% of cases that were untimely were due to the alleged victim being unavailable.

Another reason captured for a worker's delay in making a timely initial contact is the fluctuation of the worker's caseload. Maryland last completed a workload measurement study in 2008. Since then, several best practices and policy changes have been implemented: alternative response, risk of harm assessments for substance exposed newborns and domestic violence, as well as several others. Currently, DHS/SSA collects data about CPS caseworker positions filled and divides that by the CPS cases assigned in the calendar year. This has been determined to not be an accurate reflection of caseloads across the state. This data does not include positions that have been vacant for most of the year or where workers had to be on leave for various reasons. Nor does this data reflect positions that have had to be utilized for non-case carrying positions such as Family Team Decision Making (FTDM) facilitators and appeals coordinators. These implementations have occurred while following caseload standards versus workload. This has resulted in Maryland's current caseload ratios appearing to be in compliance with Child Welfare League of America (CWLA) caseload standards (required by Maryland statute). CWLA has recently identified that this alone is not sufficient, and that the workload associated with the individual families should also be considered. CWLA is undertaking an initiative to update its caseload and workload standards, shifting the focus from caseload standards (which identify the number of cases/families a worker should be responsible for) to workload standards (which measure the amount, complexity, and intensity of work associated with an assigned caseload of families).

There are times when a worker's workload temporarily exceeds the worker's ability to meet all the timeframes and, instead, requires some triage based on urgency and risk. On occasion, it is the nature of and not the size of the caseload that might result in delay. For example, the time it takes to immediately remove a child from a dangerous home might eclipse the response time in another case. In addition, during TA sessions it has been reported that the LDSS are experiencing staff shortages due to staff using Family Medical Leave Act (FMLA) leave or being on restricted duty. Further, the opioid epidemic has changed the complexion of caseloads. Workers may need to spend a significant amount of time with a family to support a caregiver in entering treatment. New programs, such as the Sobriety Treatment and Recovery Team (START), suggest a different approach to working with these families that requires a CPS investigator to spend significant time engaging and building rapport with a family so that the family will accept services and move towards recovery. This increases the *workload* which makes it more difficult for staff to meet initial contact for new cases. As amendments to Family Law Article § 5-706 went into effect in October 2022, DHS/SSA only has 3 months' worth of data that shows approximately 2% of cases in the last quarter of 2022 missed the initial mandate due to workload.

Activities to Improve Performance:

- In 2021, SSA developed an internal Audit, Compliance, and Quality Improvement (ACQI) unit to assist with supporting local departments in completing key child welfare activities including responding to maltreatment reports in a timely manner. During 2022, the ACQI unit continued to partner with the CPS unit to make enhancements to the CPS milestone report. This report is available in CJAMS to front line staff and management to assist them in tracking and monitoring the LDSS performance on face-to-face contact in CPS cases.
- Throughout 2022 the ACQI and CPS units held at minimum monthly TA sessions with metro LDSSs, to review, among other things, Safety Outcome 1 data. During these TA

sessions, the group discussed barriers LDSS staff identified in making timely CPS responses.

- DHS/SSA enhanced CJAMS to resolve glitches and capture data around timeliness of CPS responses to include a broader array of individuals (i.e., additional caregivers, other children in the home) to better understand performance related to initiating a CPS response with the family unit. DHS/SSA will continue to utilize this data monitoring tool paired with technical support and coaching to the local departments that are not meeting the 95% initial face-to-face contact requirement to improve outcomes.
- In May, ACQI and CPS units began bi-weekly statewide TA sessions. During the Statewide TA sessions, the group focused on and explored practices that enabled a local department to perform at or above the standard for Safety Outcome 1. The TA sessions utilized a problem-solving model involving "plan-do-study-act" (PDSA) cycles that are used to improve or make changes to a process. The PDSA cycles focused on addressing documentation delays and challenges with making initial contacts.
- In September 2021, ACQI began weekly distribution of selected CJAMS data to local departments to allow them to track compliance including safety outcome 1 data. This weekly distribution continued through 2022.
- Documentation training continues to be provided to ensure the workforce is documenting the contacts in a way the system can accurately detect. To further support these efforts, DHS/SSA's Audit, Compliance, and Quality Improvement and Child Protective Services units are partnering to offer joint technical assistance.
- Implementation of the 2022 amendments to Family Law Article §5-706 brought to light the reasons why some cases fall in the "not-achieved" category for timely initial contact. As a result, DHS/SSA is now able to identify trends around barriers for the initial response.

Activities Planned for 2024

- In accordance with Family Law §507 in 2023 DHS/SSA will review studies and methodologies related to analyzing workloads in child welfare systems.
- Following the review of methodologies, in 2024 DHS/SSA will complete a child welfare workload assessment. DHS/SSA can utilize information from this assessment to analyze workload versus caseload. This will help DHS/SSA better understand staffing needs that could improve outcomes for Safety Outcomes 1: Children are first and foremost, protected from abuse and neglect.
- Moving forward SSA is going to explore how to track the actual number of case-carrying positions and workers available to receive cases. This will be done in partnership with Human Resources Development and Training (HDRT) and data from our time management system, Workday.

Safety Outcome 2

Table 3: Safety Outcome 2 CY2019 - 2022

Safety Outcomes	***Time Period***	***Overall Determination***	***State Performance***

Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate	January-December 2022	Not in Substantial Conformity	88% Substantially Achieved
	January-December 2021	Not in Substantial Conformity	83% Substantially Achieved
	January-December 2020	Not in Substantial Conformity	76% Substantially Achieved
	January-December 2019	Not in Substantial Conformity	63% Substantially Achieved

Safety Outcome 2 Performance Items	***Time Period***	***Performance Item Rating***	
		S	***ANI***
Services to Family to Protect Child(ren) in the Home and Prevent Removal or Reentry into Foster Care	January-December 2022	90.24%	9.76%
	January-December 2021	94.87%	5.13%
	January-December 2020	91.3%	8.7%
	January-December 2019	70.83%	29.17%
Risk and Safety Assessment and Management	January-December 2022	90%	10%
	January-December 2021	83.08%	16.92%
	January-December 2020	75.94%	24.06%
	January-December 2019	63.08%	36.92%
Data Source: Online Monitoring System (OMS)			

Table 4: Safety Indicators CY2022

Statewide Data Indicator	National Performance Target	Directions of Desired Performance	Baseline Data, CY2018	State Data, CY2019	State Data, CY2020	State Data, CY2021	State Data, CY2022	MD Target for 2024
Reentry to foster care in 12 months	8.1%	Lower	16.0%	14.0%	10.0%	10.0%	9.0%	8.1%
Recurrence of Maltreatment	9.5%	Lower	14%	12%	9.0%	7.0%	7.0%	9.5%
Maltreatment in foster care	9.67	Lower	12.4	13.8	12.2	11.7	8.6	9.67

(victimizations per 100,000 days in care)								
Data Source: CJAMS 2022 (CYs 2018-CY2022 Maltreatment items revised due to previous data issues)								

Assessment of Performance:
Maryland did not meet substantial conformity between January 2022 and December 2022 for Safety Outcome 2 as 88% of the cases reviewed received a substantially achieved rating (Data source: OMS). However, this performance demonstrates a positive trend with a five percent increase from CY2021 performance of 83%.

Overall performance for CFSR Item 2: Services to Family to Protect Child(ren) in the Home and Prevent Removal or Re-entry into Foster Care during CY2022 was 90.24%. CFSR Item 3: Risk and Safety Assessment and Management during CY2022 was 90%. In reviewing CFSR data related to risk and safety assessments, a few examples of cases that were areas needing improvement involved a case with multiple substantiated maltreatment allegations during the review period involving similar circumstances and another case where the assessment was completed in the out-of-home case but not the in-home case. DHS/SSA achieved a satisfactory outcome for the recurrence of maltreatment in CY2022 at 7% which is lower than the national target of 9.5% (data source: CJAMS). DHS/SSA child maltreatment of foster youth while in care decreased this reporting period going from 11.7 in CY2021 to 8.6% (victimizations per 100,000 days) in CY2022. Re-entry into foster care in 12 months decreased slightly during CY2022 from 10% in CY2021 to 9% in CY2022. DHS/SSA is continuing to explore data points related to this outcome in efforts to identify ongoing strengths as well as continued areas of concern and to identify strategies likely to improve outcomes.

In reviewing the data from CJAMS, it is noted that DHS/SSA made substantial improvements to CJAMS in 2022 that appear to provide a more accurate representation of the actual compliance rate. It should be noted that data from 2021 has been updated from what was submitted last year after improvements were made to CJAMS in capturing data.

Strengths:
Overall, Maryland has continued to demonstrate efforts towards improvement for safety outcomes. The implementation of the Integrated Practice Model (IPM) training that DHS/SSA developed to increase engagement and teaming efforts between child welfare staff and families served in CPS, Family Preservation, and Foster Care programs is showing a shift in practice evident by the data.

Although the CFSR data shows a decrease in CY2022, 93% of children in Maryland who were victims of indicated or unsubstantiated maltreatment did not have another report within 12 months of the previous maltreatment finding (Maryland's Headline Indicators). Additionally, 95% of children who received Family Preservation Services did not have a maltreatment report within one year according to Maryland's Headline Indicators. Although this is 1% higher than the state goal of <4% it does show the positive impact Family Preservation Services have on supporting families. While Maryland did not meet substantial conformity regarding services to stabilize

families and prevent a child's entry into foster care, the recurrence of maltreatment at 7% which is below the national target (9.5%).

Following the release of the Family Teaming policy in September 2021, which provides guidance to the LDSS on the expectation of teaming as a core practice of Maryland's Integrated Practice Model (IPM), a follow up frequently asked questions (FAQ) document was released in May 2022. The Coach Approach Model training was offered to LDSS leadership staff throughout 2022. The Coach Approach Model works to build LDSS leadership skills in an effort to empower staff to solve problems. This is then modeled for staff to utilize the same skills to empower families to solve problems. A Coach Approach Mentor program was developed and began in April 2022. Coaching is an IPM principle in action to ensure a Safe, Engaged and Well-Prepared Professional Workforce. "Coaching Intensives" continued in 2022 allowing 21 of 24 jurisdictions to complete the coaching intensives by the end of 2023. See Goal 2: Strengthen Workforce Knowledge and Skills to Support the Full Implementation of Maryland's Integrated Practice Model (IPM) for more information on Coaching Intensives. Feedback from CFSR focus groups noted youth and biological parents had an overall positive experience teaming with the LDSS.

One area of concern last year was regarding an audit finding that LDSS did not always complete the required safety and family risk assessments for substance exposed newborn (SEN) cases. Significant enhancements were made in CJAMS to provide reports for substance exposed newborn cases. This report updates daily to allow staff and leadership within the LDSS and SSA to track timely assessments for SEN cases. There were months of daily validation of this report to ensure its accuracy. The validation process included LDSS staff who reviewed the report and provided feedback for improvements. DHS/SSA is already seeing improvements in the timely completion of assessments with this new report available. See Section 3 Item 19 for further information on the SEN report.

In March 2022, SSA started a state-wide push to ensure that all jurisdictions' staff were up-to-date and trained in Child and Adolescent Needs and Strengths (CANS) and /or Child and Adolescent Needs and Strengths-Family (CANS-F), as appropriate. As of December, 20 of the 24 jurisdictions received CANS/CANS-F training and 3 others were making arrangements to complete their training by March. See Service Array section 3 item 29 for further information on strengths and concerns related to available services for youth and families.

Concerns:
Safety Outcome 2 did not meet the target goal of 90%. Maryland did have a decrease in providing services to stabilize families and prevent a child's entry into foster care as shown by the state's CFSR data that went from 94.87% in CY2021 to 90.24% in CY2022. This was an increase of two families that did not receive safety related services from last year. In CFSR data it was noted that with one family there were barriers for the LDSS to provide safety related services although no further details were provided about the barriers. Some overall barriers are discussed in the Service Array section 3 item 29. It will be important to continue to explore what barriers exist and how SSA can support LDSS staff in overcoming these barriers.

Staff challenges were a prominent theme throughout all the CFSR focus groups. Although staff challenges are not systemic areas that are measured through the CFSR process, it was such a consistent theme in the focus groups that it was included in the summary of the focus group.

When there are staff challenges it can make it more difficult for staff to think creatively of safety related services that could be provided to families.

Activities to Improve Performance:
DHS/SSA plans to implement the following activities to improve performance on supporting children safely staying in their homes whenever possible:

- Continue to offer TA to staff using coaching skills as a way of modeling what "teaming" can look like with families.
- Continue "Coaching Intensive" training for supervisors to improve transfer of knowledge to caseworkers to support skills and competencies in creating authentic partnerships with youth and families.
- Continue the Coach Approach training that enhances critical thinking and core components of the IPM.
- Weekly meetings involving SSA's CPS/Family Preservation staff, ACQI, and Systems Development Teams will continue to be held to create User Stories to correct defects and develop enhancements to CJAMS to improve functionality and capture more accurate data including trends around assessments. These weekly meetings also provide for the development of Tip Sheets and How-to Guides to support staff use of CJAMS and accurately recording information and data.

Permanency Outcome 1

Tables 5 and 6 below represent DHS/SSA's performance on Permanency Outcome 1 between January - December 2022.

Table 5: Permanency Outcome 1 CY2019 - 2022

Permanency Outcomes	***Time Period***	***Overall Determination***	***State Performance***
Permanency Outcome 1: Children have permanency and stability in their living situations	January-December 2022	Not in Substantial Conformity	21% Substantially Achieved
	January-December 2021	Not in Substantial Conformity	26% Substantially Achieved
	January-December 2020	Not in Substantial Conformity	12% Substantially Achieved
	January-December 2019	Not in Substantial Conformity	10% Substantially Achieved
Data Source: Online Monitoring System (OMS)			

Table 6: Permanency Outcome 1 Performance Items CY2019 - 2022

Permanency Outcome 1 Performance Items	***Time Period***	***Performance Item Rating***	
		S	***ANI***

Item 4 Stability of Foster Care Placement	January-December 2022	84%	16%
	January-December 2021	74%	26%
	January-December 2020	83%	17%
	January-December 2019	70%	30%
Item 5 Permanency Goal for Child	January-December 2022	50%	50%
	January-December 2021	55%	45%
	January-December 2020	39%	61%
	January-December 2019	25%	75%
Item 6 Achieving Reunification, Guardianship, Adoption, or Other Planned	January-December 2022	31%	69%
	January-December 2021	34%	66%
	January-December 2020	16%	84%
	January-December 2019	22.5%	77.5%
Data Source: Online Monitoring System (OMS)			

Table 7: Permanency Indicators CY2022

Statewide Data Indicator	National Performance Target	Directions of Desired Performance	Baseline Data, CY2018	State Data, CY2019	State Data, CY2020	State Data, CY2021	State Data, CY2022	MD Target for 2024
Permanency in 12 months for children entering foster care	42.7%	Higher	37.5%	34%	30.8% COVID (Mar – Dec)	29.4% COVID (Jan-Jun)	28%	42.7%
Permanency in 12 months for children in foster care 12-23 months	45.9%	Higher	44.3%	34%	24.8% COVID (Mar – Dec)	28.7% COVID (Jan-Jun)	31%	45.9%
Permanency in 12 months for children	31.8%	Higher	28.3%	20%	20.2%	28.4% COVID	28%	31.8%

Statewide Data Indicator	National Performance Target	Directions of Desired Performance	Baseline Data, CY2018	State Data, CY2019	State Data, CY2020	State Data, CY2021	State Data, CY2022	MD Target for 2024
in foster care 24 or more months					COVID (Mar – Dec)	(Jan-Jun)		
Placement stability (moves per 1,000 days in care)	4.12	Lower	4.38	4.36	5.27 COVID (Mar – Dec)	6.47 COVID (Jan-Jun)	6.83	4.12
Data Source: CJAMS (2022)								

Assessment of Performance:
Maryland's percentage of timely permanency within 12 months from the date a child enters foster care is currently 28%. Maryland's target is currently 35.2%. In assessing the decrease noted since 2018, the concern shared by local departments is the reluctance of the courts to approve the proposed permanency plan. Even though LDSS have the authority to change a permanency plan prior to the courts formal order, many LDSS indicate a hesitancy to make changes until the court formally acknowledges the change. This delay impacts timelines, as legal representatives advise the parents to focus on the goal set by the court not by the LDSS. Circumstances, such as mental health and substance use treatment, also impact the courts supporting the permanency plan.

Permanency for children in the12 months of care for 12-23 months is currently 31% while Maryland's target is 43.8%. Permanency for children in foster care for 24+ months is currently 28% while Maryland's target 31.8%. As noted in the CFSR, and in comparison, to last year, Maryland is still challenged in its permanency performance measures. As it relates to the achievement of appropriate permanency goals, 68.75% of cases reviewed were rated as areas needing improvement. Placement stability rates have shown a slight increase in CY2022 with 6.83 moves per 1,000 days in care from the 6.47 moves reported in CY2021 and above the national target of 4.12 indicating that children are experiencing more moves in their foster care placements. In evaluating reasons, anecdotally, youth coming into care have more complex mental health needs, limited local resource homes, and specialized placements such as treatment foster care agencies and congregate care providers are experiencing placement limits due to hiring and retaining staff, contributing to more frequent placement disruptions.

Strengths:
Stability of foster care placement was noted as a strength at 83.75% according to the Item 4 rating in the CFSR. DHS/SSA leadership actively participated in quarterly meetings with the Foster Care Court Improvement Program (FCCIP) and presented the CFSR permanency measures for their review in the fall of 2022. It was agreed that continued focus on the permanency outcomes and strategies to adjust the downward trend of achieving timely permanency (Item 6) outcomes were necessary. A collaborative effort between Permanency, Operations, Court partners and CQI was developed to begin addressing permanency outcomes in CY2023.

Concerns:
The timely identification of appropriate permanency goals (Item 5) at 50% and achieving permanency timely (Item 6) 31.25% remains a concern. Court postponements caused by

continuations, exceptions, or appeals initiated by legal representatives of parents, coupled with a lack of clarity and awareness among the workforce regarding effective concurrent planning, are believed to be significant factors contributing to the delays. Meetings with local jurisdictions and court partners to review permanency data are planned for 2023 to address barriers to permanency. SSA also plans to provide a refresher technical assistance on concurrent planning for both the workforce and court partners.

Activities to Improve Performance:

- DHS/SSA will be providing local staff with technical assistance on concurrent permanency planning, establishing the most beneficial permanency goals, and seeking assistance from the LDSS attorney to be the liaison between the courts and the local departments regarding case specific permanency goal establishment. In 2023, specialized technical assistance in partnership with the FCCIP will be offered to each LDSS with special attention to data and strategic, customized planning to improve permanency outcomes. For upcoming CFSR counties, the overlay of this data analysis and strategic planning for each sample case ahead of the reviews will be offered.
- Targeted recruitment and retention of foster parents as well as consideration of a new training curriculum for foster parents to increase their preparedness to meet the more complex needs of youth is being planned for next year.
- Maryland is also exploring respite options and exploring putting out a new request for proposal (RFP) to solicit new providers for specialized placements and respite options in 2023.

Table 8: Activities to Improve Performance

Activities for Permanency 1	Target Completion Date
REVISED ACTIVITY 2019: Define quality residential treatment services and performance measures.	**2019**
Implementation Status: Completed 2022 Progress: ● During 2022, a proposed definition of residential treatment services and performance measures was developed through the Quality Service Reform Initiative (QSRI) Workgroup. This included proposed clinical and direct care classes of services that would create care standards tied to higher rates for residential treatment facilities that meet the specified standards; updated medical necessity criteria for the clinical services; refined staffing qualifications; a logic model and continuous quality improvement process in partnership with provider organizations; aligned the activities to implement Qualified Residential Treatment Programs (QRTP) with the QSRI, including providing training on a transition tool to support discharge planning that will support the stability of youth exists to permanency; and mapping referral and care pathways for youth to enroll in residential interventions. On-going monitoring of performance would be required for providers to be paid the higher rates. ● Residential childcare (RCC) and child placement agency (CPA) providers were updated on the rate revision process proposal. This proposal is designed to align with QRTP requirements and will be based on performance measures.	
Develop referral mechanisms and pathway documents for decision-making about a child's placement.	**2019**
Implementation Status: In Progress	

Activities for Permanency 1	Target Completion Date
2022 Progress: ● The Placement and Permanency Team members as well as IPM Implementation Team members and the CJAMS Team worked to develop a comprehensive placement referral process that incorporated a new placement referral form, family team decision meeting summary and referral forms, and a placement algorithm to support placement decisions. Stories were written for the new referral form, the family team decision referral process, and the Qualified Individual assessment in alignment with each other. Fillable forms were designed until the stories could be scheduled to be added in CJAMS. The form serves as a mechanism to document the referral process and decision points leading to appropriate placements and expedited permanency. ● Qualified Individuals (QI) were trained to assess youth for QRTP settings. QRTP and Non-Family Based Settings policy SSA# 21-07 was finalized for release on June 21, 2022. Webinar training was provided to LDSS staff on June 28, 2022. This policy also introduced a new Placement Request Form, which will replace the current 818 Purchase of Care referral form as well as the Child Information Form. The June training also incorporated training on the use of the "Attachment A" or Placement Request Form. This form also serves as the referral to Qualified Individuals for assessment for QRTP placements. ● For 2023, enhancements will be made to the placement request form in order to align with the requirements of the Child Information Form that provides information to resource parents. The CJAMS enhancements will include the updated form, which will be able to pre-populate with information already entered in the case record. The CANS decision support tool will be added to CJAMS and included in placement decision support for recommended levels of treatment for children in care. In addition, the QI assessment will be added to CJAMS.	
Begin using a new transition planning tool with the goal of transitioning children out of group homes to non congregate placements that will increase permanency achievement. (Plan to phase in a group of children in group care for 12 + months.)	**2020**
This is a new activity added with a start date scheduled for fall 2020, pending successful completion of the upcoming pilot of the new transition process and tool. SSA plans to phase in use of a transition planning tool for children and youth eventually in all QRTP congregate care settings 12 months or more, starting with the QRTP pilot. **Implementation Status: Delayed** 2022 Progress: ● DHS in conjunction with DJS is still determining the date that this activity will be fully implemented. ● Qualified Individuals identified in the four QRTP pilot jurisdictions were trained and began performing assessments using a transition tool for assessing and reassessing readiness and clinical progress for discharge from a QRTP setting to another setting. This activity will continue to be a focus in 2023. ● The pilot began July 2022 and the six/twelve month length of stay reviews and reassessments will begin in 2023. Additional training and refresher training is planned for 2023.	
Begin implementation of strategies to implement QRTP and tracking of performance data in pilot jurisdictions (new activity added in 2020)	**2020**
Implementation Status: Delayed 2022 Progress: ● QRTP began to be implemented for DHS and DJS July 1, 2022. Due to staffing challenges at LDSS, QRTP was piloted in jurisdictions that were able to nominate QIs who met the qualifications and could be assigned these duties given current staffing shortages. Strategies for QRTP implementation included piloting in the jurisdictions able to nominate Qualified Individuals and planning a learning collaborative to support QIs in implementation. ● A joint QI meeting, including DHS and DJS staff was held November 18, 2022, to gather information regarding process and status of assessments and begin tracking performance data. In November it was	

Activities for Permanency 1	Target Completion Date
learned that due to LDSS staffing turnover, challenges continued for jurisdictions to maintain consistent QIs. ● For 2023, ongoing meetings with QIs for implementation support will be scheduled. Information will be collected from jurisdictions regarding referrals, assessments, outcomes and placement. Provider performance measures will be identified, to monitor compliance with requirements as well as outcome measures. A second application period is planned for 2023 in order for more providers to be designated as QRTP.	
Identify strategies to address permanency through root cause analysis of reassessment findings of youth in QRTPs (new activity added in 2020)	**2020**
Implementation Status: Delayed 2022 Progress ● Due to implementation challenges including QI turnover and placement availability for youth, the root cause analysis exercise was delayed as only 4 QI assessments and successful placements had occurred by the end of 2022.	
Train child Placement & Permanency Units and Providers on new placement tool and process (new activity added in 2020)	**2020**
2022 Progress: ● A standardized referral for placement, Placement Request Form was developed and included as part of the QRTP and Non-Family Based Settings policy (SSA# 21-07). Training was provided to LDSS staff in late June 2022 in preparation for the QRTP implementation on July 1, 2022. This referral form will also be part of revised placement policy, which is in the process of being updated. Efforts are currently under way to have the referral put into the current electronic case information system (CJAMS) to further standardize the referral. Information has been provided to providers during regularly scheduled RTC/RCC Coalition meetings as well as Placement and Permanency Implementation Team meetings. This activity will continue to be a focus during 2023. ● In 2023 the new placement request form will be introduced and discussed during provider meetings, including Placement and Permanency Implementation Team, Provider Relations, PAC. Feedback will be sought for any future enhancements if necessary.	
Provide technical assistance to LDSS and private provider agencies related to decision making about child placement.	**2020**
Implementation Status: Completed/Ongoing 2022 Progress: ● The Placement Unit was able to increase in size during 2022, allowing for increased technical assistance to LDSS and private provider agencies. Technical assistance meetings have been possible with LDSS to include private providers, hospitals, other state agencies including Maryland Department of Health, Developmental Disabilities Administration, and Behavioral Health Administration as appropriate. Technical assistance is being formalized for QIs providing assessment and recommendations for QRTP. Technical assistance and support will continue to be a focus in 2023.	
Analyze CQI related to the appropriate placement efforts and placement stability and refine practice based on results.	**2020-2024**
Implementation Status: Delayed 2022 Progress: ● This past year, quantitative and qualitative data have been compiled and analyzed to evaluate placement stability and placement efforts in local jurisdictions and across the state. Headline Indicator reports, which	

Activities for Permanency 1	Target Completion Date
highlight state and local trends in the placement stability rate (measured by how many moves occurred for every 1,000 days that children were in care) were shared with the local departments on a quarterly basis. Additionally, the nine local jurisdictions who participated in the CFSR in 2022 received a CFSR results report following the on-site review, detailing the local department's strengths in practice and areas in need of improvement based on aggregate results from the on-site review and Headline Indicator data in order to support the development of their Continuous Improvement Plan (CIP). Based on these results, three jurisdictions developed actionable strategies for preventing unplanned placement changes and supporting unstable placements to promote the continuity of the placement that were outlined in their CIP. Barriers to maintain stable placements were illuminated by bi-annual focus groups held with key stakeholders across the child welfare system in April and October 2022 and Orientation and Practical Data Meetings with local departments participating in upcoming on-site reviews. The barriers discussed included lack of available placement resources (i.e., foster homes, group homes, RTCs), youth with mental/behavioral health concerns that necessitate a higher level of care, and insufficient teaming between resource providers and the local departments.	
Review Headline data for Placement Stability process that will ensure that children are placed in the most appropriate placements the first time and monitor the reduction of placement disruptions.	**2020**
Implementation Status: In Progress 2022 Progress: ● A draft of SSA Policy 23-03 has been completed and is scheduled to be released in 2023. This policy will supersede #10-11 and features a comprehensive assessment and combining of policies related to assessing, gathering, and sharing information on the placement needs of youth to match with the most appropriate placement. This policy release has led to building into CJAMS validation of the least restrictive placement efforts. ● In reviewing and monitoring the placement stability headline data between 2021 and 2022, it has been determined that the need to take a deeper dive into the placement disruptions per provider is an important next step as this number has increased slightly from an average of 6.5 placement disruptions per 1,000 days in care to 6.83.	
Revise policy as needed (one on one) in the Placement & Permanency Meeting process (new activity added).	**2020**
Implementation Status: Delayed 2022 Progress: ● Use of one-to-ones to preserve placements and improve stability of youth has become a critical tool. The need to clarify the parameters of using one-to-ones made it necessary to revise the one-to-one policy. It was submitted for review, and issues related to procurement were raised and will need to be addressed before finalization. This activity will be a focus in 2023 to resolve the issues related to procurement and funding to finalize the review of the one-to-one policy.	
Center for Excellence (CfE) in Foster Family Development Resource Parent Training Model Development	**2020**

Activities for Permanency 1	Target Completion Date
Implementation Status: In Progress 2022 Progress: ● Maryland continues to implement the CfE model with the five selected LDSS. The goal of the CfE model is to promote reunification of children with their families of origin and to minimize congregate care placements by providing resource parents with enhanced support services and building partnerships between resource parents and families of origin. The KEEP (Keeping Foster and Kinship Parents Supported and Trained) groups and training model continues to be used to enhance CfE resource parent skills to partner with families of origin and support reunification efforts.	
New Activity 2021: Evaluate fidelity and outcomes for the resource parent model. Use findings to inform refinements to implementation and training. (PIP Activity)	**2024**
Implementation Status: In Progress 2022 Progress: ● The CfE Evaluation and Research Team completed pretests and posttests on resource parents who completed the 16 weeks KEEP groups and training to assess child behavior using a Parent Daily Report/PDR(36 items yes/no caregiver survey), caregiver strain using a Caregiver Strain Questionnaire/CSQ (13 items with scores ranging 13 to 65), and discipline practices. Additionally, brief telephone surveys were conducted with KEEP graduates to ascertain the transfer of learning (TOL) of group concepts (specific to KEEP) and satisfaction with the CfE experience. Evaluation data, including survey outcomes and findings from the telephone interviews suggests that KEEP: Is effective in reducing problematic child behavior • Changes parent externalized behavior • Changes the ratio of positive reinforcement to discipline techniques • Maintains placement (placement stability) • Is enjoyed, endorsed, and appreciated by participants. These tools will continue to be used throughout the training process.	
Begin a process to transition youth out of congregate care and into family settings.	**2021**
Implementation Status: Delayed 2022 Progress: ● The transition of youth out of congregate care to family-based settings continued to be delayed in 2022 due to ongoing capacity challenges with providers. The capacity of providers and child placement agencies continued to be negatively impacted by staffing shortages and the availability of providers to accept youths with complex care needs. Since the implementation of QRTP in July 2022 QIs will be trained in the reassessment of youth needs for continued placement at QRTPs. Due to the placement staffing shortage and shortage of step-down placements, it was decided that the pilot QRTP jurisdictions would begin this process first.	
Implement Placement Referral process statewide to target placement stability	**2021**
Implementation Status: In Process 2022 Progress: ● The new placement request form was finalized and implemented initially as part of the QRTP and Non-Family Based policy (SSA# 21-07, Attachment A) on July 1, 2022. There have been some issues with the functionality of the placement referral form in CJAMS which will be addressed in 2023.	
Design and implement CQI protocols, including performance data from providers	**2021-2024**
Implementation Status: Delayed 2022 Progress:	

Activities for Permanency 1	Target Completion Date
• The QSRI plan was further developed in 2022. This initiative aligns with requirements for QRTPs and is connected to services such as trauma-informed care and aftercare programs that support stability and permanency for youth. • With the full implementation of QSRI, which includes specific standards that align with QRTP, requirements tied to performance for providers is being delayed until 2026. Some CQI implementation to include performance data from providers is being delayed until rates related information specific to the rate development has been completed. • In 2023, some data tracking around specific placement disruptions per provider will be tracked and monitored to inform CQI, training, TA, and other efforts to address the needs of providers to improve stability and permanency.	

Permanency Outcome 2

Table 9: Permanency Outcome 2 CY2019 - 2022

Permanency Outcome	***Time Period***	***Overall Determination***	***State Performance***
Permanency Outcome 2: The continuity of family relationships and connections is preserved for children	January-December 2022	Substantially Achieved	82.5% Substantially Achieved
	January-December 2021	Substantially Achieved	81.25% Substantially Achieved
	January-December 2020	Not in Substantial Conformity	67% Substantially Achieved
	January-December 2019	Not in Substantial Conformity	43% Substantially Achieved
Permanency Outcome 2 Performance Items	***Time Period***	***Performance Item Rating***	
		S	***ANI***
Placement with siblings	January-December 2022	87.18%	12.82%
	January-December 2021	82.4%	17.6%
	January-December 2020	84.2%	15.8%
	January-December 2019	82.5%	17.5%
Permanency Outcome 2 Performance Items	***Time Period***	***Performance Item Rating***	
		S	***ANI***

Visiting with parents and siblings in foster care	January-December 2022	84.06%	15.94%
	January-December 2021	82.5%	17.5%
	January-December 2020	74%	26%
	January-December 2019	51.1%	48.9%
Preserving connections	January-December 2022	86.25%	13.75%
	January-December 2021	88.8%	11.2%
	January-December 2020	83%	17%
	January-December 2019	55%	45%
Relative placement	January-December 2022	79.69%	20.31%
	January-December 2021	74%	26%
	January-December 2020	73%	27%
	January-December 2019	55.3%	44.7%
Relationship of child in care with parents	January-December 2022	74.63%	25.37%
	January-December 2021	74.4%	25.6%
	January-December 2020	77%	23%
	January-December 2019	49.3%	50.7%
Data Source: Online Monitoring System (OMS)			

Assessment of Performance:

DHS/SSA continues to improve its Permanency Outcome 2 by achieving 82.5% conformity in this measure. Although there was a slight decrease in preserving connections, likely due to older youth and acuity of youth entering care requiring specialized placements, numbers diminished from 88.75% in CY2021 to 86.25% for CY2022, all other areas continued to move in a positive upward direction for CY2022: placements with siblings (87.18%), visiting with parents and siblings in foster care (84.06%), relative placements (79.69%) and relationships of child in care

with parents (74.63%). The increase of almost six percent in relative placements over the past year continues to show the state's commitment to partnering with families and children when youth come into care.

Strengths:
There continue to be improvements in placements with siblings, visits with parents and siblings in foster care, relative placements, and relationships of children in care with parents due to the increased use of FTDM's and other family planning meetings. The most prominent improvement of these areas during CY2022 was the increase in youth placed in a relative placement. This improvement is the result of IPM and the state's position on the importance of kin as a placement connection and supports family bonds for youth and biological parents. In CY2022 there were a total of 730 children placed in Formal Kinship/Relative placements. This was 18 percent of the total number of (4,015) children in care during CY2022.

Concerns:
The slight decrease in preserving connections by less than two percent is not the focus in CY2022; the concern was visiting with parents and siblings in foster care which has shown an increase of almost two percent. However, the percentages are so small, they may be an anomaly that balances itself out in CY2023. Maryland will reevaluate the data in CY2023 to determine whether the trend continues.

Activities to Improve Performance:
- Continuation of the previous strategies and activities in the CFSP surrounding the empowerment of families of origin and youth in partnering in their child welfare experiences, the continuation of CfE efforts to support and guide the re-envisioning and implementing expectations of resource parent roles and responsibilities.
- The Placement and Permanency Workgroup will continue to work on policies connected to fostering relationships between both birthparent/families of origin, and the timely achievement of permanency to include family finding as a regularly occurring practice during the lifecycle of the case.
- Continue to monitor/track parent/child/sibling visitation on a quarterly basis and provide technical assistance to the LDSS as needed to ensure quality visitation between birth parents, resource parents, and youth/siblings by SSA staff.
- Coordination between Permanency, Operations, CQI and LDSS to address barriers to maintain family bonds through the utilization of data, technical assistance and other methods to support local departments.

Well-being Outcome 1
Table 10 below represents DHS/SSA performance on Well-being Outcome 1 between January - December 2022.

Table 10: Well-being Outcome 1 CY2019 - 2022

Well-being Outcomes	Time Period	Overall Determination	State Performance

Well-being Outcome 1: Families have enhanced capacity to provide for their children's needs	January-December 2022	Not in Substantial Conformity	43.9% Substantially Achieved
	January-December 2021	Not in Substantial Conformity	48% Substantially Achieved
	January-December 2020	Not in Substantial Conformity	39% Substantially Achieved
	January-December 2019	Not in Substantial Conformity	22% Substantially Achieved
Data Source: Online Monitoring System (OMS)			

Strengths:
The agency continues to show progress in Well-being Outcome 1. As shown in Table 10, the most recent CFSR report from March 2023 with reviews from January to December 2022, indicates 44% of cases reviewed substantially achieved this outcome of families having enhanced capacity to provide for their children's needs. Although not in substantial conformity, the agency has continued progress towards this outcome since 2019. The CFSR Progress Improvement Plan (PIP) target was set for 37.6% and the state's latest performance (January 2022-December 2022) indicates that the agency has surpassed this target and shows a positive trajectory. The state was able to achieve the identified CFSR PIP target for assessing the needs and services to children (Item 12A). The CFSR PIP target was set for 37.6% and the state's CFSR 2022 data for 12A indicates 95% of cases were rated as a strength. For CFSR Item 12C Needs and Needs Assessment and Services to Foster Parents, the CFSR data indicates 84% of cases were rated as a strength. When examining the frequency and quality of caseworker visits with children (Item 14), the CFSR PIP target was 79.4%, and the CFSR data report indicates 95% of cases were rated as a strength.

CFSR Qualitative Focus Group Report of October 2022 stakeholder responses focused on ten key topic areas including involving the parents and children in the case planning process, overall workers acknowledged the significance of including family members in the case planning process and collaboratively establishing goals with them based on the family's willingness and ability to engage with the agency. While youth reported being involved, most biological parents indicated that the caseworker did not team with them to incorporate their goals, strength, and self-identified needs in the case plan. This information supports the CFSR data that indicates the agency is doing slightly better at engaging and teaming with youth than biological parents. This information is consistent with data from the latest CFSR report for Item 12B; Needs Assessment and Services to Parents in which only 45% of cases were rated as a strength. For CFSR Item 13; Child and Family Involvement in Case Planning, 55% of cases were rated as a strength.

Caseworkers and supervisors discussed times in which teaming with families can be challenging, especially when biological parents are absent and actively struggling with substance use and mental illness, addressing staffing challenges and high caseloads, and teaming experiences across and within stakeholder groups. Families, youth, and biological parents who participated in the

focus group expressed mixed experiences of teaming, both positive and negative experiences throughout the life of the case.

The agency does well in assessing the needs and services to children, quality of caseworker visits, and adequately assessing the need of foster parents and providing the services needed to ensure they have the capacity to provide for children in their care. The agency's continued implementation of the IPM into practice has shown improved outcomes with workforce enhancing core practices such as engaging, assessing, and teaming with parents and caregivers as well as service providers. This is informed by qualitative data from FTM and stakeholder interviews in which parents report that their voice was heard when they attended Family Involvement Meetings (FIMs) or FTDMs. Family members expressed that they were able to express themselves and partner with their workers throughout their work together. These activities are described in more detail in the Goal 2: Strengthen workforce knowledge and skills to support the full implementation of Maryland's IPM Section and Item 20 – Written Case Plan.

During this reporting period, the agency continued its efforts to strengthen system partnerships to support children and families. The activities focused on this outcome are described in Goal 5: Strengthen system partnerships to improve safety, permanency, and well-being of youth and families as well as build a prevention service array to support children and families in their homes and community.

Even though this report suggests that there are areas of improvement, the report also suggests that the agency continues to make progress toward meeting and exceeding the CFSR PIP targets.

Concerns:
The agency's ability to visit with parents directly impacts caseworkers' ability to involve parents in assessing needs and in case planning. As previously noted in the Child and Family Services Plan (CFSP), the agency struggled with engaging biological parents to assess needs and case plans. During this reporting period, the most recent CFSR data for Item 15; caseworker visits with parents, reflects 45% of cases rated as a strength. At this time SSA is unable to extract caseworker visits with parents from CJAMS as visits can't be filtered in this capacity.

Data continues to reflect the need for further improvement in accurately assessing the needs and services of children, parents, and foster parents, and providing those services. There is a need to further explore services to meet the needs of older youth related to life skills. The majority of the out of home cases, the foster parent's needs were not identified. Transportation and respite assistance were the most provided service for foster parents. Most of the cases that were an Area Needing Improvement (ANI) were the result of 1) lack of consistent engagement with all applicable parents to assess their needs, 2) lack of service provision which included housing, mental health, and substance abuse, and 3) lack of specialized services for parents with cognitive delays.

Most recent CFSR report from March 2023 with reviews from January to December 2022 for Item 12; Needs and Services of Child, Parents, and Foster Parents indicate 56% of cases reviewed as an area needing improvement. CANS data indicate that for CY2022, there were 14,84 children who entered care and only 26% (386) had a CANS completed. 74% of children who entered care did not have a CANS assessment completed within the first six months.

Also noted above and previously reported, major themes impacting families having enhanced capacity to provide for their children's needs is the service array and the lack of available quality critical services as well as effectively teaming with absent parents and/or parents who are actively struggling with substance use and mental illness. Concerns and activities related to service gap barriers are described in further detail in the Service Array Systemic Factor section.

As previously reported, in many instances, caseworkers have difficulty engaging parents perceived as resistant who may not be as active in the planning and establishing of goals as needed. Caseworkers have identified incarceration, previous negative experiences with the agency or the negative perception of CPS, severe substance abuse, mental illness and absent parenting, and high turnover of caseworker staff as factors contributing to poor parent engagement.

Multiple agency data sources such as the CFSR, Focus Group Sessions, Community Partnership and Services Survey reflect a major theme impacting families having enhanced capacity to provide for their children's needs is the service Array and the lack of availability and quality of critical services as well as parents who are absent and/or actively struggling with substance use and mental illness.

Activities to Improve Performance:
The agency intends to continue to support the workforce in meeting the needs of complex families through continued coaching, application of the Integrated Practice Model and enhanced offering of training at the Child Welfare Academy (CWA). These activities are updated in Goal 4: Improve workforce wellness to reduce the impact of secondary traumatic stress and decrease turnover rates.

Additionally, the agency intends to improve training and technical assistance related to appropriate case planning with the family and enhancing efforts to support an array of services that are available for families to access when needed. The agency will continue to partner with the local departments to reinforce attending training, address staffing and family engagement to address the needs of foster parents and link biological families with supportive services.

The agency also intends to support the workforce to ensure quality assessments are taking place for each child within the IPM framework with a focus on data integrity. There are future opportunities to analyze data to assess disproportionality in CANS and CANS-F assessments, case planning and service provisions. Future activities include a more robust data analysis of these activities. The agency will continue to partner with the local department and CJAMS developers to enhance available reports, assess data validation, and resolve data entry barriers that will support child welfare caseworkers and state oversight.

Well-being Outcome 2
Table 11 below represents DHS/SSA performance on Well-being Outcome 2 between January – December 2022.

Table 11: Well-being Outcome 2 CY2022

Well-Being 2 Outcomes	Overall Determination	State Performance

Well-being Outcome 2: Children receive appropriate services to meet their educational needs	Substantial Conformity	100% Substantially Achieved
Data Source: Online Monitoring System (OMS) 2022		

Table 12: Education Indicator CY2018-2022

Education Measure	*Target*	*CY2018*	*CY2019*	*CY2020*	*CY2021*	*CY2022*
Children entering foster care and enrolled in school within five days	85%	76.7%	81%	43%	76%	92.5%
Data Source: CJAMS (2022)						

Assessment of Performance:
During calendar year CY2022, CFSR Item 16: Educational Needs of the Children, which assessed children receiving appropriate services to meet their educational needs, met substantial conformity with 100% of the 61 cases reviewed rated as substantially achieved and 69 cases were rated as not applicable. Item 16 assesses whether, during the period under review, the agency made concerted efforts to assess children's educational needs at the initial contact with the child (if the case was opened during the period under review) or on an ongoing basis (if the case was opened before the period under review), and whether identified needs were appropriately addressed in case planning and case management activities. This means that for 69 cases no needs were identified and in 61 cases needs were identified and addressed appropriately.

Strengths:
The most recent round of CFSR case reviews found that for Well-Being Outcome 2: Children receive appropriate services to meet their educational needs, was substantially achieved in 100% of cases reviewed. In CY2022, CJAMS data shows 92.5% of children entering foster care were timely enrolled in school within five days of initial placement or a change in placement. This is a significant increase from CY2021, which was 76%, and meets the target goal of 85%. Twenty of the twenty-four jurisdictions in Maryland have timely enrollment performance levels at 85% or higher meeting the target goal, while four jurisdictions are below target performance for timely enrollment. During technical assistance meetings with the LDSS they expressed improvements with the local school systems process and procedures. For example, online enrollment is now the standard in several counties which decreases the time it typically takes to enroll a new student. Also, the data shows that 59% of youth remained in their school or origin after removal which improved school stability. The CJAMS data reflects that 81% of children that entered foster care or changed placements during the summer had timely enrollment in school, but 96.4% of children who entered foster care during the school year had timely enrollment in school. The difference between enrollment during the school year versus summer could be due to the fact that in the summer school office staff work altered schedules (Monday – Thursday) or school offices are closed, which leads to delays in enrollment during the summer.

In addition, the CJAMS data from CY2022 was analyzed based on youth race and ethnicity for any disparities in timely enrollment. The data shows for school age youth (age 5 to 18 years old)

that identified as Asian 5 of 7 (71.43%) were enrolled within 5 days of placement. For Black or African American youth 443 of 495 (92.89%) were enrolled within 5 days of placement and for White youth 214 of 236 (95.11%) were enrolled within 5 days of placement. While 54 of 57 (96.43%) youth that identified as two or more races were enrolled within 5 days of placement. While youth that identified as Asian had a timely enrollment below 90% compared to youth of other races, due to the small sample size it was not a statistically significant difference. At this time there is no evidence of disparity or disproportionately in timely enrollment based on youth race or ethnicity. SSA will continue to improve data capturing within CJAMS and plan to analyze our data to examine disparities and disproportionality in students that receive special education services in the next year.

Throughout the year, the agency worked to enhance partnerships needed to respond to enrollment barriers brought on by the pandemic and beyond. SSA continued to improve contact with LDSS and school systems to ensure educational needs are meet, especially with the increase in requests for students to be enrolled in virtual classes or homeschooled due to difficulty with their academic performance (falling behind due to virtual learning or multiple grades failed due to school behavior and grades). Weekly data reports are sent to LDSS by the ACQI unit for monitoring with a compliance goal of 90% of school age children in out-of-home care having an updated case record. At the end of January 2022, 5% of school age youth did not have a current school record for the year throughout the state of Maryland. In December 2022, that percentage had dropped to 1% of school age youth who did not have a current school record for the year throughout the state of Maryland. In addition, a CJAMS update was made to create alerts for when placement changes occur for youth and quarterly reminders to maintain school records and upload report cards for school age youth.

Concerns:
While CJAMS and CFSR data is showing progression and a positive trajectory, there are persistent barriers that continue to impede children receiving timely enrollment and appropriate education services. Through technical assistance provided to the LDSS, identified contributing factors are the lack of knowledge, availability, and accessibility of services to meet specialized education services such as tutoring and educational testing. A continued contributing factor is inconsistent communication with the local school system to enroll children in an education setting or address attendance concerns. The CJAMS data reflects that 81% of children that entered foster care or changed placements during the summer had timely enrollment in school. Timely enrollment into school for children who enter care continues to be a mutual responsibility between the LDSS caseworker, the Local Education Authority (LEA) school liaison, the school staff involved including the prior and receiving school administration staff as well as the caregivers of the youth. In order to improve our efforts to ensure that children in foster care are enrolled in school and have access to the education services, there needs to be stronger collaboration and communication between all parties. One ongoing issue is keeping the contact lists for LDSS and the local school systems up to date to ensure the appropriate personnel are contacted for example the foster care liaisons, transportation coordinators and non-public school coordinators. The agency will be coordinating regular meetings with the Maryland State Department of Education (MSDE) to ensure any personnel changes are updated on our contact lists which can then be distributed to LDSS.

During technical assistance meetings concerns were expressed by local DSS and school liaisons about the lack of knowledge and confusion usually among new staff around the best interest determination and enrollment process. At times the appropriate and necessary people are not attending the best interest determination meetings which can lead to the receiving or new school's inability to meet the students' educational needs due to lack of educational records, information and coordination with previous school youth attended. This problem is exacerbated if a student is transitioning to a school in another jurisdiction. The agency is working with MSDE to address this issue and plans to create an informational webinar to explain the Best Interest Determination process and to give tips on information that should be shared between schools that will be recorded and can be used by current and new staff whenever they need it. In addition, the agency continues to work with LDSS and provide guidance focused on the quality of education services and how to intervene and support youth in care with education needs.

The Citizens Review Board which reviews cases of children in out-of-home placement and monitors child welfare programs, making recommendations for system improvements during their 2022 Annual Review report (July 1, 2021-June 30, 2022) found that 109 (59%) of the 186 school age children/youths enrolled in school or another educational/vocational program had a 504 or Individualized Education Plan (IEP). A copy of the 504 or IEP plan was uploaded in the record for 69 (63%) of the 109 students. Also, the Citizens Review Board reported that the local boards agreed that 138 (73%) of the 190 children/youths enrolled in school or another educational/vocational program were being appropriately prepared to meet educational goals. This data identifies that there is a continued need for additional support and information needed for youth with special education needs to ensure the agency has the most accurate information and that SSA can advocate for our vulnerable youth to ensure they get the accommodations and services necessary to meet their educational needs. The agency is working with MSDE to identify local school resources that DHS/SSA workers can utilize to support youth and families receiving special education services, such as the Family Support Centers. The agency is exploring training opportunities for the next school year for LDSS on special education compliance requirements and processes to better support and advocate for youth and families. Also, it was identified that additional refinements were necessary to CJAMS to more accurately capture timely enrollment and explain why timely enrollment wasn't achieved and to create the capability of uploading the report card directly to the education tab. These stories are the development team to be created which is expected to occur by June 2023.

Activities to Improve Performance:
Tables 13 and 14 below outline the agency's activities to improve performance on Well-being Outcome 2.

Table 13: Activities to Improve Performance: Well-being Outcome 2

Activities for Educational Needs (Well-being Outcome 2)	Target Completion Date
Improve data sharing between MSDE and DHS/SSA to ensure SSA and LDSS have access to up to date education data for children in care	**June 2024**
Implementation Status: In Progress 2022 Progress:	

● SSA and MSDE developed a new Memorandum of Agreement (MOA) for the local department of social service and local educational agency to enter into for the next five years. An updated section specific to timely data-sharing and increased online access was incorporated to ensure LDSS can access school attendance and grade records for foster youth. An informational webinar highlighting the changes in the MOA template and expectations for the local jurisdictions was provided in November 2022 and attended by over 100 individuals from the 24 jurisdictions. The local department of social services and local educational agencies were encouraged to discuss and collaborate to ensure the MOAs are implemented effectively.	
Conduct a statewide review and analysis of education data related to academic performance for children in out-of-home care (Demographics, School Attendance, Student Performance)	**June 2024**
Implementation Status: In Progress 2022 Progress: ● The foster care milestone is used weekly to review education enrollment and current school information. Improvements in CJAMS have been identified to improve the accuracy of school enrollment and tracking of school performance (report cards) to be completed by June 2023. Data will be reviewed at the end of the 2022-2023 academic year to review school performance for accuracy and completeness, in order to determine if additional enhancements are necessary.	

Table 14: Activities to Improve Performance: School Enrollment

Activities for Measure: Children enrolled in school within 5 days	Target Completion Date
Coordinate with MSDE to develop processes that will enhance collaboration between the LDSS and the LEA around timely school enrollment.	**June 2024**
Implementation Status: In Progress 2022 Progress: ● The Education Stability Memorandum of Agreement has been updated to include additional data sharing between LDSS and LEA's and is in the process of being renewed for a 5-year time period (2023-2028). ● Ongoing coordination with MSDE to ensure contact lists for foster care liaisons, transportation coordinators and special education directors are kept up to date throughout the school year.	
Conduct routine monitoring of school enrollment data related to children in Out-of-Home placements to ensure compliance with education requirements followed by technical assistance to LDSS to address barriers and areas of concern.	**June 2024**
Implementation Status: In Progress 2022 Progress: ● The ACQI unit creates weekly reports of the current documentation in the digital child welfare record, which is sent to all local departments of social services for monitoring. The education specialist monitors the reports for ongoing compliance with the goal of 90% of school age children in out-of-home care having an updated case record and if any county is not meeting that goal technical assistance is offered. The agency conducts quarterly case reviews of children in out-of-home placement for compliance and appropriate documentation. Technical assistance is provided to any jurisdiction that requests assistance. CJAMS enhancements have been identified to improve compliance with enrollment dates and documentation, the creation of those enhancements are scheduled to occur in 2023.	

Well-being Outcome 3

Table 15: Well-being 3 Outcomes CY2019 - 2022

Health Outcomes	Time Period	Overall Determination	State Performance
Well-being Outcome 3: Children receive adequate services to meet their physical and mental health needs	January-December 2022	Not in Substantial Conformity	87.5% Substantially Achieved
	January-December 2021	Not in Substantial Conformity	86% Substantially Achieved
	January-December 2020	Not in Substantial Conformity	85% Substantially Achieved
	January-December 2019	Not in Substantial Conformity	66% Substantially Achieved
Data Source: Online Monitoring System (OMS)			

Table 16: Health Indicators CY2019-2022

Health Measures	*Target*	*CY2019*	*CY2020*	*CY2021*	*CY2022*
Comprehensive Health Assessment for foster children within 60 Days	90%	90%	66%	64%	79%
Annual Health Assessment for foster children in care throughout the year	90%	84%	51%	59%	72%
Annual Dental Assessment for foster children in care throughout the year	90%	66%	45%	51%	52%
Data Source: CJAMS (2022)					

Assessment of Performance:

During this reporting period, DHS/SSA saw a slight increase in Well-Being Outcome 3, children receive adequate services to meet their physical and mental health needs, from 86% to 87.5%. This area continues to be a strength for the agency demonstrating positive and consistent performance in this area. Although Maryland's state of emergency due to the COVID-19 pandemic was lifted July 1, 2021, the agency has continued to collaborate with key stakeholders to provide guidance to LDSS staff and placement providers on accessing health care services including behavioral health, specifically telehealth services that can be accessed post-pandemic when a child, youth, or resource provider has been impacted by COVID.

Health indicator performance measures for CY2022 (Table 16) overall reflects an increase across all health measures with the most notable increases for comprehensive and annual health exams. For CY2022, both comprehensive and annual health exams show an increase of over 10% for timely completion and the dental performance reflects a slight increase of 1%. The agency's progress is moving in a positive trajectory for health performance measures. The agency

continues to assess, explore, and test CJAMS data validity (impacted by the agency's transition to CJAMS in 2019) and post-pandemic in this area as the health data showed a significant decline since 2019.

Strengths:
In terms of ensuring health services are adequately provided and supporting health outcomes including behavioral health, SSA's program staff collaborated throughout the reporting period to facilitate ongoing TA calls with LDSS program staff to discuss performance measures, understand current barriers with completing timely health exams, and provide resources and guidance to maintain progress in this area. During the ACQI TA calls with the LDSS, the role of the MCO's Special Needs Coordinator to support health care services, state agency dental contractor resources available, and behavioral health care coordination services to support local frontline staff &, resource providers and to promote well-being for children in care were areas of focus.

Partnerships with other state agencies continues to be an effective approach to identifying strategies to address barriers and improve health benchmarks at a jurisdictional and state level. DHS/SSA's ongoing health monitoring and technical assistance serves as another method to improve health performance measures by addressing data discrepancies (incomplete, missing, or untimely documentation) and workforce development for frontline staff on understanding the importance of data.

Several activities conducted by the agency during this reporting period served to strengthen and continue progress in this area. See below in the *Activities to Improve Performance* section for more specific information and updates on TA activities conducted with the local jurisdiction during CY2022.

Concerns:
TA sessions with the LDSS' revealed various barriers and challenges that impacted the timely completion of health exams: 1. Workforce vacancies increased across the state, 2. Children/youth detained in juvenile or correctional facilities, 3. Resource or health providers failing to provide LDSS program staff with child's health exam information.

Timely and accurate data entry remains an area that requires improvement. Without accurate and timely documentation of health services, the agency is unable to fully assess health service needs and address barriers. The Activities to Improve Performance section provides additional information.

Activities to Improve Performance:
During this reporting period, SSA's program staff and the ACQI unit collaborated to support monitoring and compliance of health services for children. The ACQI unit, medical director, and program staff conducted 1:1 meetings with local program directors and staff to inform and emphasize the role of the MCO's Special Needs Coordinator to support health care services. In addition, the TA calls identified local success with timely completion of health exams including dental, accurate data entry, and addressed needs/barriers that resulted in non-compliance based on the Out-of-Home (OOH) Milestone Health report. TA calls with LDSS provided an opportunity

for SSA's program staff and ACQI Unit to identify CJAMS enhancements and best practices that may assist with addressing non-compliance and timely completion of health exams. The agency continues to strive towards achieving the health performance measure target through work conducted in-state lead workgroups and collaboration among DHS/SSA's program areas, resource parent association, and state agency partners such as Maryland's Department of Health (MDH) to identify system challenges, resources, and best practices.

Post-pandemic the state has continued its efforts to build strong state and local collaborations to improve communication and collaboration with LDSS staff, community providers, and MDH programs including Medicaid and the Administrative Care Coordination Unit (ACCU). Collaborating with MDH's Managed Care Organization (MCO), HealthySmiles and Public Behavioral Health service provider Optum identifying and targeting systematic challenges and resources has been a top priority to improving coordination of health services for children and youth in foster care. Technical assistance provided to the LDSS has been ongoing to address timely and accurate documentation in CJAMS. State level partners such as Maryland's MCOs, HealthySmiles dental contractor SkyGen, LLC and Optum providing the LDSS support with addressing some specific barriers has been a key strategy employed by the agency. Meaningful engagement with SkyGen, LLC has supported resolutions to dental challenges (provider reimbursement when dental exam required before next routine bi-annual exam; lack of dental providers to serve foster care population; lack of providers in the jurisdiction) and provided a state level contact person to address dental service questions or issues from LDSS staff. SSA program staff collaborated with MDH's Office of Eligibility and Enrollment to address LDSS program staff challenges regarding Medicaid changes, MCO enrollment, and other Medicaid issues that impact timely completion of health services.

Chapin Hall provided TA to the agency's Health Workgroup during the 2021 reporting period and conducted a root cause analysis to further explore contributing factors in this area. The analysis was conducted by workgroup members examining the agency's health data and identifying the situations/circumstances that impacted the timely completion of health exams. As a result of the RCA, during 2022 SSA in partnership with MDH facilitated a virtual Health Services Town Hall held with LDSS foster care staff, state partners, and key external stakeholders to enhance system collaboration and create innovative ways of working together to ensure children and youth receive timely and quality health services. The Town Hall included presentations by Maryland's Foster Care Association, Maryland Department of Health's MCO's and Optum, DHS' Office of Attorney General, and SSA's Placement staff. Topics addressed were the role of the MCO Special Needs Coordinator to support health care coordination for children in foster care, case consultation services available for LDSS program staff to adequately address the mental health needs of children (including substance use), and the responsibilities of the LDSS, resource parents and placement providers to support a child's well-being and timely completion of required health exams. access to health care services including behavioral health services.

The Health Workgroup members are a diverse group of professionals with lived experience and experience in child welfare, health care services including dental, case management, behavioral health and school health services at the state and local level. Workgroup members' active participation allowed for a variety of perspectives on the delivery and coordination of health services for children in foster care and supported shared decision making on strategies or

activities to increase performance measures. This workgroup serves as a feedback loop to inform SSA on systematic changes, workforce development, and state level capacity building. In addition to activities identified in Table 17 below utilizing expertise from workgroup members and engagement with state and local partners, the agency during the next reporting period plans to partner with MDH to facilitate 60-90 min health care services workshops. These workshops will serve to educate LDSS staff and placement providers on health topics including behavioral health and dental needs common among the foster care population as well as answer questions from LDSS staff and resource placement providers related to health care needs, available services, and common Medicaid issues (that delay services being received).

In August 2022, SSA issued an updated health policy, Health Care Services Oversight and Monitoring Policy # 22-09 along with practice guidance. Three health policy trainings were held to ensure compliance with laws and regulations but more importantly support effective implementation of the updated health policy by providing guidance, information, and resources to improve consistency in practice. The target audience was LDSS foster care staff, resource providers (foster parents; private placement providers), and health care practitioners including Local Health Department staff responsible for service coordination. The health policy training was facilitated by SSA with state agency partners MDH's Medicaid Eligibility Unit, MCO providers, and HealthySmiles contractor SkyGen offering information and resources to address barriers impacting timely completion of health exams identified by LDSS staff and resource providers.

The agency continued to participate in the Centers for Medicare and Medicaid (CMS) quality improvement learning collaborative during 2022. The goal is to drive measurable improvement on the completion of comprehensive health assessments within-state guidelines among children and youth newly enrolled in Title IV-E foster care and Medicaid. This is a state level group consisting of Maryland's child welfare agency program staff and Maryland's Department of Health's program staff addressing systemic challenges and pursuing innovative system changes that may lead to improving timely health care for children in foster care.

To address the barrier related to LDSS staff not receiving the child's health exam information from resource providers, SSA's Contracts Unit developed a process to address challenges with private placement providers to ensure the LDSS receives the health information necessary to record the health exam in CJAMS and inform the child's case plan. In addition, the agency continues to work with state partners to address challenges related to transportation (service providers not in close proximity to the child's current placement), issues with providers completing the required health passport (631 forms), and challenges with timely enrollment into a MCO when a child comes into care.

The agency will continue to identify CJAMS system enhancements to reduce worker data entry errors and improve health data reports that may inform the agency on systematic, program and policy changes i.e., capture day-to-day health exam challenges (reason for missed or untimely appts due to circumstances beyond child welfare staff's control).

Table 17 below outlines the agency's activities to improve performance on Well-being Outcome 3.

Table 17: Activities to Improve Performance: Health Indicators

Activities for Health Measures: Comprehensive Assessment within 60 days, Annual Health Assessment, and Dental Assessment	Target Date
Enhance cross-system collaboration with Maryland's Managed Care Organizations (MCO) to improve coordination of health care services including strategies addressing scarcity of dental providers accepting Medicaid and/or limited providers in rural areas impeding dental performance measures and oral health outcomes.	**September 2024**
Implementation Status: In Progress 2022 Progress: ● Monthly: DHS/SSA along with Maryland's MCOs, and SkyGen, LLC (dental contractor) provided support to the LDSS' by attending program staff meetings and individualized case consultation meetings to identify potential solutions for jurisdictional or case specific barriers. Health Services Town Hall scheduled for February 2022	
Conduct routine monitoring of health assessments and provide LDSS Permanency Units TA addressing barriers and areas of concerns to ensure compliance with health performance measures. MCO's and SkyGen, LLC partnering with the state to support and assist the LDSS' with meeting health performance measures.	**December 2024**
Implementation Status: In Progress 2022 Progress: ● Monthly: The agency's ACQI unit oversight and monitoring included meetings with LDSS leadership and foster care program staff to address timely documentation of health exams and jurisdictional challenges faced by the LDSS related to completing the required health exams. Formal presentations by Maryland's MCOs, SkyGen, LLC, and Optum to the LDSS' have been held to support the LDSS with meeting health performance measures. The presentation objectives are to discuss and identify the role of the state level provider as a resource for LDSS staff and an effective approach to coordinating care for children and youth.	
Coordination at state and local levels with MCO's to assess Transitioning Youth barriers to health services and identify strategies to improve health outcomes for this population.	**December 2024**
Implementation Status: In Progress 2022 Progress: Pending ● Preliminary planning on this activity was initiated at the end of 2021. SSA will resume work on this activity during 2023 to identify specific strategies to improve health outcomes for this population.	

Section 3: Systemic Factors

Item 19 - Statewide Information System

The State of Maryland recently implemented the statewide Comprehensive Child Welfare Information System (CCWIS) called Child, Juvenile, and Adult Management System (CJAMS). The child welfare portion of CJAMS has been launched statewide as of July 2020; the adult services and provider module, separate from the public facing Provider Portal, was launched early 2021, March. It is anticipated that the juvenile services portion will be launched in 2024. The web-based application operates on the Maryland Total Human-services Integrated NetworK (MD THINK) platform and is built using open-source technologies. These technologies, frameworks, or architecture were used to improve application performance, scalability, and maintainability.

This product has been customized in almost all areas to serve the requirements of Maryland's child welfare agency.

The agency engages the MDTHINK team weekly to address Data Quality Priorities and the Solutions Roadmap related to the CCWIS Data Quality Plan. During Calendar Year 2022 the Agency improved understanding of documenting efforts in CJAMS (where, how frequently, and multiple places to enter the same information) and identified issues. Having more than one place to document information leads to inconsistencies in documentation across the local departments. Enhancement stories have been written to address key focus areas such as contact notes, court documents, medical appointments, and service plans that affect all programs and data quality. These enhancement stories directly impact and increase quality assurance. During every CQI review, a preliminary debrief is held to allow the reviewers to communicate any challenges they have noted in CJAMS. This information is then discussed with MDThink to determine what enhancements or training needs to occur to resolve the challenge brought forward.
Child welfare caseworkers across all Maryland counties and jurisdictions are responsible for updating the child/case record. CJAMS is the system of record, and all data entry and documents are housed in this system. Each entry uses a date stamp to record the trail of work completed within the system. The system incorporates ticklers and reminders for staff to complete certain required activities.

The State of Maryland utilizes an application interfaced within CJAMS called Quality-Learning-Interaction and Knowledge (QLIK) to report the data points from the CJAMS application, identifying the child's foster care removal status, demographic characteristics, placement and location, and permanency goals for every child who is within foster care. Please refer to Item 22: Permanency Hearings section for more information on permanency goal data. Table 18 below provides detailed information on foster care children in care:

Table 18: Demographics and Location Documented in CJAMS for Children in Foster Care

Child Welfare Demographics and Location in CJAMS CY2022 (January 1, 2022 - December 30, 2022)	
Gender	**% of Children**
Female	49.75%
Male	50.25%
Other	0%
Race	**% of Children**
Black	54.94%
White	29.73%
Other (all other races)	10.44%
Unknown	4.89%

Ethnicity	% of Children
Hispanic	8.71%
Not Hispanic	85.37%
Unknown	5.92%
Placement (location)	**% of Children**
Family Homes	74.50%
Group Homes	11.71
Residential Treatment Centers	2.66%
Independent Living	5.76%
Other	5.37%

For validation of data, we use a variety of ways to ensure the data is pulling as designed. One of those ways is utilizing local departments of social services (LDSS) testers to validate enhancements prior to the release of the enhancement into production. Report validation is completed in the staging environment to ensure all data in the system is being pulled to the report as designed. This logic is validated by referring to the Section-by-Section documents that have been created in partnership with MD THINK. Section-by-Section documents have the established logic of where each data section is being pulled from in the CJAMS System as well as the established compliance measures that align with policy. LDSS staff have access to these documents to aid in the validation and data integrity process. Data validation occurs throughout the system to ensure that the correct data types are entered (i.e., date fields are valid dates, drop downs support consistency with federal data requirements). Enhancements such as data hints have been added throughout the system to support the user with understanding the requirements in the data fields. When data is entered incorrectly, users submit a ticket to address the data error. Please also refer to the Quality Assurance process utilized in other sections of this document.

For data quality, the system is designed to ensure that mandatory fields are required prior to the end user progressing further within the case. Mandatory fields are identified with a red asterisk. When a worker goes to a screen with a field that has a red asterisk, they will not be able to save and move from that screen until the data is entered in the field with the red asterisk. Adoption and Foster Care Analysis and Reporting System (AFCARS) fields are identified with a yellow highlight. These are not all mandatory fields. The limitation with both the red asterisk fields and the AFCARS fields is the worker must go to this area in the CJAMS in order for the mandatory feature of being unable to save to take place. Milestones and the upcoming AFCARS reports are in place to identify areas in a case where pertinent child information is needed but missing at the time the report is run.

Users have access to reports that verify that the data is accurate and entered into CJAMS with varying levels of access. The Foster Care Milestone report tracks data on children receiving care

from authorized foster care service providers in each of the 24 local departments of social services. Users can easily access this report and filter it to show their assigned children in foster care. A wide variety of data is collected on this report, including race, ethnicity, date of birth, gender, placement structure, primary provider or caregiver name, and many other data points which allow the worker to assess, analyze, and determine types of service needs for the youth in foster care. The report includes all children as well as those recently exiting foster care, to verify that there are valid exit dates when appropriate. An AFCARS report is in development and will soon be available to the locals to monitor these federally mandated fields.

Maryland Department of Human Services/Social Services Administration (DHS/SSA) has an established training program to assist workers in understanding data entry within the application and the purpose of the data point. While there are systematic checks within the CJAMS application to alert users to not proceed until certain items are entered, the goal in the coming years is to make the system more intuitive to support users in their work in safeguarding our state's youth and families.

Strengths
DHS/SSA Operations, working closely with the CJAMS coordinators for child welfare, adult services, and resource providers from each local department to provide technical assistance and to identify solutions for both long and short-term issues. In 2022, DHS chose a collaborative strategy for training caseworkers on application updates and changes to help with their understanding of timely data entry of accurate information. The team has used small group sessions such as workgroups focused on Report Development, larger group sessions like LDSS Coordinator Groups for Child Welfare that works with the SSA Training Team in partnership with MD THINK staff, and weekly focus sessions through our Audit, Compliance, and Quality Improvement (ACQI) unit. These sessions allow the Department to evaluate the effectiveness of the reports and listen to potential areas of concern the jurisdictions are facing in their efforts to document data. The ACQI unit researches, evaluates, assesses reports and data, then works with Program staff to communicate through periodic meetings with LDSS leadership and staff to discuss information that is missing, data that is required and why it is required. The state has also expanded its use of technical written documents through the form of how-to guides for CJAMS and all modules.

Concerns:
There are limited personnel resources both at MD THINK and DHS/SSA who can develop necessary enhancements while simultaneously handling the considerable volume of issues that require logging, triage, and resolution and response. MD THINK staff are split between resolving defects and creating enhancements and are often involved in multiple CJAMS modules in addition to working with other agencies on the MD THINK platform.

Through validating reports weekly, it was discovered that cases with outstanding tickets (defects) must be resolved to ensure the data is accurate. During this reporting period there remains migration issues from Children's Electronic Social Services Information Exchange (CHESSIE) to CJAMS that are being resolved by MD THINK. It has been identified that some areas of CJAMS were not originally designed to be conducive to collecting the data we need on families and are not user friendly for workers entering the data, which are both instrumental to sustain data

integrity. The plan in place to mitigate these systematic functioning concerns are enhancements that fully redesign an area in CJAMS. Another way we are working to address these concerns is to enhance the communication around tickets. MD THINK has developed a ticket dashboard to allow end users and supervisors to view and address the status of all tickets in their LDSS. This will aid in ensuring all tickets are approved in a timely manner, agency leadership is able to view the issues their workers are having in the system and then able to advocate at a higher level the trends they are able to see in the local, and SSA staff is able to track this information to determine what training needs are warranted to address ticket trends occurring around the state.

As enhancements continue to occur in the system to capture data needed to identify and support child safety, well-being, and permanency audit trails are being added in the system to properly capture step by step who and what data is being entered in the CJAMS system. This is imperative to identify and track for data quality. Audit trails are being added or enhanced starting in the intake module and throughout the whole CJAMS system. During this review period, barriers were identified around entry/exit dates in the child removal tab. After further review of this data training, enhanced audit trails, and addressing outstanding ticket issues that include data errors and migration concerns are warranted to improve data quality in this area of the system.

Activities to Improve Performance

Table 19: Activities to Improve Performance

Current or planned Activity to improve performance	Target completion date
Organizing for Data Success	
Implement Data Council decisions concerning data security, data standards, and data sharing:	**2019/monitored quarterly**
Implementation Status: In Progress 2022 Progress: ● The Data Council continues to develop recommendations and innovative solutions that will improve the data quality in CJAMS. The Master Database Management (MDM) continues to progress with the integration of additional agencies. In CY2022, MD THINK introduced the Entity 360 (E360) application as a tool to minimize the duplication of clients within CJAMS. While the system has been introduced to the team, The team is finalizing the procedures for consolidating erroneous client records across various agency platforms and we hope to see results in the upcoming year as the system is implemented. The E360 system will support improvements in data integrity for client records. To accompany the introduction of E360, the Data Council has established roles and responsibilities for "Data Stewards" across the MD THINK platform. These roles will standardize the process for data integrity management under the golden record concept. In addition, the IT office has presented a new Data Quality review tool that identifies potential data integrity issues and validates each record according to established standards. SSA has been working with the Data Quality application to use the Foster Care Milestone report as the basis for our initial data validation. Next steps: ● Implementation of Entity 360 and the reduction in duplicate client entries into MD THINK. ● With new leadership at SSA, the agency will look to revamp the Data Quality plan.	
Review the results and feedback concerning data quality in CJAMS with a State/Local Modernization Network that is responsible for reviewing and recommending improvements to the CJAMS system	**2020/monitored quarterly**

Current or planned Activity to improve performance	Target completion date
Implementation Status: In Progress 2022 Progress: ● The department is working to reestablish the Modernization committee as part of the Outcome Improvements Steering Committee (OISC). The Department continues to work with the OISC to review headline indicators and generate feedback about the validity and accuracy of the data. In-depth analysis of the measures occurs during the Child and Family Services Reviews (CFSR) technical assistance reviews with the local departments' leadership and quality assurance staff, providing a strong review of factors that may be impacting the frontline staff's ability to enter the data timely and accurately. Next steps: ● The agency is looking for more jurisdictional involvement in the planning and refining of CJAMS. With the Modernization committee, we will be writing additional enhancements using the end-user perspective.	
Selected data elements will be reviewed as part of the Continuous Quality Improvement (CQI) and CFSR reviews that will be conducted on an ongoing basis, for data accuracy, reliability, and timeliness.	**2021/monitored monthly**
Implementation Status: In Progress 2022 Progress: ● Monthly through Orientation and Practical Data Meetings for local jurisdictions scheduled for upcoming on-site reviews or Continuous Improvement Planning (CIP) Meetings with local departments who recently had an onsite review, the Headline Indicator dashboard (based on the CFSR state-wide indicators) was presented as part of a collaborative discussion with the jurisdiction's leadership and frontline staff. DHS/SSA and the local department reviewed and analyzed the jurisdiction's trend data analysis, data accuracy and timeliness, and system defects or deficiencies that are impacting the integrity of the data. During 2022 there was the addition of storylines concerning race/ethnicity and age along with circumstances of removal for all the permanency measures and the placement stability measure. These storylines allowed for a deeper dive into the jurisdiction outcomes, thus allowing for directed focus areas for the CIP. The Headline Indicator dashboard has been an effective tool to ensure data integrity and accuracy as well as a means for jurisdictions to understand their trend data in comparison to the samples reviewed during the on-site and determine the best areas to focus on in their CIP. Next Steps: ● Continued Orientation and Practical Data Meetings and CIP Meetings with the LDSS to review Headline Indicators dashboards. ● Continue to compare Headline Indicator dashboards and CFSR results for consistency while considering upcoming changes for CFSR Round 4.	
Develop data sharing master agreements that are coordinated through the Data Council to build trust among participating member agencies.	**2022/monitor quarterly**
Implementation Status: In Progress 2022 Progress: ● Data sharing agreements are now in place and are being used when integrating data. The need for additional data sharing agreements has also been evaluated as more collaborative work is occurring, based on new legislative requirements, and other needs identified by the DHS/SSA and the LDSS. Next Steps: ● As new partner agencies are implemented with the MD THINK platform, evaluate the need for data sharing and ensure master sharing agreements are in place.	
Standards for Data Clarity	

Current or planned Activity to improve performance	Target completion date
Establish clear definitions of data elements and picklist values; and distribute data definitions throughout the interagency structure.	**2022/monitor quarterly**
Implementation Status: In Progress 2022 Progress: ● SSA works with MD THINK developers to improve the system, providing updates and informational tools within the system. For example, the team has established help tips using system icons as well as highlighting specific data points critical to AFCARS. These system enhancements have been a point of emphasis during CY2022. ● In addition, the team has recently completed a "Section-by-Section" report review tool, providing a description of the logic to performance measures within reports. This allows the user to use the reports with a better understanding of the data and outcome measures produced in the report. This has been an effective tool for the end-user to evaluate the integrity of the data and further train staff in understanding the importance of data accuracy. These tools are developed for each report and are updated when enhancements or additions are developed. Next Steps: ● New trend Foster Care reports are scheduled for development in the upcoming year. As new reports are developed, the team will need to continue to educate the end user on data definition.	
Provide training and support on an ongoing basis in order to reinforce the reliable use of data elements.	**2022/provided and monitored quarterly**
Implementation Status: In Progress 2022 Progress: ● SSA's continued emphasis on building system understanding during the Child Welfare Academy (CWA) Pre-Service, produces effective results in developing a strong foundation for new staff. The CJAMS How-to guides are updated regularly to give clear guidance to users on the various screens and application functional areas. Updates are made both when there is a system change and when the department identifies inaccurate or potentially confusing information within the guides. MD THINK has an established procedure for handling support tickets for user defects and data concerns. The JIRA ticket system allows the IT office to quickly triage the reported ticket to the appropriate personnel to address the concern and monitor the status of any follow up defect management. Data errors are handled through this process and communication continues between MD THINK and the end-user. Next Steps: ● Develop enhanced reporting surrounding JIRA tickets and support the management at the jurisdictional level to identify areas of concern and training needs.	
Provide caseworkers the support they need to use SmartLists to help guide their work, making the system more user-friendly and useful.	**2023/monitored quarterly**
Implementation Status: In Progress 2022 Progress: ● The use of SmartLists is no longer a goal for the department.	
Technical Tools to Improve Data Quality	
On-line help will be available to include both how to use CJAMS as well as links to policies and practices that relate to the screen and data elements required.	**2023/monitored quarterly**

Current or planned Activity to improve performance	Target completion date
Implementation Status: In Progress 2022 Progress: ● As part of the system development process, the agency develops how-to guides and other training materials to support staff with understanding CJAMS processes and data elements. The materials are a strong supportive service to the end users and are continuously updated as new enhancements are developed. Technical assistance training sessions are also provided to jurisdictions requiring additional guidance and direction on areas of CJAMS where documentation challenges have been identified; these have been done in conjunction with Audit, Compliance, and Quality Improvement (ACQI) around audit compliance areas. Next Steps: ● Practices to support local jurisdictions with validating the data are ongoing. The information provided during the technical assistance training has led the agency to look for better training techniques to support the end user.	
Employ Master Data Management tools across the interagency structure to avoid duplicated clients and services.	**2023/monitored monthly**
Implementation Status: In Progress 2022 Progress: ● Work towards the Master Data Management occurred throughout 2022 with monthly meetings involving MD THINK, Family Investment Administration (FIA), Child Support Enforcement Administration (CSEA), Social Services Administration (SSA), Department of Juvenile Services (DJS), Maryland Department of Health (MDH), and other administrations who share clients and provide services across systems however this has not yet been finalized. Priorities were set regarding the level of reliability for different data types from the various administrations and continues into 2023.	
Revised 2023: Implement a Data Quality Scorecard application	**2024**
Implementation Status: In Progress The agency is in the preliminary stage of the development of a Data Quality Scorecard application utilizing Informatica. The initial focus will be on our Out of Home program performance data. The Data Quality Scorecard application will have rules for Validity, Conformity, and Completeness.	

Case Review System

Item 20 - Written Case Plan

Parent involvement in case planning is tracked 3 ways in Maryland: CFSR, Family Team Decision Meeting (FTDMs) feedback surveys, and Stakeholder Focus Groups. According to CFSR data from CY2022, FTDMs were used to support positive case planning practices with at least one caregiver in 10.0% of all foster care cases reviewed in 2022. The CJAMS system currently is challenged with the ability to extrapolate accurate data for parent's participation in case planning for FTDMs. The stakeholder focus groups do not currently separate data of parents and caregivers, versus others.

The FTDM process underwent transformation in 2022 to gain more feedback from families. Surveys are administered in March and October of each year to gather feedback from participants on their experience at FTDMs. When the surveys were administered to participants in FTDMs in March 2022, the response rate was minimal from parents with only 10% completed.

SSA partnered with the University of Maryland, School of Social Work (UMSSW) to analyze trends in response rates across jurisdictions, explore barriers to survey completion, and revise methodology. The feedback from discussions sessions and brainstorming determined that the survey was too long, impacting parents/caregivers' investment in completing the form, and facilitators didn't know or remember to offer the surveys. Based on the feedback gathered, SSA and UMSSW determined three key strategies to improve parent response rates: 1) shorten the length of the survey, 2) provide incentives, in the form of a $10 electronic gift card, to all participants who complete the survey, and 3) provide clearer guidance to facilitators on how to best implement and distribute surveys to FTDM attendees. In preparation for the October 2022 implementation, all FTDM facilitators across the state were provided the updated surveys and the revised survey implementation protocol. There was an increase in surveys completed in October 2022 from March 2022 suggesting that the three key strategies utilized were effective. During 2022, enhancements to CJAMS were started to assist in data collection. This work will continue into 2023.

Analysis of Performance:
In CY2022 Maryland had 4,053 children in foster care, of which 1,950 or 48% had written case plans. Out of 80 CFSRs done for foster care children in 2022, 17 (21.3%) identified both mother and father as caregivers and being involved in case planning, 20 (25%) reviews identified only the mother as a caregiver and identified her as involved in case planning, 11 (13.8%) reviews identified that both parents were caregivers, but only the mother was involved in case planning, and 2 (2.5%) reviews identified both parents as caregivers, but only the father was involved in case planning.

FTDMs are a primary strategy for collaborating and jointly developing goals and tasks that become a part of written case plans with families. FTDMs are scheduled to address specific concerns: when separation is considered, during youth transitional planning, when a change in placement is being considered, and when there is a potential change in permanency plan. Facilitated family meetings and other visits with parents may also be used for incorporating family voice in written case plans; unfortunately, there is not a way to adequately capture this data yet. Facilitated family meetings are the meetings with families that are facilitated but occur at times other than specified in the new FTDM policy (as indicated above).

Strengths:
FTDMs are the primary strategy for collaborating and jointly developing goals and tasks that become a part of written case plans with families. In March 2022, 85.7% of parents surveyed stated they felt heard at an FTDM meeting. In October 2022, the surveys revealed that 77.7% of parents felt they were given an opportunity to share their goals. In addition, 69% of parents felt the plan addressed their concerns about their family. However, the size of the sample was small compared to the general population served. Maryland will continue to solicit feedback from parents to better understand their involvement in their plan.

Concerns:
Currently, there is not a way to separate out parents' responses to questions on the survey from other participants in the FTDM. To provide some data, although combined, there were decreases

for families and youth in the surveys with regards to FTDM success and case planning from March to October 2022: where understanding what the meeting was about decreased from 95.3% to 89.7%, understanding next steps decreased from 92.1% to 87.5%, and feeling as if the family's needs were discussed decreased from 78% to 76.2%.

In addition, the gap between staff thoughts of success and families' thoughts of success surrounding the FTDM and involving the family in case planning is still wide. This is not unexpected as both groups come with different expectations of outcomes. This data is shared with FTDM facilitators at quarterly meetings to explore barriers and develop strategies to promote family-driven case planning in FTDMs.

Activities to Improve Performance:
To evaluate parents' involvement more accurately in case planning, an update to the CJAMS system is needed. A request will be written in 2023 so that an upgrade can occur for better tracking of the data for parents and caregivers. Additionally, a referral form is being developed to be added to CJAMS which should have an update attached. This update would alert a caseworker of when a meeting needs to be scheduled. FTDM facilitators will be trained on how to use this new form and give feedback for any changes needed.

To increase the participation of parents in the FTDM process and the development of case plans, SSA will design a statewide FTDM brochure to educate parents about the importance of their involvement. Facilitators can provide families with the brochure before the meeting. A consent form will be rewritten, so that it is more family friendly to promote participation in FTDM meetings and case planning.

Stakeholder Focus Group data will be collected in a way that parents/caregiver feedback is able to be shown separately from others especially when it comes to case planning questions. In addition, at least one specific question about case planning involvement will be added to the survey.

Item 21 - Periodic Reviews
Analysis of Performance:
Court Hearings are conducted by the courts every 3-6 months in Maryland depending on the jurisdiction. Periodic Review Hearings are held to review progress in the case at a minimum of 6 months. Of the 2,878 children and youth in care during the entire review period, 49% had review hearings. There was a total of 4,015 children who were in care as of December 31, 2022, of which, 577 were in care up to 6 months. For this subset of children, .69% had a permanency plan hearing, 3.81% had a permanency plan review hearing, and .52% had a guardianship review, and 88.39% did not have a review hearing. In addition, there were 2,878 children in care on the last day of the reporting period who had been in care for at least 1 year. Of this group of children, 19.87% had a permanency plan hearing, 49.20% had a permanency plan review hearing, 8.72% had a guardianship review, and 13.03% had no review. See Table 20 in Item 22: Permanency Hearings.

Of the children and youth that had been in care a year during the last reporting period, the number having had permanency review hearings increased slightly from 42.6% to 49.2%. However, there are many challenges that continue to interfere with the timeliness of periodic reviews occurring

every 6 months including attorney scheduling, contested hearings and findings according to attorney, parent, worker and supervisor focus groups that were held in April and October of 2022. Confusion over concurrent planning was also noted by focus group participants.

Strengths:
There are some jurisdictions whose courts review cases before the 6-month requirement in Maryland and some that require scheduling before the 6-month mark in order to manage the scheduling and contested hearing issues that get in the way of timely reviews.

Concerns:
In both April and October, CQI focus group participants indicated many concerns about the scheduling issues, contested hearings, and confusion over concurrent planning. Some LDSS staff indicated that the courts would not approve concurrent plans at periodic reviews. Some attorney focus group participants perceive that workers don't truly work both plans concurrently. Therefore, the effectiveness of the reviews in achieving timely permanency is impacted by the timeliness of the reviews as well as the content of what is being reviewed in the hearings due to the confusion about concurrent planning.

Activities to Improve Performance:
The Permanency Team at SSA has worked with Court Outreach Workgroup participants to co-design an enhanced concurrent planning refresher training that features both attorney and social worker perspectives on effective concurrent planning. This training is expected to be launched in 2023.

The Permanency Team in partnership with the Foster Care Court Improvement Program (FCCIP) will also be conducting in-depth reviews of data and technical assistance around achieving permanency in 2023. It is intended to assist in looking at root causes for permanency delays including the functioning of the periodic review systemic factor and help LDSS develop individualized teaming with local courts to address the low compliance with timely reviews.

Item 22 - Permanency Hearings

The permanency plan hearings are to be held prior to 12 months in care. The Qlik milestone report also captures when the permanency plan hearings occurred and when there should be another hearing. The milestone reports indicate if a court hearing is missing or completed.

One area of concern is the lack of permanency plan hearings held within 12 months for youth in care. The data below show that 37.44% of youth requiring a permanency plan hearing had one within 12 months of entering care. SSA and the Foster Care Court Improvement Project are planning to take a deeper dive into the data and/or lack of accurate data that may be causing the low percentages of youth in care with permanency plan hearings occurring within 12 months.

Activities to Improve Performance:
SSA will be meeting with each local department to review their individual permanency data and offer technical assistance during CY2023. The purpose of these meetings is to address permanency, specifically looking into any issues that may be causing delays in permanency

hearings. This will help ensure that the local departments are equipped to address permanency effectively in the upcoming year.

The permanency team at SSA will do a Concurrent Permanency Plan refresher training for all locals. During the refresher, the different types of hearings will be discussed.

Table 20: Hearing Types

Permanency Hearing Within 12 months of Entry (N = 1,063)	
Number of Children	**Perm. Plan Hearing**
1,063	398/ 37.44%
Source: CJAMS Children entering care between 1/1/2021 and 12/31/2021 and stayed in care for at least 12 months	

Item 23 - Termination of Parental Rights (TPR)
Analysis of Performance:
During CY22, the data outlined in Table 21 below shows that out of the 4,197 youth in care on January 1, 2022, 2,178 (51.9%) youth were in care for 15 of the past 22 months.

Table 21: TPR Cases CY2022 for the youth who had been in care 15 of 22 months.

	In care as of 1/1/2022	In Care 15 of 22 months	Total TPRs During 2022
Total Children In Care	4,197	2,178	84 (4%)

Strengths:
The CJAMS How-to Guide: Termination of Parental Rights was completed in October 2021. In 2022 LDSS staff reported improvements with documentation in CJAMS as a result of the How to Guide and additional information and support provided through TA offerings.

Most LDSSs have a formal procedure in place for tracking their own TPR timelines. LDSS staff indicate that it is a shared responsibility between the agency, DSS attorneys, and the courts but it can vary from jurisdiction to jurisdiction.

SSA policy directs the LDSS to petition to terminate parental rights for youth who have been in care for 15 out of the past 22 months. There are some instances where it is not appropriate to file for TPR. This would be documented in the court order and in FTDM meetings when planning for permanency plan change.

Concerns:
During TA sessions LDSS staff report experiencing longer than preferred wait times to file for TPR due to court hearings being postponed or continued, disruptions in placements, lack of resources in the communities and the lack of treatment options for the parents. The postponement of hearings can prolong the life of a case especially if it is determined that a parent is making progress.

There continue to be delays in filing for TPR and there can be case specific issues for the delay. Some courts and DSS' request more time for parents to work on the case plans if they are showing progress as this could be a compelling reason to delay filing TPR. An example of this is if parents are struggling with substance use or mental health concerns but start to engage in services outlined in their case plan. Limited availability of resources can delay a parent receiving treatment which can prolong the case. For any delay in the TPR filing, the caseworkers are responsible for documenting these reasons in CJAMS as reasonable efforts that have been completed and also must document compelling reasons not to file for TPR. However, this information is not entered in a field that can be pulled to a report at this time.

There continue to be challenges with accessing data to identify the actual filings of the TPR hearings as well as ensuring that the hearings are occurring timely. DHS/SSA continues to be aware that changes need to occur with regards to data availability for timeliness of TPR filings including the need for additional data from the courts and the LDSS regarding the number of TPR filings and the dates in which the filings have been requested from the courts. Although it appears that there is a general consensus around TPR's being filed timely, the state does not have the data currently within CJAMS to accurately reflect if that is true. Therefore, there is a need for further enhancements to CJAMS to be able to track TPR filings. The state will need to assess youth in care 15 out of the 22 months who did not have a petition for guardianship filed.

Activities to Improve Performance:
CJAMS does not currently track when TPR's are filed, instead tracks when the TPR occurs in court. CJAMS enhancements will need to occur to track the filing of the TPR.

Item 24 - Notification of Hearings
The Permanency and Placement Implementation Team has discussed the concern of notifications of hearings. CJAMS enhancements are being developed to ensure timely notifications of hearings. This will include the right to be heard in any review hearing with respect to the child.

SSA and the Citizens Review Board for Children (CRBC) together have created a work plan for targeted reviews of children in out-of-home placement. This work plan includes conducting case reviews of children in out-of-home care, making timely individual case and systemic child welfare recommendations, and advocating for legislative and systematic child welfare improvements to promote safety and permanency. CRBC conducted a total of 172 individual out-of-home case reviews (each case reviewed represents one child/youth) in 16 Jurisdictions on 48 boards that held reviews during the 3rd quarter of fiscal year 2022.

Foster Parent Ombuds continues to address concerns of resource parents attending hearings, but not being provided the opportunity to be heard. SSA will be following up to address the concerns that may be case specific and with good cause. The Foster Parent Ombuds and LDSS staff continue to share information with foster parents regarding their right to be notified of court hearings as well as any opportunity to be heard at each hearing. The Foster Parent Ombuds responds to and addresses calls from foster families who have not been notified of court hearings.

Each LDSS is required to notify resource parents, pre-adoptive parents, and relative caregivers for any child in the care of the LDSS. Notifications must be documented and placed in the child's record.

Activities to improve performance:
SSA is working with operations to determine ways to track the notification for court hearings in the electronic system of record. SSA will further develop a process to ensure that foster parents, pre-adoptive parents, and relative caregivers of children in foster care are notified of and have the opportunity to be heard in any review hearing held with respect to the child. Each LDSS will be advised that being heard can be in the form of letters, through attorneys, and other means.

Item 25 - Quality Assurance System
Maryland continues to grow and leverage its Quality Assurance (QA)/Continuous Quality Improvement System to implement improvement activities outlined in the 2020-2024 Child and Family Services Plan (CFSP) across all 24 jurisdictions in the state.

Maryland's Quality Assurance System
Maryland's QA system continues to function statewide in alignment with federal standards. DHS/SSA uses performance measures for safety, permanency, and well-being outcomes, known as Headline Indicators, to regularly generate and distribute dashboards reflecting statewide and local department performance. To illuminate the practice that impacts the performance indicators, Maryland continues to conduct monthly qualitative case reviews (MD CFSRs) in four small, two medium, and three large jurisdictions, including Baltimore City (metro) which is reviewed biannually. The ongoing case review schedule spans through March 2024 and includes six 6-month review periods. The reviews use a random sampling methodology to ensure comparability between each 6-month period. In 2022, a total of 130 cases (80 foster care cases and 50 in-home cases) were reviewed across nine LDSS: Baltimore County, Worcester, St. Mary's, Baltimore City, Frederick, Montgomery, Garrett, Wicomico, and Howard. Maryland also implemented stakeholder focus groups in April and October 2022 to evaluate the quality of services and systemic factors impacting the child welfare system in Maryland. The jurisdictions included in the focus groups are jurisdictions that have participated in the CFSR on-site review process in the six months prior to the focus group implementation. In the April 2021 implementation, these jurisdictions included: Baltimore City, Baltimore County, Washington, Worcester, and St. Mary's. In October 2022 implementation, Baltimore City met inclusion criteria again in addition to the following jurisdictions: Montgomery, Frederick, Wicomico, and Garrett. The results of the focus groups were shared with DHS/SSA leadership and will be presented to the OISC in the Spring of 2023.

Maryland has continued implementation of a Local QA Process designed to assess compliance with key child welfare activities, using a standardized tool. These QA reviews allow each LDSS to critically assess the quality of practice and local level processes. Included are case-level and resource-provider level reviews to support an ongoing understanding of LDSS performance related to national and statewide standards. These efforts are informing opportunities to improve practice and ensure quality service delivery for children and families receiving in-home and out-of-home services. In addition, these reviews facilitate targeted course corrections where needed in local jurisdictions. The LDSS QA reviews occur in parallel with the statewide CFSR reviews and aid the state in identifying statewide versus local trends in practice and understanding which additional resources, training, technical assistance, or other supports are needed to address gaps and areas needing improvement. Through these reviews, LDSSs can elevate local insights on performance for DHS/SSA to review cumulatively in tandem with other evidence and data gathered on statewide performance. Insights and trends noted through QA reviews are leveraged for statewide policy and program decision-making while also enabling LDSSs to monitor their own performance to guide locally driven improvement efforts.

Standards to Evaluate the Quality of Services

Maryland's CFSR uses the federal Onsite Review Instrument (OSRI) and Headline Indicator dashboard to evaluate the quality of services provided to children. DHS/SSA identifies practice strengths and needs using CFSR results, which are extracted from reports within the federal Online Monitoring System (OMS), and Headline Indicator dashboard performance. Statewide CFSR results are disseminated to external and internal stakeholders every 6-months or after each review period along with Headline Indicator results. Through bi-annual stakeholder focus groups and Orientation and Practical Data meetings with each local department, LDSS staff can share their experiences with receiving and integrating feedback from DHS/SSA in their local CQI/QA efforts. Additionally, DHS/SSA can review the relevancy and accuracy of the reported CFSR through these conversations as well as identify the supports each LDSS needs in order to interpret and apply the data to their practice. Based on focus group data from the two implementations held in 2022, DHS/SSA continues to bridge the gap between practices efforts and policy compliance by providing technical assistance around data comprehension and exploring the clinical work that is informing the data so that best practices are celebrated and areas in need of improvement are bolstered.

Strengths and Needs of the Service Delivery System

Maryland continues to utilize the statewide and local performance on Headline Indicators, aggregate CFSR performance data, and anecdotal experiences from the LDSS staff and community stakeholders during Orientation and Practical Data meetings to develop comprehensive CFSR Results Reports, which are shared with the local department following their CFSR implementation, and inform discussions during CIP meetings for performance improvement with internal and external stakeholders at a variety of venues within the DHS/SSA Implementation Structure. These discussions are critical for identifying trends across program and service areas and assessing progress in meeting performance goals. During these discussions, stakeholders reflect on practice strengths and barriers to performance and specify contributing factors and analyze root causes to further improve planning conversations. Additionally, focus group results are utilized to understand the service delivery system and implementation of the Family First Prevention Services Act (FFPSA) through the perspectives of staff within the local

departments and external stakeholders, including youth and families, community services providers, resource parents, and court personnel. Over the last year, the CQI Unit has expanded and continues to develop skills around analyzing the various sets of performance data.

Quality Assurance Related Reports

The CQI unit provides the local departments with quantitative and qualitative data to support their internal CQI/QA processes. Quantitative Headline Indicator data reports are provided to the local departments on a quarterly basis to outline trends in the local department's efforts to meet targeted performance outcomes related to safety, permanency, and wellbeing. In 2022, storylines were added to the Headline Indicator reports to support the local departments in considering racial disparities and other child-level factors associated with performance outcomes. Additionally, to support the development of a CIP, each local department is provided a CFSR results report following the completion of their onsite review. The CFSR results report incorporates anecdotal feedback gathered from the local department during their Orientation and Practical Data meeting, qualitative CFSR results, and the Headline Indicators to summarize the identified strengths in practice, area needing improvement, and recommendations to bolster the local department's work with children and families. Lastly, following the focus groups held in April 2022 and October 2022 to explore systemic factors impacting child welfare practice, partners at the UMSSW developed reports based on the qualitative analysis of the focus group transcripts, identifying practice themes as it relates to the CFSR systemic factors and the IPM. The focus group reports were shared with DHS/SSA leadership and will be disseminated to the OISC in the Spring of 2023.

Evaluation of Implemented Program Improvement Measures

The CQI Unit has developed a comprehensive guided template and enhanced skills around facilitating rich discussions following an onsite CFSR case review at a LDSS to inform a data-driven CIP. Following the development of the CIP, the CQI Unit reviews the plan and collaborates with the LDSS to make necessary adjustments prior to finalizing. Once the CIP has been finalized, the CQI Unit continues to provide targeted technical assistance to the LDSS and facilitates CIP Monitoring meetings with the LDSS and necessary stakeholders bi-annually to evaluate the implementation of program improvement measures identified in the CIP. During these monitoring meetings, participants track progress of strategy implementation, celebrate successes, address challenges, and adjust the plan as needed in response to lessons learned. In addition to the bi-annual monitoring meetings, the CQI Unit also monitors and evaluates the implementation of the program improvement measures by corresponding with the LDSS periodically in between the formal meetings via telephone and email. The CQI Unit also continues to develop and share presentations and summary analysis of local and statewide CFSR performance each quarter to the LDSS and SSA leadership.

Plans for Improvement

SSA will continue to work with the LDSS to strengthen their local CQI practices, increase access to CFSR outcomes by internal and external stakeholders, and address limitations to CFSR performance data. A major limitation of the CFSR data is the lack of participation from biological parents, given the voluntary nature of the on-site review. When biological parents decline to participate in the on-site review the CQI Unit reaches out to families directly to explain the CFSR

process and how their feedback will be used to improve practice across the state. If biological parents still decline to participate, reviewers are reliant on biological parents' attorneys or other family members to speak on behalf of the biological parent to avoid case elimination. Family voice is a critical aspect of the CFSR process that is necessary to capture a holistic perspective of the local departments' strengths and weaknesses within their practice. The lack of biological parent participation, particularly for in-home cases, must be explored to better understand barriers to participation and differences among families who choose to participate in the CFSR and those who do not. Further, DHS/SSA will work with the LDSS to review and strategize effective recruitment efforts that will address these identified barriers and ensure an equitable representation of family voice.

One inherent limitation to collecting and analyzing qualitative data is the potential for researcher bias in the data collection and data analysis process. However, within the CFSR process there are several ways that this potential limitation is minimized. First, the use of peer review teams ensures that both peer reviewers are included in the data collection process and must come to an agreement on case ratings which minimizes any potential bias held by any one reviewer. Additionally, the case debrief process provides another layer of discussion of the data. Further, the Quality Assurance process aids in ensuring that the data collected is being analyzed and reported correctly. In addition to these CFSR processes, DHS/SSA will continue to hold regular follow-up trainings for peer reviewers, conduct quality assurance checks on the interviewing process, seek guidance and support from the Children's Bureau, and make adjustments to the process as needed to ensure the validity and consistency of the data compiled through the on-site review instrument. Although there are inherent limitations to collecting and analyzing qualitative data, the benefits of the CFSR and the data gleaned from this process far outweigh any potential limitations.

The usefulness of Headline Indicator data in CQI/QA processes is limited by data accuracy and LDSS staff's data literacy. To address these limitations, DHS/SSA regularly reviews the Headline Indicator dashboards in meetings with each LDSS and provides supplemental information on the individual cases informing each Headline Indicator. The LDSS is then able to reconcile data discrepancies with DHS/SSA in real time and identify data entry challenges in the state's administrative system (i.e., CJAMS) that are impacting data accuracy. Additional TA through department-wide staff training is provided by DHS/SSA to the LDSS to improve the data literacy of all staff across the LDSS hierarchy.

Limitations of the stakeholder focus groups include the inclusion criteria for jurisdiction participation being limited to completing the CFSR in the six months prior to the focus group implementation and low participation rates across stakeholder groups. As such, the qualitative data cannot be reliably generalized to all Maryland jurisdictions, impacting the ability to provide applicable technical assistance to support CQI/QA efforts to all jurisdictions across the state. To address these limitations, the focus groups will be held once a year, starting in 2023, to increase the number of jurisdictions who will be participating in the focus groups. Additionally, DHS/SSA plans to collaborate with individuals with lived experience to revise recruitment materials and methodology to increase the participation rate for youth and families.

Staff and Provider Training System

Item 26 - Initial Staff Training

SSA continues to partner with the CWA to provide mandated pre-service training for all newly hired child welfare case workers and supervisors. Through a long-standing partnership with SSA, the CWA is contracted to support the strategic vision of SSA through the provision of meaningful, impactful training programs and support for the child welfare workforce. This includes a comprehensive, competency based preservice training for new child welfare workers to equip them with the foundational knowledge and skills needed to operationalize Maryland's child welfare transformation efforts including the Integrated Practice Model (IPM) and FFPSA. Grounded in adult learning theory and training best practice, preservice training addresses foundational child welfare concepts, guiding principles and practices, and mandated laws/policies with a strong focus on family-centered, strengths based, culturally responsive, and trauma-responsive practice. Recognizing that training is just one step toward a well-prepared and competent workforce, there is an intentional emphasis on the reinforcement and practical application of knowledge and skills through enhanced simulations and transfer of learning (TOL) opportunities before, during and after training completion. All modules build along a continuum from awareness to knowledge to skill building to application in the field.

New child welfare employees are required to complete pre-service upon starting employment. At the completion of the training all attendees take a competency exam. Potential barriers to the completing pre-service as mandated occur when anyone misses more than 3 hours of a module (generally personal reasons or illness), they then are assigned to make-up the missed modules in the subsequent cycle, or if they resign in the middle of the cohort. These barriers result in extending the pre-service program timeframe. While rare, if a participant doesn’t pass the exam after 3 attempts, they would not be eligible to work in direct child welfare service. If an employee is a licensed social worker with two years of child welfare experience, they can request to be exempt from preservice training and proceed straight to taking the exam. If the individual does not pass the exam, they will be registered to complete the pre-service training.

The pre-service series has remained totally virtual since January 2021. Qualitative feedback from the October 2022 CFSR Focus Group Report indicates that participants and supervisors identify the breadth of learning content and the virtual online format as a noted strength of the series. Each LDSS determines what caseload ratios will look like after completion of pre-service. The virtual training has not had an impact on this practice. As of June 2022, the CJAMS portion of the Pre-Service required that students either participate in their designated local or a regional office, such as Baltimore City. This plan was implemented to allow for hands-on activities to be completed and better connectivity than when in the home.

A total of six (6) pre-service training cycles were offered in 2022, with a total of 139 staff successfully completing the full 8-modules (CWA 2022 Annual Report). As indicated in Table 22 below, data gathered through evaluations over the past four years 2019 to 2022 notably and consistently reflects participant satisfaction with the quality of pre-service training, the expertise of trainers and the relevance and applicability of training to actual worker duties. This longitudinal data is significant and suggests that initial training is helping to build and maintain a knowledgeable, competent, high functioning and outcomes driven workforce. Although there

appears to be a slight decrease in some areas CWA reports that this is not statistically significant given the standard deviations across questions.

Table 22: **Staff Satisfaction with Pre-service Training FY2022**

FY	Number Participating in Pre-service	Staff satisfaction with quality and content of training	Staff satisfaction with trainer knowledge and expertise	Staff belief that training is relevant to their work	Staff belief that they will consistently apply knowledge and skills learned
2022	139	9.4 / 10	9.5 / 10	9.4 / 10	9.1 / 10

*The CWA reports data out on a FY and not a calendar year. This data is pulled from the FY22 CWA IOTTA report. All items were rated on a scale of 1 to 10, with higher scores indicating more positive ratings. There is a standard deviation ranging between 1 and 1.6 for these measurements.

Table 23: **Staff Satisfaction with Pre-service Training CY2019-2022**

CY	Number Participating in Pre-service	Staff satisfaction with quality and content of training	Staff satisfaction with trainer knowledge and expertise	Staff belief that training is relevant to their work	Staff belief that they will consistently apply knowledge and skills learned
2021	140	97%	96%	96%	86%
2020	171	97%	94%	93%	91%
2019	188	96%	94%	94%	89%

Once pre-service training is complete, staff are required to pass the competency exam with a 70% or higher score. There is a comprehensive module-by-module study guide and a class review with a question-and-answer period to help participants prepare for the exam. Staff have three (3) attempts to pass the exam. In instances when staff do not pass the initial exam, they are given written feedback on areas that need continued study and attention for the subsequent make-up exam(s).

The FY2022 CWA Annual Report shows that most staff are passing the exam on their first attempt. Of the total of 139 students, 137 passed the exam:

- 93% (n=129) of staff passed the competency exam in their first attempt
- 6% (n=8) passed the second attempt

The above suggests that staff are leaving pre-service training with knowledge of core competencies related to child welfare practice.

The Foundations Training track is also mandatory and immediately follows pre-service training. This series offers more specialized instruction in child welfare practice areas including Child Protective Services, Family Preservation, Foster Care and Placement and Permanency. The series dissects these service areas to provide participants with a more in-depth knowledge of child welfare legislation, policy, theory, research, and practice. Specialized training by subject matter experts in the areas of Human Sex Trafficking, LGBTQ Competency (both required by Maryland Legislation) and Secondary Traumatic Stress are also thoroughly covered in Foundations Training. To shorten the duration of the Foundations training series and expose participants to

essential learning content earlier in the training cycle, the following courses and themes were moved from Foundations to Pre-Service in January 2022: Intimate Partner Violence, Trauma Informed Case Work and Dynamics of Mental Health and Substance Abuse Practice. From July 2021 through June 2022 appropriately 575 individuals attended foundation track courses. This count encompasses both pre-service staff and current employees.

To assist staff in completing the series more expediently, all Foundations courses must be completed in one year (effective January 2022). It was previously two years. This one-year completion period enables staff to stay more focused on their training requirements and reduce the likelihood of them getting "lost" in the training continuum. With the transition of the CWA Learning Management System (LMS) functions to the DHS LMS, (discussed below) enrollment and completion of the Foundations track can be monitored in a more timely and seamless manner. From July 2021 through June 2022 approximately 575 individuals attended foundation track courses. There are plans for 2023 to enhance data to track on an individual basis completion of Foundation courses (see Tracking Foundations Training Enrollment and Completion below).

Initial Training Strengths:
Quality of Training – As the above training evaluation results indicate, staff and supervisors are satisfied with overall quality and relevance of pre-service training. In October and November 2022 13 CFSR focus groups were conducted during a two-week period. Additionally, individual interviews were conducted with some youth and judges/magistrates who were unable to attend the scheduled focus groups. The jurisdictions were chosen to participate in this focus group series as they each recently participated in the CFSR on-site review process from April 2022 to September 2022. These jurisdictions include Baltimore City, Montgomery County, Frederick County, Wicomico County, and Garrett County. CQI Analysts from SSA along with individuals from each of these jurisdictions identified individuals from each of the following key participant groups as potential participants: youth, biological parents, caseworkers, supervisors, resource parents, resource home workers, attorneys, judges and magistrates, service providers, and directors and assistant directors at each local jurisdiction. A total of 35 individuals participated. Feedback from the CFSR Focus Group Report indicates that the simulation learning activities are particularly helpful to staff. The family engagement simulation activities have been augmented to better assist staff with honing their interpersonal, assessment, motivational interviewing, communication, and case planning skills. Structured debriefing sessions between actors and participants also allows for direct feedback regarding skill development.

Training Attendance – Attendance during pre-service training is noticeably strong with all cohorts maintaining perfect attendance in 2022. Impressively, there was no need for any make-up sessions. This is important in filling the child welfare workforce gap as staff must complete pre-service before independently taking cases.

Staff "Actors" for Simulation Activities – Another strength is the growing and steady "acting pool" of SSA, CWA, and LDSS staff to support training simulations and TOL for staff. The 12-15 staff/actors with already busy work schedules volunteer their time to actively participate in pre-service role plays (various characters and dynamics) to support staff skill development. There is also a consistent pool of 3 to 4 attorneys and court personnel who participate in the simulated court hearings that include Child Protective Services (CPS), case review, and placement scenarios

that require expert testimony on the witness stand and "subpoenaed" client documentation. Qualitative feedback gleaned from participant feedback surveys suggests that participants find the simulations to be helpful in developing and practicing skills in a safe and supportive environment where they can receive structured feedback.

Virtual Training Format – All pre-service modules remain virtual at this time. This has eliminated the need for staff travel and lodging in Baltimore City. This is particularly beneficial for staff who would be traveling from the more remote areas of the state. Participant feedback surveys completed following each preservice module and in-service training include a section on the virtual learning experience. In FY22, 87% of participants across all trainings offered through CWA indicated that the virtual platform was very or somewhat effective, and 94% indicated that they had a very positive or somewhat positive experience with the online platform.

Completion and Approval of Post Training Evaluation Plan – A major accomplishment for pre-service and the entire training system is the approval of the Post Training Evaluation Plan. The Workforce Development Network (WDN) in partnership with CWA had been working on this task for over 2 years. The evaluation plan was vetted and approved by SSA Executive Leadership, the OISC and the LDSS Affiliates (Assistant Directors) in 2022. Post Training Evaluation Surveys will be administered at two- and six-month intervals and will use a Likert rating scale to monitor/evaluate the following:

- As a new worker, pre-service provided me with a solid foundation of relevant knowledge and skills
- Pre-service training is an important component in preparing new child welfare workers for their job
- What I have learned from pre-service has made me a more effective worker
- I have been able to successfully apply what I have learned in pre-service to my work
- I believe I will see a positive impact when I apply what I have learned in pre-service training
- The family engagement, interviewing and court simulations have prepared me to do my job more effectively
- The opportunity to participate in field experiences during pre-service allowed me to apply newly learned and information and skills
- What I learned in training is still valid and beneficial to my current work duties

Initial Training Concerns:
Tracking Foundations Training Enrollment and Completion – This has been a long-standing issue with modest improvements. Staff are assigned full caseloads often immediately upon completion of pre-service training and the passing of the competency exam. The various dynamics of their caseloads may impede their time and availability to fully engage in another and more in-depth training series so quickly after pre-service. Although not specific to the Foundations Training staff did express that they continue to experience "training fatigue" due to frequent and competing training priorities required by SSA. They further added that while they and their supervisors have continuously expressed this concern, there has been no reprieve with training requirements and question if their "Voices are being heard" (CFSR Focus Group Report – October 2022).

Now that the entire training system has been embedded into the HUB, the Foundations Tracking system will be fully implemented in January 2023 and according to the Workforce Development Work Plan (November 2022) will at minimum track the following:

- Completion date of pre-service training
- Enrollment and completion dates of Foundations Courses
- Training attendance record
- Training transcript accessible to participant and supervisor
- Record of Continuing Education Units (CEUs) earned
- Certificates of completion
- Quarterly training reports to supervisors

Item 27 - Ongoing Staff Training

A comprehensive in-service training series is offered to meet the diverse professional development needs of child welfare staff. The in-service training catalog is updated annually and reviewed/modified quarterly by the WDN to ensure alignment with SSA system transformation efforts/initiatives and legislative policies and priorities. Other factors such as recommendations from SSA CQI reviews, participant training surveys and special requests from LDSS managers are also considered when building the training catalog. In-service training is offered steadily throughout the year to approximately 3,500 child welfare staff statewide. The In-service training series is designed to provide staff with the advanced knowledge and skills to successfully meet the diverse and complex needs of children and families served. There were over 150 distinct in-service training topics and 218 in-service training days offered throughout CY2022 (CWA 2022 Annual Report). The in-service series covers a wide and extensive spectrum and includes standard courses such as ethics and child welfare policy, as well as more specialized courses such as clinical diagnoses, paradigms/interventions, trauma informed assessment/intervention, substance abuse/addiction, diverse family dynamics and matters of systemic racism and racial equity and inclusion. Practical skill building courses such as effective communication, case planning and clinical documentation are also offered. Continued attention was given to SSA priority initiatives which include the IPM, Family First Prevention Services, Human Sex Trafficking and LGBTQ Competency. These courses were mandatory and offered consistently throughout the year.

Aggregated CWA quarterly training reports show that 3,044 child welfare staff (duplicated count) participated in various training throughout 2022. Workshops range from 2-3 hours to a full day training. Several of these classes are included in the Foundation Track training series which is required for all new workers upon completing the competency exam. The workshops include:

- Introduction to CPS Responses
- Introduction to Family Preservation
- Introduction to Permanency and Placement
- SOS: Growing Our Practice
- Secondary Traumatic Stress
- Photography 101: Merging Your Trauma and Development Lenses to Capture the Whole Picture
- Enhancing Your Credibility in Court
- Basic LGBTQ Competency for Child Welfare Professionals

- Engaging Child Victims of Sex Trafficking: The Role of the Child Welfare Worker

All the Foundation Track workshops are full day classes. The Foundation Track class training, while required, has not been able to be fully enforced by SSA due to how the system was tracking completion of training. This resulted in a varied participant response of completion. The Workforce Development Workgroup is looking at ways to monitor and enforce the completion of this training.

Evaluation data from in-service sessions highlight the following[1]:

- 93% (N=3,044) were satisfied with the overall quality of in-service training
- 91% (N=3,044) were satisfied with knowledge and expertise of trainers
- 90% (N=3,044) believed the comprehensive scope is conducive to diverse training needs
- 88% (N=3,044) believed training would have direct impact on their job
- 86% (N=3,044) believed they would be able to integrate what they learned in training within two months of the completing the training

In-service Training-Strengths:
Transfer of CWA Training Catalog to DHS LMS (HUB) – The DHS Learning Office, SSA Workforce Development Team and CWA Program Management and IT Teams worked extensively to facilitate the transition of all Learning Management System (LMS) functions from the CWA Ideas@TheInstitute System to the HUB System. This included Pre-Service, Foundations and In-Service training curricula, manuals, handouts, and assignments. In compliance with Section 508 of The Rehabilitation Act of 1975, all content was remediated to support the needs of any staff with identified disabilities. The transfer of the LMS offers a "One Stop Shopping" experience for staff as they can review the training catalog, register for courses, download training materials, and monitor their personal transcripts on the HUB. Additionally, this will assist with the ability to pull unduplicated reports to track completion of required Foundations training and other ongoing training requirements.

LGBTQ Competency Training – This mandated training has remained a priority with a total of 12 full day sessions offered throughout 2022, and a total of 188 staff successfully completed the training. The LGBTQ Competency training is required for all child welfare workers and supervisors. In total, approximately 2,000 have completed the training between 2019-2022. The training is still scheduled routinely as part of the in-service. SSA is re-evaluating the training that was initially offered to staff to come up with an alternative training to complete the mandate. However, it is now part of the mandated Foundations Track effective February 2023.
LGBTQ training continues to be delivered by qualified facilitators. Core content of the training includes but is not limited to: Best Practice Language, Use of Appropriate Pronouns, Early

[1] This data is provided by the CWA. The CWA has reported the same staff may participate in multiple in-service training sessions throughout the year, resulting in a duplicated total count across all offerings. The duplicated count is useful to the CWA in providing individual "units" of training that were provided, with some participants just receiving more units than others. The CWA is reporting that un-duplication is complicated because there is not some sort of collected unique ID that does not change. The CWA is reporting that sometimes names and IDs are entered differently for different sessions and/or names can change for various reasons which can impact our ability to un-duplicate with complete accuracy.

Messaging, Understanding the Coming Out Process, Accessing LGBTQ Community Resources and Strategies to Build an Affirming LGBTQ Organization.

The Family First Prevention Services Training – This training series initially rolled out in October 2021 with 1,032 staff from 13 identified jurisdictions completing the training between October – December 2021, with enrollment posted through the HUB. Cohort II was rolled out in January – February 2022 with HUB reports documenting 243 staff completing the training. A recorded session remains on the HUB for on-going review and access. Course content includes the following:

- History of Family First Legislation
- Guiding principles of Family First Prevention Services
- Understanding Family First Eligibility Criteria
- Role of Workforce in Implementing Family First Services
- Developing Child Specific Case Plans
- Conducting Risk and Safety Assessments

Supervisors monitor training completion and include training as part of performance evaluations.

Supervision Matters – As part of SSA systems transformation efforts and the overall training system redesign, the Supervision Matters Training series was revamped and approved by SSA Leadership and the OISC in December 2022. The redesigned series was vetted by multiple channels to ensure input was gathered from LDSS administrators and SSA leadership. Information was gathered in multiple ways, such as via survey regarding program strengths, challenges and what was missing. Input from past Supervision Matters participants was also gathered which indicated attendee's desire for more practice and time for reflection. Supervision Matters also merged content with that of DHS Fast Track Supervisory Training Series to build a more comprehensive series and reduce duplication across the training series. The redesigned Supervision Matters series is scheduled to rollout in February 2023.

Enrollment for Supervision Matters (voluntary program) is set at 25 participants to facilitate a more intimate environment, increased participation and communication between participants and trainers. A total of 20 supervisors statewide completed the fall/winter 2022 cohort prior to the redesign. The training series is designed to support new supervisors (five or less years as a supervisor) and has enhanced content and sessions to incorporate the following: Racial Equity and Inclusion in Supervision, Effective Coaching and Family First Preventions Services. Supervision Matters is only one option of supervisory training available to staff. Other non-mandatory supervisory training is offered throughout the year (such as Clinical Supervision, Supervisor's Role in a Trauma Responsive Child Welfare System or SOS: The Supervisor's Role in Implementation etc.). Additionally, the DHS Learning Office requires supervisors to attend Fast Track classes.

Continuing Professional Education (CPE) – Child welfare staff also participate in the Continuing Professional Education (CPE) courses purchased by SSA and offered by the University of Maryland. Prior to CY2022 purchased slots covered a wide variety of training topics and multiple slots were allocated among the LDSSs based on the size of their respective child welfare workforce. Due to budget constraints effective January 2022 training slots were only purchased for the social work licensure preparation course. A total of 108 slots were used in

CY2022 with 92% passing the exam. SSA needs to work with DHS Human Resource and Retention services to determine the number of staff who stay with DHS for a year or more after passing the exam.

Virtual Format – Like pre-service and Foundations Training. In-service training remains totally virtual currently. The plan is to eventually offer a hybrid platform for both virtual and in-person sessions, but an implementation has not been determined. In-service participants were asked to evaluate the current training format. A total of 75% of participants completed the survey, and the results are below:

"How Would You Describe Your Overall Learning Experience Using an Online Platform?"

- 62% described experience as very positive
- 32% described experiences as somewhat positive
- 06% described experience as neither positive nor negative
- 0% described experience as somewhat negative

"If Given the Choice between Taking Courses in Person or Online, What Would You Prefer?"

- 53% indicated they prefer online
- 11% indicated they prefer in person
- 32% indicated they prefer a hybrid of both online and in person
- 04% indicated they had no preference

In-service Training Concerns:

Standardized No Show Policy for Training – The WDN was working on a standardized no-show policy to be implemented throughout the state. The goal of the policy is to maximize the return on investment of the offered training, ensuring that staff who commit to the training are participating. DHS/SSA is looking to establish procedures on disciplinary action to be taken as part of the staff performance.

Required In-service Training – Like the no-show policy the WDN was working to identify required annual training for all child welfare staff. This was being done to support the commitment of building and maintaining a knowledgeable and competent workforce. This is currently being reviewed every quarter with our partners at UMSSW.

Activities Planned for 2023

- Enhancements will be implemented for pre-service to include better technical hands-on activities for transfer of knowledge.
- Supervision Matters update will be launched in 2023.
- Utilizing data from the HUB training system to track completion of training that will allow for an unduplicated county.
- Revamping of the Pre-Service training curriculum
- Enhancements to CJAMS with Program Areas highlighted
- Post Training Evaluation Surveys will be administered at two- and six-month intervals and will use a Likert rating scale.

Item 28 - Resource Parent Training
Public Homes
Analysis of Performance:
SSA continued to provide training to current and prospective resource and adoptive parents as is required in accordance with Code of Maryland Regulations (COMAR) 07.02.25.14. Resource parents in Maryland are required to have 27 hours of pre-service training and 10 hours a year of in-service training. Table 24 below shows data from the Child Welfare Academy reports for resource parents that participated in both required pre-service opportunities and in-service opportunities. The state has shown a decrease in participation of new resource parents in pre-service training over the last calendar years with a 48% participation rate among all providers, signaling a decline in recruitment of new foster parents. While the total number of providers is listed for each calendar year, it is important to note that there are resource parents who would have completed their required pre-service training in a prior reporting period and therefore are not captured in the pre-service and in-service training numbers for each calendar year. The resource parents could have also obtained the training hours from outside the Child Welfare Academy (CWA) or Foster Parent College (FPC) which is a nationally recognized interactive, multi-media training course for adoptive, kinship and foster parents. It is available to resource parents 24 hours a day.

Table 24: **CWA Resource Parent Training Participation CY2019-2022**

Resource Parent Training					
Reporting Period	**Total Providers**	**In-Service**		**Pre-Service**	
		Total No. of Providers	**10 or more training hours**	**Total No. of Providers**	**27 or more training hours**
January – December 2022	1,672	408 (24%)*	Not available	501	244 (48.7%)*
January – December 2021	1,021	785	720 (92%)	207	200 (97%)
January – December 2020	763	652	592 (91%)	129	122 (95%)
January – December 2019	1,542	637	521 (82%)	124	123 (99%)

Strengths:
In 2022, SSA partnered with Maryland Resource Parent Association (MRPA), LDSS, and Child Welfare League of America (CWLA) to improve training opportunities for the resource parents in Maryland. In January 2022, MRPA educated resource parents on the topic of Maryland's IPM and other topics of concern such as current policies, day care issues and some concerns around the disbursements of the pandemic relief funds. MRPA continues to provide support services to all

resource families in the state of Maryland providing various virtual trainings and webinars to meet the needs of youths and families. The LDSS continues to offer ongoing training and recruitment efforts for the ongoing needs of resource homes within all 24 jurisdictions. The continuation of virtual training has allowed for greater accessibility and reach across jurisdictions, enabling more resource parents to take advantage of training opportunities throughout the year. SSA and the CWLA provided training to DSS staff and private providers in August of 2022. This was a week-long training and 14 DSS staff were trained, and three private providers were trained. The CWLA training was a train the trainer titled, PRIDE, The New Generation.

SSA also offers the Foster Parent College (FPC) webinars online to all resource parents in Maryland. See CY2022 data below.

Training Activity Report Totals - FPC
Report Period: 1/1/22 – 12/31/22

- Number of individuals who participated in FPC online training: **2,996**
- Number of courses started: **20,183**
- Number of courses completed: **19,473**

Course Evaluation Report
"This report includes course evaluation data submitted anonymously by your members after taking a course on FPC. All responses are optional. Members are asked to rate statements on a scale from one to five, one (1) being strongly disagree and five (5) being strongly agree."

- Total Evaluations: 14,597
- User feedback ratio" 79.9%
- Average Likert scale rating of each statement:
    - *This course added to my knowledge about caring for children – 4.45*
    - *I liked the presentation of the training material – 4.37*
    - *I would recommend this course to others – 4.39*
    - *I feel the training was worth the time spent – 4.39*

The Resource Parent Training (RPT) division of CWA will continue to work collaboratively with SSA, MRPA, contract trainers, and the LDSSs to identify and respond to the training needs of foster, kinship, and adoptive parents throughout the state. There were 413 trainees that attended resource parent training sessions between July 1, 2022, and December 31, 2022. July 1, 2022-September 30, 2022, there were 282 trainees and October 1 -December 3, 2022, there were 131 trainees.

Concerns:
RPT results showed a significant decrease in the number of resource parents that participated in training through the CWA compared to previous years. In 2022 there was a 56% decrease in training completed compared to those who attended training 2021. One area of concern is the enrollment number versus the attended number for the Spring Regional Training that MRPA, SSA and CWA hosted. In April 2022, the Spring Resource Parent conference had 194 enrolled and only 93 participants that attended. This significant difference could be attributed to families enrolling as individuals but attending as a single-family unit which would decrease the number of attendees.

The resource parents were able to participate in a virtual regional training on November 5, 2022. MRPA, SSA and CWA worked collaboratively on the virtual event. For this event, 146 resource parents enrolled in training and 88 parents completed training. Again, this shows a decrease in attendance, but it is important to note that families could have enrolled as individuals and participated as family units.

In 2022, SSA met with LDSS representatives weekly and identified enhancements needed in CJAMS to ensure data was available and could be pulled accurately. In June 2022, SSA began planning for the provider milestone report and the work group continued to meet and discuss different areas of enhancements and information needed for the milestone report. SSA anticipated that the new report would be available in this reporting period, but it did not go to production until February 2023.

Activities to improve:
The milestone report will assist the state with correcting data inaccuracies. There will continue to be enhancements to the milestone report including but not limited to tracking the training hours for resource parents.

The Spring Resource Parent training is scheduled to be held on April 15, 2023, and planning began in November 2022. The training will be virtual again and there are opportunities for resource parents to gain more training hours. See additional progress and activities to improve performance below.

Table 25: Activities to Improve Performance

Resource and Adoptive Parent Training	
Review annual resource home survey data to determine the added support resource parents need.	**Annually**
Implementation Status: In Progress 2022 Progress: ● Due to complete staff turnover in permanency and not having a Resource Home analyst since 2019, the resource parent survey was not implemented in 2022. However, SSA continued to work collaboratively with The Resource Parent Training (RPT) division of CWA, MRPA, contract trainers, and the local departments to identify and respond to the training needs of foster, kinship and adoptive parents throughout the state by reviewing resource parent evaluations from CWA sponsored trainings. Training options that address discipline and medication management requirements were developed based on this feedback.	
Partner with Child Welfare Academy to strengthen resource parent pre-service and in-service training to include the effects of secondary trauma as it relates to child removal from resource homes.	**Semi-annually**
Implementation Status: In Progress 2022 Progress: ● DHS SSA staff designated to partner with the Child Welfare Academy are to be determined in 2023 to further address this need beyond the CFE pilot. The Resource Home Analyst position has been vacant for 3 years.	

• Implementation of the first CFE cohort began in 2022 and training for resource parents on the effects of secondary trauma was included in implementation.	
Work with the Center for Adoption Support and Education to train/strengthen the skills/knowledge of existing child welfare adoption staff.	**2020**
Implementation Status: In Progress 2022 Progress: • SSA worked on an RFP for post adoption services. The RFP does include staff training for child welfare workers. The RFP should be released in 2023.	

Child Placement Agencies and Residential Child Care (RCC) Programs

Residential Child Care Programs (Group Homes)

The training requirements for group home staff is listed in COMAR 14.31.06.05 F. Required training varies based on position:

- RCC Direct Care staff: 40 hours of initial and 40 hours annual training are required and must pass a Residential Child & Youth Care Practitioner (RCYCP) Board approved written examination.
- RCYCP certification requires 30 hours of initial and annual training per COMAR 10.57.03.03 A (2).
- RCC Program Administrators are required to become certified and receive training hours as well. Part of their recertification includes obtaining 40 hours of training every 2 years per COMAR 10.57.02.05 C (3).

All staff training curricula must be approved by the licensing agency per COMAR 14.31.06.05 F (3). To ensure that Residential Child Care Program Professionals (RCCPP) meet the certification requirement DHS's Office of Licensing and Monitoring (OLM) reviews the list of certified RCCPP provided by the Board to ensure that all direct care staff working with youth are certified.

Documentation of training is maintained in the employee record and reviewed by the OLM Licensing Specialist quarterly. Training documentation is also submitted as part of the recertification application to the RCCPP Board. Licensing Specialists also interview a random sample of staff on various subjects, including training. Interviews of RCC staff are completed by OLM on a quarterly basis based on a random sample. Interviews include questions related to whether they have received the necessary training to perform their job duties and whether they felt that the training was useful. Results of the calendar year 2022 review are listed below:

Table 26 Training Compliance for Group Homes/Residential Child Care Centers (RCC) CY2022

# of RCC employee records reviewed*	Compliant for Training	Non-Compliant for Training
382	259 (68%)	123 (32%)

**OLM meets the requirement of sampling 10%+10 (Max 20) per year.*

Programs that have not provided the required training are cited and must complete a Corrective Action Plan (CAP). During 2022 a new process was put in place by OLM to address noncompliance with training requirements which are directly related to safety. These trainings include but are not limited to CPR, First Aid, Behavior Management, and Medication Management. The provider must be in compliance in these areas before their re-licensure is issued.

Child Placement Agencies (Private Homes):
Supervisors and child placement workers employed by Child Placement Agencies (CPAs) are required to receive at least 20 hours of training activities during each employment year and the Chief Administrator annually receives at least 10 hours of training per COMAR 07.05.01.16 B (3). The required training topics are listed in COMAR 07.05.01.16 B (1). OLM provided technical assistance during a bimonthly meeting with providers and reviewed COMAR 07.05.01.16 B (3). During that meeting the regulation was reviewed and a guidance distributed to all child placement agencies with information on how to ensure compliance.

CPAs must provide 24 hours of pre-service training to prospective foster parents per, COMAR 07.05.02.12. In addition, foster parents must receive an additional 20 hours of training every year prior to being recertified as a treatment foster parent as outlined in COMAR 07.02.21.10B. The pre-service training provided to CPA homes is the PRIDE training.

Failure by the foster parent to complete the annual training hours will cause their certification to be suspended or denied. OLM completes random sample interviews of foster parents quarterly utilizing an interview tool that includes questions related to training and whether they have the adequate training knowledge to parent the children placed in their home.

To monitor compliance with training requirements OLM Licensing Specialists complete regular reviews of provider agency records. As of December 2022, there are approximately 1695 certified CPA homes by child placement agencies. The following data was based on the OLM monitoring visits for the year.

Table 27: Training compliance for Child Placement Agencies (CPA) CY2022

# of CPA home records reviewed*	Compliant for Training	Non-Compliant for Training
371	359 (97%)	12 (3%)

**OLM meets the requirement of sampling 10%+10 (Max 20) per year.*

Certified CPA homes date shows a compliance rate of 97%. This remains a consistent rate for the past three years.

Strengths

COMAR does not require quarterly monitoring of private providers; however, the data shows that increased and consistent monitoring results in a higher percentage of compliance. Program managers and licensing specialists schedule meetings to review private provider corrective action plans. Program managers ensure CAPs are detailed and in compliance with COMAR. Licensing specialists are required to monitor compliance by completing a periodic visit with the provider before the CAP can be considered resolved. In addition, a new process of identifying COMAR deficiencies that are safety related has been implemented. Providers are not able to renew their agency's license if any safety related deficiencies are outstanding.

Concerns
The OLM has no concerns with applying COMAR standards equitably across the private providers community.

Activities to Improve Performance:
Table 28 below provides updates to the activities identified to improve performance on the staff and resource parent training system.

Table 28: Activities to Improve Performance

Current or planned Activity to improve performance	Target Completion Date
Child Welfare Training System	
Partner with the CWA to develop and enhance on-line pre-service and in-service training opportunities to increase access, registration, attendance and satisfactory completion of trainings	**September 2020 Quarterly Reviews**
Implementation Status: In Progress 2022 Progress: ● All training for the child welfare workforce, inclusive of preservice and in-service opportunities, remained virtual throughout the year, allowing for greater access and increased participation across the state. ● Mandatory training rollouts, including Family First Prevention Services Act training, were initiated, and completed entirely online in 2022. ● Intentional efforts were made to infuse "best practice" strategies and techniques for virtual training to create an environment that would foster feelings of safety and inclusion and enhance participant engagement and learning. Some examples include the following: polling, break-out rooms, the chat feature, white board, small and large group discussion, community agreements, opportunities to practice critical skills and receive feedback (simulations), temperature checks to gauge learning, and frequent/consistent communication. ● SSA and CWA continued to meet monthly to identify training priorities, address issues and concerns, and discuss any needed changes to the registration/participation/attendance process and requirements to better support full participation and training completion. ● In order to establish clear and consistent expectations around virtual training participation, the participation policy was revised with particular emphasis on the need for participants to have cameras on during training, unless an extenuating circumstance exists. ● The Impact of Training and Technical Assistance (IOTTA) participant feedback survey continued to be distributed to participants following each preservice module and in-service training to assess self-reported participant knowledge gain, skill development and training satisfaction, with a section exclusively devoted to the virtual learning experience. CWA continued to develop and provide quarterly reports with participant registration and attendance numbers, as well as aggregate feedback across	

Current or planned Activity to improve performance	Target Completion Date
trainings. Feedback was readily shared with trainers and utilized by SSA and CWA to inform needed changes and enhancements to the virtual training catalog. ● Training reminders and confirmations were sent to all participants on a consistent basis to encourage attendance. ● Following preservice training completion, participants were automatically enrolled in the first class in the mandatory foundation track, as well as their program specific foundation track course in an effort to support satisfactory training completion. The Workforce Development Network developed preliminary plans to support foundation track completion, including automatic registration and the possibility of incentivizing attendance and linking it to performance reviews. Discussions around feasibility, approval, and implementation of the plan are ongoing. ● Attendance and completion reports continued to be pulled from the HUB to monitor registration and completion rates. In the event that a course had low registration, targeted messages were sent to the LDSS and announcements were made in Administrator and Supervisor meetings to bolster registration numbers *The above items were monitored and completed by the CWA and are being evaluated for a SOW for June '25*.	
Review current pre-service, foundations, and in-service training curricula to evaluate relevance to needs of child welfare workforce and offer suggestions for updates and modifications of content and activities	**September 2020 Quarterly Reviews**
Implementation Status: In Progress 2022 Progress: ● January-December 2022: SSA worked in partnership with CWA to review and evaluate the trainings offered. Meetings occurred on a bi-monthly basis to ensure that the needs of resource parents were met. The list of trainings above in the narrative were proposed and provided based on the attendee evaluations. All attendees continued to keep their camera on and maintain presence throughout the trainings. ● In 2023 meetings with LDSS staff will occur to obtain feedback on curricula. Revision of Supervision Matters, Pre-Service, Family Support worker, Licensure Prep, and Motivational Interviewing will occur in 2023.	
Consult with independent evaluator to conduct data analysis of pre-service, foundations, and in-service trainings to better assess impact and applicability of trainings	**Annually**

Current or planned Activity to improve performance	Target Completion Date
Implementation Status: In Progress 2022 Progress: ● CWA no longer contracts with an outside, independent evaluator. Once CWA merged under the umbrella of The Institute for Innovation and Implementation at the School of Social Work, they utilized internal research analysts and evaluators to support the evaluation efforts including data analysis of pre-service, foundations, and in-service trainings to better assess impact and applicability of trainings. ● In 2023 Post Training Evaluation Surveys will be administered at two- and six-month intervals and will use a Likert rating scale to monitor/evaluate the following: ● As a new worker, pre-service provided me with a solid foundation of relevant knowledge and skills ● Pre-service training is an important component in preparing new child welfare workers for their job ● What I have learned from pre-service has made me a more effective worker ● I have been able to successfully apply what I have learned in pre-service to my work ● I believe I will see a positive impact when I apply what I have learned in pre-service training ● The family engagement, interviewing and court simulations have prepared me to do my job more effectively ● The opportunity to participate in field experiences during pre-service allowed me to apply newly learned and information and skills ● What I learned in training is still valid and beneficial to my current work duties	
Consult with CWA to discuss in-service trainings that receive unsatisfactory ratings, discuss needed modifications and need for continuation of training	**Monthly**
Implementation Status: In Progress 2022 Progress: ● January-December 2022: Training satisfaction data regarding quality of content, trainer expertise and relevance of learning work duties continues to be reviewed during the bi-monthly SSA/CWA meetings. ● Starting in April 2022, CWA reported quarterly to SSA the Child Welfare Academy IOTTA. The IOTTA report shows the number of trainees and the satisfaction of the trainings attended.	
Partner with CWA and LDSSs to develop opportunities for peer-to-peer trainings among staff to better align actual and practical work experiences with training content	**December 2020 Annual Reviews**
Implementation Status: In Progress 2022 Progress: ● January-December 2022: Peer learning circles for participants in the coach approach took place to reinforce and apply skills learned in the model. Professional peers and persons with lived experience also participated in the pre-service simulation activities and will continue to be recruited. ● In 2023 peer learning circles will continue to be offered.	
Request "no show" training data from CWA to strategize with LDSSs to ensure attendance and completion of trainings	**Quarterly/Annual Reviews**
Implementation Status: In Progress 2022 Progress: Ongoing ● January-December 2022 – No show data continued to be reviewed. ● This data will continue to be reviewed in 2023	

Current or planned Activity to improve performance	Target Completion Date
Review training reports and data analyses monthly with CWA to: ● **evaluate participant satisfaction** ● **identify well received and non-well received trainings** ● **identify needed modifications to training content** ● **evaluate instruction methodologies** ● **identify need to retain or replace trainers** **This data will continue to be reviewed in 2023**	**Monthly**
Implementation Status: In Progress 2022 Progress: ● January - December 2022 - CWA provides quarterly training reports (IOTTA) to SSA for review, discussions, and recommendations for change. This process will continue. ● This process will continue in 2023.	
Share data from training reports with SSA WDN to further identify and support training needs of staff	**Monthly**
Implementation Status: In Progress 2022 Progress: ● January-December 2022: SSA worked in partnership with CWA to review and evaluate the trainings offered. Meetings occurred on a bi-monthly basis to identify further training needs of staff. Training evaluation data was shared with the IPM Implementation Team and OISC to discuss the feedback concerning the IPM Coaching and FFPSA trainings. ● This training continued in 2023	
Partner with CWA and LDSSs to develop and implement 3-4-month post training evaluation and follow-up process for select subset of in-service trainings to gauge ongoing applicability of training	**Quarterly/Annual Reviews**
Implementation Status: In Progress 2022 Progress: ● In the fall of 2022 SSA Executive Leadership, the OISC, and the LDSS Affiliates (Assistant Directors) approved Post Training Evaluation Surveys that began to be administered at two- and six-month intervals. ● In 2023 Post Training Evaluation Surveys will be administered at two- and six-month intervals and will use a Likert rating scale to monitor/evaluate the following: ● As a new worker, pre-service provided me with a solid foundation of relevant knowledge and skills ● Pre-service training is an important component in preparing new child welfare workers for their job ● What I have learned from pre-service has made me a more effective worker ● I have been able to successfully apply what I have learned in pre-service to my work ● I believe I will see a positive impact when I apply what I have learned in pre-service training ● The family engagement, interviewing and court simulations have prepared me to do my job more effectively ● The opportunity to participate in field experiences during pre-service allowed me to apply newly learned and information and skills ● What I learned in training is still valid and beneficial to my current work duties	
Establish ongoing training standards and requirements for all child welfare staff to maintain a well-prepared workforce.	**December 2020 Annual Reviews**

Current or planned Activity to improve performance	Target Completion Date
● **determine required number of training hours** ● **determine required training modules for workers and supervisors** ● **require trainings for both licensed and unlicensed staff**	
Implementation Status: Completed 2022 Progress: ● Foundation training requirements were established. Other ongoing training requirements are established on an as needed basis. For example, Family First training was required and tracked for completion see The Family First Prevention Services Training information under Ongoing Staff Training. ● These Foundations training requirements will be revisited and redefined in 2023	
Consult with SSA WDN to further analyze program and evaluation data to identify and support training needs of staff.	**Bi-Monthly**
Implementation Status: In Progress 2022 Progress: ● Quarterly January-December the WDN reviewed/modified training to ensure alignment with SSA system transformation efforts/initiatives and legislative policies and priorities. Recommendations from SSA CQI reviews, participant training surveys and special requests from LDSS managers were also reviewed to assist in training enhancements. ● This process will continue in 2023	
Develop a monthly resource home milestone report to track all resource home compliance which will include training (pre- and in-service) training data.	**2020**
Implementation Status: Delayed 2022 Progress: ● The development of the Provider module milestone experienced some delays with full production. While the report was ready for use at the end of 2022, further validation to assure the integrity of the data reported was necessary before availability is granted to users. The report will be ready in early 2023.	
Resource Parent Training	
Provide technical assistance to the LDSS to ensure that documentation of training is accurately recorded.	**September 2019 Annual Reviews**
Implementation Status: In Progress 2022 Progress: ● SSA has been unable to fill the resource home analyst position in over a year. This lack of staffing has made it difficult to monitor documentation of provider training. However, CWA has offered support and TA to resource parents in tracking and maintaining documentation for any training that they have provided in their training platform. ● This process will continue in 2023	
Implement a management level review of CAP responses to improve the quality of the responses and increase effectiveness OLM.	**2022/Monthly**
Implementation Status: Ongoing 2022 Progress: ● Monthly: Meetings held to review each CAP submitted for compliance with COMAR by the Licensing Specialist and Program Manager. Program Managers ensure the CAPs are detailed and have target dates	

Current or planned Activity to improve performance	Target Completion Date
that are appropriate to the violation. The CAP response form has been redesigned to provide clear detailed and specific timeframes for becoming COMAR compliant.	
Revise the monitoring process to include quarterly monitoring of major regulatory standards. Currently the Licensing Specialists are required to meet all the licensing requirements over the 2-year licensing period (OLM).	**2022/quarterly**
Implementation Status: Ongoing 2022 Progress: ● Licensing Specialists with oversight from Program Managers perform quarterly site visits that require monitoring of: ○ 10 records plus 10% of the current census of youth, staff, and foster parents per quarter. ○ Conduct two foster parent interviews, two staff interviews and two youth interviews per quarter. ○ Conduct physical plant inspection of all sites per quarter.	
Develop and implement a structured follow-up to CAP responses and repeat findings (OLM).	**2022/Quarterly**
Implementation Status: Ongoing 2022 Progress: ● Licensing specialists with oversight from program managers, perform periodic site visits specific to the deficiency/violation to ensure the deficiency/violation is corrected and implemented prior to OLM CAP approval. Repeat violations require a detailed step by step plan with staggered target dates to ensure eradication of recurring violations. OLM is taking further disciplinary action for repeat serious violations by issuing moratoriums/sanctions.	

Service Array

Item 29 - Service Array and Resource Development System

Assessment of Performance:

During this reporting year, DHS/SSA continued to build from the previous years' service array assessment findings and leverage opportunities to enhance and expand its service array and resource development system. The agency continues to utilize formal assessment tools, implementation structure, qualitative data from stakeholders, focus group, Community Partnership Survey and CFSR to assess the service needs of children and families and the State's ability to meet those needs across the child welfare service continuum.

Services that address the strengths and needs of children and families and determine needs

The agency assesses the strengths and needs of children through several formal and informal tools. Overall, the agency performs well as assessing needs; however, some assessment tools are utilized more appropriately and efficiently than others. The latest CFSR data indicates the agency performs well in assessing risk and safety. For Risk and Safety Assessment and Management (Item 3), which explores the agency's efforts to assess and address the risk and safety concerns relating to the child(ren) in their own homes or while in foster care, 90% of cases reviewed were

rated as a strength. This is a slight increase from the 2021 CFSR which was 83%. The agency performs well in assessing needs and services to foster parents and children; however, assessing the needs and services of parents continues to be an area needing improvement. The latest round of CFSR, for Item 12B, 45% of cases reviewed were rated as strength and 55% were rated as an area needing improvement.

As reported in previous reports, to continually assess the strengths and needs of children and families, the agency utilizes collaborative assessment tools such as the Maryland Family Risk Assessment (MFRA), Maryland Safety Assessment for Every Child (SAFE-C), Child and Adolescent Needs & Strengths (CANS), and Child and Adolescent Needs & Strengths-Family (CANS-F). These assessment tools are used to organize the collective knowledge and understanding of the individuals and family's needs and to support clear communication and sound recommendations when making safety, permanency, and well-being decisions.

During this reporting year, SSA has begun the development of an "assessment policy" and "collaborative assessment guidance" to help the workforce better understand the connection between all our system's assessment tools in order to better apply them to critical decision making throughout system interventions for families.

The Maryland Family Risk Assessment

The MFRA is used to help child welfare staff identify risk factors and determine the services the family needs to reduce risk to the child(ren). The use of the MFRA assists LDSSs by identifying if the family needs on-going services and what services are needed for the family to reduce risk. This includes the Maryland Family Initial Risk Assessment (MFIRA), which is the initial risk assessment completed for every child as part of the Child Protective Services (CPS) investigation. Subsequent Maryland Family Risk Re-Assessments (MFRRA) are completed within 30 calendar days of acceptance of services and whenever there are significant changes in family structure or dynamics and again prior to termination of services. For CY2022, children served in CPS and Family Preservation there were a total of 23,781, Initial MFIRA completed. Of the MFIRA completed, 14% was rated as low risk, 36% was rated as medium risk, 31% was rated as high risk, and 14% was rated as very high risk and 6 % of cases were missing a rating.

The Maryland Safety Assessment for Every Child

The SAFE-C is a tool designed to alert staff to situations that pose an imminent danger to children and is completed. The SAFE-C is completed for every child receiving services and is conducted for both children in-home and out-of-home placements at the time a child is initially placed in out-of-home placement and after placement changes. For CY2022 for children served in CPS, there were a total of 23,780 SAFE-C assessments completed. For children served in Family preservation services; there were a total of 11,308 SAFE-C assessments conducted. For children in out-of-home placement, there were a total of 4172 SAFE-C assessments completed.

The CANS and CANS-F

The CANS is a tool for identifying needs and collaborating in planning service delivery with families at initial and on-going intervention points throughout a case. The CANS is used to identify on-going needs of children and youth in care and to plan for service needs collaboratively with caregivers and birth families to meet permanency and reunification goals. Initial CANS

assessments are completed within 60 days of case opening and subsequently every 180 days until case closure. Of the children who entered care in CY2022 (1, 484) only 26% (386) had a CANS completed. Seventy-four (74%) percent of children who entered care did not have a CANS assessment completed.

The CANS-F for In-Home Services is an assessment intended to support caseworkers in a consensus-based approach to assessment and planning with families and youth. All Families who received Family Preservation Services (FPS) will have a CANS-F completed. The tool assists with family and youth engagement, accurate identification of a family's needs and strengths and the measurement of change in functioning throughout the life of a case. Initial CANS-F assessments are completed within 45 days of case opening and subsequently every 90 days until case closure and within 7 days of case closure. Of the children who received Family Preservation services in 2022 (13,130), 82% of children received at least one CANS-F assessment. This is an increase from the previous year's assessments.

In March, SSA started a state-wide push to ensure that all jurisdictions' staff were up-to-date and trained in CANS and /or CANS-F as appropriate. Data trends indicate that the assessments are not being conducted accurately. A large percentage of CANS and CANS-F assessments have no needs identified. As of December, 20 of the 24 jurisdictions received CANS/CANS-F training and 3 others were making arrangements to complete their training by March. In November, SSA began receiving routine CANS data after accuracy issues were resolved. Planning has commenced to support proper use of the tool as data reflects poor compliance in partnership with our TA partners to identify how CANS can be used to identify the needs of youth and inform practice tools. Linking CANS to practice effectively is believed will improve assessment completion rates.

The Lethality Assessment is a screening tool used to promote the assessment for intimate partner violence to enhance victim safety as a standard of practice. The assessment is used to assist Child Welfare and Adult Services caseworkers assess for both safety and risk concerns to determine the victim's risk of being killed by an intimate partner. The Lethality Assessment is initiated as soon as the worker suspects intimate partner violence and may be administered at any time while there is an active case with the agency. With the victim's consent, all high danger screens are referred to the domestic violence hotline and are offered services to prevent further abuse and assess the risk and safety in the home.

In February 2022, SSA identified local jurisdictions that were struggling to either complete lethality assessments or identify supportive services for the victim-parent and the children in their care. Those local jurisdictions were connected with other LDSS who were meeting the screening and reporting requirement and have been working closely with the local domestic violence service professional and other community supportive services. As a result of this initiative, SSA received 100% of the lethality reports for all 24 jurisdictions in 2022, LDSS who were previously struggling with reports and resources reported that they successfully connected with domestic violence services providers and resources from surrounding counties and have improved their partnership with local providers.

Services to meet the needs of children and families to create a safe home environment and services to enable children to stay safely with their parents when reasonable

The agency's progress towards enhancing the Service Array and service availability to meet the needs of children and families, are indicated in the latest CFSR outcomes. When assessing the provision of services to families to protect children in their homes and prevent removal or re-entry into foster care (Safety Outcome 2) the most recent CFSR data shows LDSS programs at 90%. During this reporting period, the agency engaged select LDSS in interviews to learn more about successful interventions with service agencies and how service gaps are impacting serving families. Based on information gathered through interviews, a summary of recommendations was developed for the agency to utilize in future strategic planning. Some recommendations include establishing a state-wide vision across Maryland state agencies to ensure agencies are on one accord around prioritizing Children in Foster Care and their necessary services and helping LDSS make better use of federal and state funding and support to better align funding with service needs.

While progress is made in some areas, there continues to be persistent and systematic service gaps in some areas particularly the mental and behavioral health services. During this reporting period, the agency began to track the types of children and situations in which children were receiving CPS or FPS and had a hospital overstay due to lack of appropriate behavioral health setting available to them. This information is being used for Prevention Services strategic planning as well as collaboration with Maryland Behavioral Health Administration and SSA's Placement Unit to identify how the state can meet the needs of these children sooner and avoid out-of-home placement.

As reported in previous years, the October 2022 CFSR focus group participants indicated that many families, children and in particular youth, need access to quality mental health services and substance abuse treatments. Participants indicated that both access to and quality of these resources are significant challenges. Participants highlighted the following as the reasons for interruption in service provision: the shortage of therapists in certain geographic areas such as eastern shore or western Maryland, distance to services, as well as a lack trained therapist to deal with specific needs of children and families and the overall lack of quality of these services. Participants acknowledged that while more mental health and substance use services are needed due to the high demand, these services need to be evaluated and monitored to ensure that they are of good quality. Participants indicated that with the outbreak of COVID-19, most services transitioned to a virtual format and have not yet returned to a face-to-face approach. The interview participants expressed dissatisfaction and frustration with the current telehealth services because they are not conducive to non-verbal communication and do not facilitate active interactions between the therapist and the client. Participants indicated that the overall number of therapists available in each jurisdiction is not sufficient to support every family and child in need of evaluation, treatment, or counseling. As a result, most people in need are placed on a long waiting list, as their problems persist or even worsen.

When CFSR focus group participants were also asked to identify the services, they found most helpful for families. One participant found the individual parenting assessment effective and one supervisor pointed out that the START model is a great wraparound service. Additionally, the neuropsychological evaluation was considered helpful according to service providers.

During this reporting period, SSA partnered with MCF to host three focus groups in English, and one in Spanish to parents regarding their experience in Child Welfare. A total of 56 family

members participated. When asked about services provided to their child, many participants had positive things to say. Some of the services identified as supports to them include trauma therapy, grief counseling, medical support for children with disabilities, family therapy, and mental health treatment. Some participants had very positive things to say about their child's foster parents as well.

Overall, the state performs well in supporting families to ensure children remain safely in their home. In 2022, DHS served 11,440 children through its FPS. Family Preservation are service programs designed to promote the safety and well-being of children and their families, enhance a parent's ability to create a safe and stable home environment, and maintain permanency while preserving family unity.

Each year on average, 98% of children remained in their home and avoided out-of-home placement within the first year after receiving FPS. DHS is unable to provide the exact percentage for CY22 because SSA is not a year out to compare. With the Implementation of the Family First Prevention Services Act, DHS looks forward to maintaining this trend.

In Maryland's approved Family First Prevention Plan, there are four evidence-based practices that are currently being offered and Utilized: Healthy Families America, Parent Child Interaction Therapy, Family Functional Therapy, and Multisystemic Therapy. Nurse Family Partnership is limited in use in Maryland so was not identified as a program for implementation. These were agreed to due to a Needs Assessment that the School of Social Work helped us with. Another needs assessment is due and will be completed in 2023 after all jurisdictions have been trained.

In addition to these evidence-based practices that are utilized through FFPSA, jurisdictions have their own partnerships with agencies based on the needs they notice in their own county. Some of these services include Sobriety Treatment and Recovery Teams (START) Partnership for Success, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Bester Community Services, Family Connections, Nurse Family Partnership, Parents as Teachers home visiting model.

Services to help foster and adoptive parents achieve permanency

The latest round of CFSR indicates for assessing the needs and services provided to resource parents (Item 12C), 84% of cases reviewed were rated as a strength. This is a slight increase from 2021 in which 79% cases reviewed was rated as a strength. Similarly, to the previous report, the CFSR data suggests that while the agency can provide needed services to help resource and adoptive parents achieve permanency, addressing service barriers to achieving permanency continues to be an area for growth and development. Current services the agency provides that help children in foster and adoptive placements achieve permanency are described in the Adoption Promotion and Support Services section.

Partnership interviews with the LDSS revealed a need for more behavioral health placements for youth and a need for stronger collaboration with the MDH. During the CFSR focus groups, all participants were asked to answer questions related to service gaps, delivery, and quality issues. An overwhelming response expressed concerns about obtaining stable placements, which is critical to achieving permanency in a timely manner. The placement crisis has been especially prominent for older youths because resource homes usually preferred young kids over older ones. Additionally, some of the participants emphasized that kinship providers generally require extra

support from the agency because they are oftentimes not treated as regular foster parents and are, therefore, excluded from general guidance, benefits, and rights.

For the emerging adult population (youth ages 14-17), DHS/SSA continues to provide a credit monitoring service. Credit reports are pulled annually and made available to the emerging adult. This helps to protect the emerging adult and empowers them to make decisions about the use of credit and promotes financial independence.

The free credit reports contain payment history, amounts owed, credit history. The emerging adult data was retrieved from the CJAMS generated milestone report. Approximately 955 older Maryland foster youth in Out-of-Home placements received a credit report from Equifax, Experian, and TransUnion respectively. The largest amount of credit reports (33.4%) was prepared for out-of-home youth in Baltimore City.

Concerns:
Enhancing the Service Array Continuum to ensure quality and equitable services to support children and families continues to be an area of improvement and development in Maryland. The state is not Substantial Conformity for this measure as indicated by the Maryland CFSR Final Report. As reported in 2021, there are several challenges around ensuring quality and equitable services are available and accessible across jurisdictions. As further described in the Well-being Outcome 1 section, the latest round of CFSR reflects only 44% of cases that were reviewed and substantially achieved the goal of families having enhanced capacity to provide for their children's needs.

The 2022 Community Partnership and Services Summary (CPSS) Report describes the top 5 most critical unmet services needs across jurisdictions based on LDSS respondents as well as examples provided of those service needs as described in Table 29.

Table 29: Most critical unmet service needs of child welfare-involved children, youth, and families in your jurisdiction

Category	No. of Jurisdictions Responding	Examples
Mental health/psychiatric services	22	• Behavioral health services for children/youth. • Easy access to addictions and mental health treatment. • Mental health/substance misuse for teens. • Co-occurring disorder treatment. • Emergency respite. • Respite care for families. • Emergency psychiatric services. • Psychiatric services for children and adolescents. • Medication management for youth. • Lack of psychiatrists for children. • Mental health therapy for children ages 3-6. • Intensive mental health services. • Mobile crisis services. • Lack of hospitals performing adequate psychiatric stabilization for youth in crisis.

Category	No. of Jurisdictions Responding	Examples
		● Quality trauma informed individual family therapy. ● There is a lack of trauma informed therapists and qualified counselors. ● Trauma treatment for children and adults regardless of ability to pay. ● Programs for out-of-control teenagers and their families. ● Consistent access to reliable mental health service providers. ● Specialized mental health services for children and families. ● Resources to carry out the recommendations of psychiatrists or evaluators for families and children.
Housing	14	● Safe and affordable housing. ● Housing and addiction services for pregnant and new mothers. ● Housing is a huge issue, multiple families living under the same roof.
Out-of-home placements/providers	11	● Child placements. ● Appropriate placements. ● Group home placements. ● Safe and stable (in-state) placements for children with high intensity needs. ● Foster care placements for disabled children. ● Therapeutic foster care providers. ● Placement resources for high needs youth. ● Lack of resources and residential treatment programs for children and youth with severe mental health issues/behaviors. Difficulty with finding placements for children/youth who are dually involved with DJS and DSS. ● Lack of resource homes for foster children. ● Placements for transitional aged youth & treatment foster homes. ● When children and youth have to enter out-of-home care, our resource parent cadre is ill equipped to handle even seemingly “normal” behaviors that kids who have been traumatized exhibit. There are no therapeutic foster homes in St. Mary’s and the current statewide placement crisis makes it very difficult to access appropriate levels of care for youth who need it.
Transportation	8	● An individual transportation service to assist customers in accessing transportation. ● Transportation in the most rural areas.
Substance use disorder treatment	7	● Substance Use Disorder treatment for adult ● Inpatient drug treatment facilities for teenagers. ● Evidence-based substance abuse treatment programs. ● Housing and addiction services for pregnant and new mothers. ● Substance abuse treatment for adults and youth.

Activities to Improve Performance:
During this reporting, The Service Array Implementation Team through partnership with the LDSS and stakeholders, SSA received several recommendations that will support the agency in building the Service Array Continuum and Key Partnerships. Some of these recommendations include establishing a centralized source for information on services and resources in CJAMS, Investment in true prevention services, help LDSS identify better uses of federal and state funding and supports to better align to free up funding, develop a state-wide vision across Maryland state agencies so all agencies are on one accord around prioritizing Children in Foster Care and their necessary services, establish service coordinators within each jurisdiction.

As the agency prepares to develop the next children and family service plan, the agency plans to utilize the service-related data available to the strategic plan to build the Service Array Continuum. The activities planned to improve performance are described below in Table 30.

Table 30: Activities to Improve Performance

Current or planned Activity to improve performance	Target completion date
Review existing program services and existing funding streams to ensure alignment with established priorities.	**June 2024**
Implementation Status: New 2022 Progress: ● This is a new goal as of 2022.	
Through braiding and blending funding, enhance partnerships and funding opportunities by building community partnership that creates a pathway towards prevention	**June 2024 and annually**
Implementation Status: New 2022 Progress: ● This is a new goal as of 2022.	
Strengthen allocation of funding process to the LDSS which include helping them identify better uses of federal and state funding and supports to meet the needs of children and families and maximizes available funding and addresses service gaps	**2020 and annually**
Implementation Status: In Progress 2022 Progress: ● This activity had been delayed for the last few years due to COVID-19, staff transitions and other priorities that were faced by the state. As the state began to recover from the pandemic, DHS/SSA was able to move forward with plans regarding FFPSA funding to support the Prevention Evidence-Based Programs (EBPs) included in the state plan. Discussions were also continued around opportunities to utilize other federal and state funding to support the Prevention EBPs for those families not eligible under FFPSA. By the last quarter of CY2022, 17 of 24 counties were trained in FFPSA and were implementing or had begun using startup funds for at least one EBP. In addition, the other 7 counties were scheduled for FFPSA training in early 2023. ● SSA conducted partnership survey post interviews with LDSS to understand how they currently support and fund different program areas. This helps SSA understand the information that is needed to the LDSS.	

Current or planned Activity to improve performance	Target completion date
● SSA also explored LDSS understanding of their current allocations and reporting on those funds to SSA historically and currently. ● SSA received several recommendations that will support the agency in building the Service Array Continuum and Key Partnerships.	
Include IPM language in contracts/agreements with placement and other providers to enforce consistent implementation of the IPM within contracted providers, monitor compliance, and provide technical assistance and support as needed.	**2020-2024**
Implementation Status: In Progress 2022 Progress: ● Provider contracts were extended until 2024. IPM language continued to be used.	
Conduct ongoing CQI to assess outcomes, identify strengths and areas needing improvement, and implement improvement plans as needed.	**2021-2024**
Implementation Status: In Progress 2022 Progress: ● Continued to utilize Maryland's CQI process to understand how service availability and quality impacts safety, permanency, and well-being outcomes. See Goal 3 for updates.	

Item 30 - Individualization of Services
Assessment of Performance:
The ability to provide individualized services to meet the unique needs of children and families served by the agency continues to be an area of growth and development. While individualized services exist and are available for some, qualitative data from CFRS Focus Groups and CPSS indicates that when individualized services exist, there is not enough of the services to meet the need. There is a need for more certain individualized services that can be accessible throughout the state.

The agency solicited feedback from caseworkers, biological parents, foster parents, attorneys, service providers, youth, judges/magistrates, and parents about the accessibility and quality of services through CFSR Focus Groups. In a targeted effort to focus on parents including Spanish speaking, SSA partnered with Maryland Coalition of Families to host three focus groups in English, and one in Spanish to parents regarding their experience in Child Welfare. A total of 56 family members participated. The latest CFSR Focus Group interviews identified a theme of a lack of available, quality services. These services include:

- Mental health services provided by quality therapist with a range of background to treat complex trauma
- Therapist serving the entire family
- Services for individuals with co-occurring disorder treatment
- Substance use assessments,
- Residential substance abuse treatment; mother-baby programs

- Intensive in-home services for children with complex needs, autism, lower functioning or cognitive limitations,
- Services to support parent-child visitation
- Father targeted services such as engagement, reunification, and mentorship
- Services to support parents of children with severe disabilities
- Onsite interpretation services to support communication with families (outside of utilizing currently available translation services such as the Language Line)
- Transportation assistance in rural communities
- Skill development services for pregnant and parenting teens and youth that are aging out or in the independent living program
- Supportive services for LGBTQ+ youth
- Victim and survivors of Human Trafficking

SSA allocates flex funding to LDSSs to meet individual needs of families. Flex funds are utilized to provide supportive services for families being served through Family Preservation such as interpreter services for non-English speaking families; Supportive services not covered by medical assistance, anger management, In-Home Aide services that provides teaching and modeling of parenting skills, life skills, employment and job search techniques and advocacy, play therapy, classes, Daycare/summer camps; supportive services for kinship families, rent and utility assistance.

Parents that participated in the focus group conducted with MCF indicated that when certain individualized services were provided to them, they found them helpful to them and their families. These participants had positive things to say. Such services identified to be helpful include trauma therapy, grief counseling, medical support for children with disabilities, family therapy, and mental health treatment. One participant shared how these services were helping her to be a better parent.

The latter portion of the reporting period, the agency restructured to develop The Prevention Services unit. This unit is designed to focus on a "front porch" approach, community pathways to prevention that aims to ensure families can access services within their community without or limited involvement with child welfare. Prevention Services programs are designed to reorient child welfare services and how families access services through community-based providers rather than child welfare programs. The unit has initiated discussions with community-based providers and participate in various councils to support the development of pathways to prevention from early childhood intervention and the education system, working with grandparent and kin caregivers and informing Maryland's FFPSA implementation and evidence-based model that support children living safely with their families reducing and preventing entry into foster care or open services cases in the child welfare system.

Concerns:
The state is not in substantial conformity in the Individualization of Services Systemic Factor. Some of the challenges that impact the agency in making progress include accurate child-specific data to inform decisions. This includes data to understand the number of and type of disabilities and children with special needs that are served by the agency, the ability to determine which services were met once they have been identified and provided. The agency utilizes the CANS and CANS-F tools to track services however caseworkers struggle with accurate use of this

assessment tool. We plan to work with our TA partners on the utilization of the CANS for assessing youth needs and services in 2023/2024. Caseworkers need additional training and guidance on the development and monitoring of service plans. This would support the agency in data collected from the Service Plan. In order to strategically plan with the lens of diversity, equity and inclusion and determine if services are racially/ethnically and culturally appropriate, the state needs to improve the capturing of race data as it relates to service delivery. This information is not currently being captured consistently.

Activities to Improve Performance:
As indicated above in the Service Array and Resource Development System, the agency plans to make progress towards this outcome through improved strategic planning. This includes improving data collection and use of data to assess individualization of services and measures of progress, scale up of existing services, align funding streams with needs and priorities, further develop community pathways to prevention focus by and utilizing existing agencies and funding streams to partner to meet the unique needs of children and families served by the agency, and utilize opportunities within Family First to expand Service Array Continuum. DHS will explore what opportunities exist to accurately assess race data as it relates to service delivery.

Agency Responsiveness to the Community

Item 31 - State Engagement and Consultation with Stakeholders Pursuant to CFSP and APSR
As noted in the Collaboration and Feedback Loops section, SSA continued to utilize its implementation structure to support the ongoing consultation of Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies in the development, monitoring and adjusting the goals, objectives, and annual updates of the CFSP. For additional information related to SSA's Implementation structure and the status of other teams and networks engaging an array of stakeholders in the development, monitoring, and adjusting the goals, objectives, and annual updates of the CFSP as well as coordinating services or benefits of other federal or federally assisted programs service the same population, please see the Collaborations and Feedback Loops section.

Assessment of Performance:
During the reporting period, SSA evaluated its implementation structure and identified strategies to strengthen its effectiveness. The decision to evaluate and consider adjusting the implementation structure was based on the fact that some teams and cross-cutting networks were very active, others seemed to be outliving their initial purpose. During this process, it was decided that the Integrated Practice Implementation Team would dissolve in the coming months as the CPS and Family Preservation Implementation Team and Placement and Permanency Implementation Team would absorb the work of sustaining the practice model since implementation was ending. Two groups within the implementation structure were initially addressed during this review process, the OISC and the Policy Network. New representation from LDSSs, sister agencies such as DJS, the Health Department, and community providers were sought and added to implementation teams as well.

Based on feedback from OISC stakeholders and concerns about ensuring that each Implementation Team and Cross-cutting Network had sufficient time to share updates and discuss

challenges and needs, a new framework was introduced at the January 2022 OISC meeting. Clarification of the roles of the teams and workgroups in relationship to the work of the agency was explored. The team encouraged more dialogue among membership instead of just report outs on the work being done. The new agenda allowed for dedicated time every three months for each of the Implementation Teams and Network groups to present as well as to have space for dialogue in each meeting. To further assist with evaluation of the outcomes, a monthly data presentation was also added to the agenda. The Deputy Executive Directors of Programs and Operations were identified as facilitators, with the Director of Adult Services coming on board in the late spring. In the agenda there was also space for new business, which allowed for presentations to further strengthen the resources available to the teams and groups. Continual evaluation occurred throughout the year on how the revised structure was working, additional LDSS representation was identified as a need and it was agreed that such evaluation of effectiveness and adjustments to the structure would occur every January moving forward.

During 2022, SSA continued to conduct plan-do-study-act (PDSA) cycles with the policy development process to enhance the process and gather feedback from stakeholders. The Foster Parent Ombuds and Foster Youth Ombuds continue to play crucial roles in the Policy Network Group (PNG). In 2022 the PNG continued to make intentional efforts to ensure that persons with lived experiences and other external stakeholders impacted by SSA policies were included in the drafting of new or revised policies, and/or providing feedback. One example of this was in revising the Trafficking Policy. A workgroup was formed of different stakeholders including:

- National Center for Missing and Exploited Children
- Polaris Project and Human Trafficking Hotline
- Department of Justice US Attorneys for the state of Maryland
- Victim Services Office in Maryland
- Maryland Department of Juvenile Services
- Maryland Office of the Attorney General
- Maryland State Police Recovery Unit
- Regional Navigators
- Prevention of Adolescent Risks Initiative (PARI) at the UMSSW
- Children Advocacy Center Medical experts
- Maryland Children's Alliance
- National Children's Advocacy Center
- Governor's Office Crime Prevention Youth and Victim Services
- Maryland Children Advocacy Centers
- LDSS CPS staff
- SSA Permanency Team
- Individuals with live experience

The workgroup gathered information and the latest research and trends on the subject of human trafficking. This workgroup reviewed research and current trends in practice to improve our response to human trafficking across Maryland. A new validated screening tool was selected. The tool was taken to the State Youth Advisory Board (SYAB) who reviewed the tool and provided suggestions for how workers should introduce the tool to youth. This input was included in the

Trafficking Guidance. This work was incorporated into the draft of the new policy that was released in 2023.

Throughout 2022, SSA changed the weekly meeting with LDSS Directors and Assistant Directors to bi-monthly to provide updates and seek feedback on key priorities and provide opportunities to engage with external stakeholders. These external stakeholders included Maryland Association of Resources for Families and Youth (MARFY), DJS, and University of Kentucky. Through these regular meetings, SSA was able to obtain critical feedback from LDSSs, identify areas where further discussion was needed, and support LDSS in their ongoing practice in light of the ongoing pandemic.

Placement providers are another key stakeholder group that supports children and families in foster care. In 2022, SSA continued regular meetings with The MARFY Leadership Team and reorganized the Provider Advisory Council in August 2022. These conversations provided an opportunity to partner with providers with the goal of identifying and addressing barriers related to the placement crisis and create better teaming opportunities with LDSSs of social services. The implementation of FFPSA, service needs of children and families in foster care, and providing updates to contracting processes were also the topics addressed at these meetings. Originally, a quarterly cadence was introduced. However, the group decided to increase the frequency of meetings to provide a much-needed communication and feedback loop to improve relations with LDSSs, and address barriers to placement needs. Listening sessions with providers were planned for early 2023 to dive deeper into some of the issues and make recommendations to address provider, service gap, and youth needs.

Strengths:
The changes made to OISC yielded an improved ability to share the work of the other teams equally and leave time for discussion. The work and number of meetings held has been more streamlined as well.

SSA policy collaboration allowed for significant input from stakeholders during drafting. This resulted in fewer questions following the release of a policy as stakeholders provided input on possible unintended consequences during the drafting stages.

SSA has been successful in evaluating needs, adjusting the implementation structure to streamline meetings and get more stakeholders to the table. The implementation teamwork was more integrated and comprehensive of newly implemented programs such as the integrated practice model and Family First Prevention and Services Act. All work of the implementation teams is regularly reviewed and provided feedback by the OISC with the new meeting cadence and schedule. In addition, SSA has continued to use the implementation structure to provide information related to performance on outcomes via Headline indicators and CFSR results.

SSA found that completing a CQI review of its implementation structure yielded constructive feedback resulting in several enhancements planned for the next reporting period. These enhancements include continuing to add new members, adjusting meeting frequency, and

streamlining agendas to ensure the state is poised to effectively plan for the next CFSP which will be taking place in the next reporting period.

Concerns:
Though adjustments have been made to the implementation structure at SSA, this is and should remain an on-going process. In 2022, SSA has seen increased productivity in getting policies revised and released, integrating the work of the implementation teams, but SSA is still struggling to incorporate family voice in our implementation structure. While dialogue and discussion in meetings has improved, SSA is still missing opportunities to include family and youth voice. While SSA is more consistently bringing the work of the implementation teams to the OISC, the full agendas often limit time for needed dialogue.

Activities to Improve Performance:
Table 31 below highlights updates to planned activities to improve performance.

Table 31: Activities to Improve Performance: Agency Responsiveness to the Community

Current or Planned Activity to Improve Performance	Target completion date
Review membership of stakeholder groups to ensure inclusive representation of local representatives, Tribal representatives, service providers, public and private child and family serving agencies, service providers, courts.	**2019 and ongoing**
Implementation Status: In Progress 2022 Progress: ● January 2022 - The Service Array Implementation Team was able to retain its membership which include members of the LDSS, private provider agencies, MSDE, Court Appointed Special Advocates (CASA), Local Behavioral Health Authorities, Community Based Agencies such as MCF as well as expand membership by including family voice of a resource parent and members of the Governor's Office of Crime Prevention, Youth, and Victim Services and Maryland Family Network; Maryland's Community-Based Child Abuse Prevention (CBCAP) provider. ● In February 2022 the CPS/Family Preservation Team reconvened with new membership. New membership was sought to provide representation of several new LDSS, Maryland Family Network, new SSA staff - Kinship Specialist, Education Specialist and Family Engagement Specialist to bring in more lived experience to the team. ● The WDN includes a diverse and devoted membership of SSA, CWA, LDSS Managers and Caseworkers, University of Maryland and Morgan State University Title IV-E Faculty, DHS Learning Office Staff and members with "lived experience." The members with lived experience include an adult mother of 3, who was previously in foster care and a mother with a special needs son with autism. The WDN does not have court represented membership at this time despite rigorous recruitment efforts. However lawyers and court personnel are actively involved in our pre-training activities. Initial discussions with SSA Emerging Staff have also occurred to discuss the appropriateness and subsequent recruitment of youth to the WDN. ● Implementing Maryland's Title IV-E Prevention Services Plan has led to the forming of many teams to include Implementation, team leads, strategy teams, LDSS check-ins, claiming meetings, and planning and CQI meetings. These teams have representation from the DJS, Chapin Hall, UMSSW, LDSS staff from various jurisdictions, the judicial system, Maryland Department of Health, and especially has included partners and staff with "lived experience." ● OISC determined that additional local leadership was needed, as well as private providers along with additional voices from those with lived experiences and these would be invited during 2023.	

Current or Planned Activity to Improve Performance	Target completion date
Continue to refine and enhance headline indicators and the CFSR results dashboards to support utilization of data by State and local staff as well as stakeholders.	**2019**
Implementation Status: In Progress 2022 Progress: ● Headline Indicators were updated with storylines including demographic data of race/ethnicity and age, along with circumstances of removal for all permanency measures and the placement stability measure. These storylines were available to jurisdictions during their Orientation and Practical Data meetings and/or CIP meetings. Storylines for recurrence of maltreatment after investigative response (IR) (timeliness of initial face-to-face) and maltreatment following Family Preservation (caseworker visits with children) remained under development at the end of the year but will hopefully be available during 2023.	
Develop a schedule to regularly review and clarify goals, objectives, and updates of the CFSP with stakeholders and as part of SSA's Implementation Structure.	**2019 and Semi Annually**
Implementation Status: In Progress 2022 Progress: ● CQI Network group presented each quarter at OISC meetings to review the most recent CFSR performance and progress towards Timeliness of Initial Face to Face for Investigations/Assessments and Permanency Achievement, which were the two remaining goals that had not yet been achieved. ● Implementation team meetings for Placement and Permanency and network group meetings for CQI allowed for continued identification of barriers towards achievement of these two goals, along with two discussions with the Foster Care Court Improvement group around the court role around achievement of permanency. ● See Collaboration and Feedback Loops section for more details on SSA's Implementation teams, networks, and workgroups that meet regularly with stakeholders to review and clarify goals, objectives, and updates of the CFSP.	
Increase stakeholder accessibility of headline indicators and the CFSR results dashboards.	**2020**
Implementation Status: In Progress 2022 Progress: ● Similar to the progress from last year, the Headline Indicators were provided in a variety of platforms although the dashboard is presented in a static format. Close to the end of the year, discussion regarding how to provide the Headline Indicator Dashboard in a different structure which would allow for deeper exploration of the details as well as allow jurisdictions to have quicker access to the detailed information behind their trends to improve understanding. This will be explored more in detail in 2023.	
Enhance State CQI cycle to support regular reviews of progress, identify areas of growth, and test out small measures of change.	**2020-2021**
Implementation Status: In Progress 2022 Progress: ● Qualitative data collected through the state CFSR case review process using the narrative summaries from the OSRI continues to inform practice improvements related to permanency and well-being. The CQI Unit in partnership with Implementation Teams within the SSA Implementation Structure and local jurisdictions have used this information to identify areas of growth to improve teaming efforts between the agency, court, and families. Through the existing CQI process, stakeholders were engaged in LDSS convenings. In addition, each jurisdiction receives targeted assistance and facilitation from the CQI Unit following their site's CFSR case reviews to construct a data-driven, comprehensive continuous	

Current or Planned Activity to Improve Performance	Target completion date
improvement plan that is tailored to address opportunities for improvement illuminated during the on-site review process.	
Monitor implementation of CQI cycle making adjustments as needed.	**2021-2024**
Implementation Status: In Progress 2022 Progress: ● The CQI Unit continued to monitor implementation of Maryland's State CQI cycle. This has included regular review and discussion of outcomes data to identify performance improvement opportunities, prioritize performance issues, conduct root cause analyses, and develop strategies to address the priority areas needing improvement. CFSR and Headline Indicator performance data were regularly reviewed with key internal and external stakeholders through the SSA Implementation Structure. These groups were actively involved in a variety of root cause analyses related to improving performance on OSRI items assessed through the CFSR process. Specifically, the SSA Service Array Implementation Team's Health Workgroup identified improving coordination of health care services to support timely completion of required health exams and preventive health services including behavioral health as key improvement areas to address.	

Item 32 - Coordination with Other Federal Programs
Analysis of Performance:
Maryland continues to maximize opportunities to leverage federal and federally assisted programs to ensure coordination with those services identified in DHS/SSA's CFSP. In January of 2022, SSA partnered with DJS to create a YTP Judicial Bench Card which provided youth engagement best practices that align with the new Youth Transition Plan. In June of 2022, the first Kinship Overview training was provided to key Family Investment Administration (FIA) staff which was completed in Kent County. Following this training another two training sessions were completed for Allegany and Garrett County FIA staff. This training included an overview of the FFPSA, the IPM, Kinship terminology and COMAR regulations as it relates to kinship, benefits and challenges facing kinship caregivers, the importance of teaming and creating a single point of access for kinship caregivers to apply for caretaker/relative only Temporary Cash Assistance (TCA) and Supplemental Nutrition Assistance Program (SNAP) benefits. Training is being planned for other counties as well.

From April 2022 through July 2022 meet and greet sessions were held between the SSA Kinship Specialist, MCF Kinship Navigator and LDSS Kinship Navigators along with LDSS assistant directors in Wicomico, Worcester and Cecil with key staff involved in the Enhanced Kinship Navigator Pilot Program to increase collaborative partnership and coordination of services. The SSA Kinship Specialist partnered with MSDE pupil personnel and state liaison for a presentation during the monthly Kinship Peer Support meeting to discuss access to services through McKinney Vento law for children at risk of being displaced or children in transition to assist with educational stability and services. The Kinship Navigators then shared this information with kin caregivers within each local jurisdiction.

In November 2022, SSA began collaborative work with the National Center for Housing & Child Welfare to create a comprehensive toolkit for successful Housing Choice Voucher applications for emerging adults transitioning out of foster care. This toolkit will specifically focus on the Family Unification Program (FUP) for older foster youth and Fostering Youth to Independence (FYI), highlighting all the necessary focuses of these programs, as well as how to request additional FYI vouchers.

Also, during this reporting period, the agency hired an Early Childhood Specialist (ECS). One of the key focus areas of this role is to coordinate efforts with early childhood programs and service providers such as maternal and child health, head start, infants and toddlers, early childhood centers, family resource centers, home visiting/family support services, pediatrics, parenting education, Temporary Assistance for Needy Families (TANF), Women Infants and Children (WIC). Currently this collaboration is taking place through the Building Better Beginning Initiative (B3) with Maryland Family Network. SSA and the ECS also collaborate with Maryland Family Network on strategies to coordinate services and initiatives through the CBCAP grant.

To address parental substance abuse, the agency has continued its partners and collaboration with MDH, Behavioral Health Administration (BHA). BHA utilizes the resources and services provided through the Federal Substance Abuse Prevention and Treatment Block Grant (SABG) program to support the implementation of the START services. The coordination and partnership with BHA and the SABG program allow the agency to leverage existing resources to enhance services of Peer support to Pregnant women and women with dependent children while focusing on preventing children from entering out-of-home placement. For additional details related to START implementation, please refer to Section 9, CAPTA state plan.

The agency also partners with programs to address Human Trafficking. The Maryland Regional Navigator Program (RNPG) was developed after the legislature enacted the Child Sex Trafficking Screening Services Act of 2019. The law requires law enforcement and LDSS that suspect or have reason to believe a child is a victim of sex trafficking to notify a regional navigator in their jurisdiction or region to obtain needed services for the child. The law required that, as of January 2022, each county or region in Maryland would have a designated regional coordinator of victim services for high-risk and trafficked youth. During this reporting period, the agency released the trafficking response in child welfare policy that provides guidance for local involvement in the program. By making these referrals not only in cases where the child is known to be trafficked but also in cases where the child is at high risk of trafficking, SSA is aiming to reduce the number of affected children. These referrals to the regional navigator can be made for both sex and labor trafficking concerns as a part of both state and federal initiatives.

DHS and DJS have a close working relationship especially in relation to prevention services. DJS and DHS have monthly meetings about prevention and DHS is awaiting DJS's revised written proposal on how they will put the Maryland Title IV-E Prevention Plan into action. Once submitted, this written proposal will need to be cross walked to ensure it aligns with the federal law and Maryland's state plan and then, it will be approved. In July of 2022, DHS and DJS held a "Quality Improvement: DJS/DHS Quarterly Collaborative" with the Institute at the School of Social Work focusing on best practices for referrals and Multisystemic Therapy

(MST)/Functional Family Therapy (FFT) services; it was received positively. The following quarterly collaborative meeting focused on engagement and barriers.

Throughout 2022 DHS/SSA continued to partner with MDH to ensure that birth matches were made and sent to LDSS for assessment of newborns who parents who have had their parental rights of another youth terminated because of child abuse or neglect. Partnerships also exist with the judiciary system as birth matches are completed for individuals convicted of murder, attempted murder, or manslaughter of a child by the courts. DHS/SSA received 142 matches in 2022. There were 2 open matches as of December 31, 2022.

During 2022 DHS/SSA and LDSS collaborated with the Maryland Network Against Domestic Violence (MNADV) to develop an updated Intimate Partner Violence (IPV) curriculum with the goal of a 2023 roll out. Discussions were started regarding utilizing a new Lethality Assessment Program (LAP) – Maryland Model database for easier data collection and sharing of raw data. SSA also supported the LDSS with identifying a lead LAP Coordinator who can provide on-site support and clinical decisions. SSA has continued to support the LDSS and provide TA regarding IPV when requested. There was a total of 771 LAP screens completed in 2022.

Strengths:
DHS/SSA, in conjunction with LDSSs, have continued to partner with other federal programs that serve similar populations as demonstrated by the collaborations listed above. Specific strengths of these partnerships include:

- Kinship navigation work for streamlining access to benefits for kinship providers.
- The hiring of Early Childhood Specialists that allowed for targeted partnerships with federal and state programs.
- Federal Substance Abuse Prevention and Treatment Block Grant program to support the implementation of the Sobriety Treatment and Recovery Programs services.

Concerns:
Placement capacity reductions due to impacts of COVID-19, staffing shortages, and program closures have resulted in challenges in locating/securing placements to meet the care and treatment needs of children/youth in care. These challenges have extended to hospital discharges and overstays. In January 2022, weekly interagency workgroup meetings were started to address hospital overstays. This workgroup includes DHS/SSA, MDH/BHA, and Developmental Disabilities Administration (DDA), DJS, and MSDE. Information and strategies were also presented at weekly meetings that included the Secretaries of DHS, MDH, and DJS. These efforts provided information as to the complex care needs that often-prevented discharge to appropriate settings.

Activities to Improve Performance:

- Kinship Navigation Program Administrator (KNPA)/Policy Analyst will continue to work in conjunction with seasoned LDSS Kinship Navigators to revise the current Kinship Navigator Services policy to improve practice and develop a more standardized approach.
- KNPA will engage in conferences, workgroups, and committee's with MSDE, Local Behavioral Health Authority (LBHA), FIA and other community partners to improve

communication and awareness of resources and supports afforded to kinship caregivers and their families.

- KNPA will continue to track barriers and trends affecting kinship caregivers and include family voices to alleviate unnecessary hardships.
- Weekly interagency meetings will continue into 2023 to strategize and collaborate to meet the complex care needs of children in care. Through the collaboration with MDH, a pathway was created for payment for a youth to have single occupancy of a normally double occupancy room to maintain safety and allow the youth to receive treatment.
- Collaboration with MDH, including BHA, and DDA will continue to be a focus in 2023 to provide services and treatment to children in care.
- For older youth in care, over age 18, who have been determined DDA-eligible, DHS has worked closely with DDA in placement with adult DDA-licensed group homes. These efforts strive to provide transitional support in a community setting and minimize transitions when they exit care at age 21.

Resource and Adoptive Parent Licensing, Recruitment, and Retention

Item 33 - Standards Applied Equally

Assessment of Performance:

Public Homes

According to data in CJAMS, SSA had 1,672 active public resource homes in CY2022 compared to 1,021 in CY2021. Resource Home eligibility requirements continue to be outlined in state regulation, statute, and policy for the purpose of assessing resource parent's ability to meet the needs of children in placement and ensuring that standards are applied equally[2]. Much time was spent aligning the policy that was issued last year in CJAMS. During this reporting period, SSA and LDSS continued to experience ongoing delays in finalizing data reports to assist with monitoring many of the licensing requirements for resource and adoptive parents. In 2022, SSA met with LDSS representatives weekly and identified the enhancements needed in CJAMS to ensure data was available and could be pulled accurately. The work group continued to meet and discussed different areas of enhancements and information needed for the milestone report. SSA anticipated that the new report would be available in the next reporting period. This did not go to production until February 2023.

The Permanency Team started working with MRPA in November 2022 to improve the resource parent appreciation event in 2023. Resource parent appreciation event was held on May 21, 2022, at Six Flags of America in Prince George's County, MD. Ninety (90) resource family members attended the event. The event celebrated the Resource Parents of Year for 2022 for each jurisdiction. This event focused on retention of the resource parents by celebrating their work throughout the year.

Child Placement Agencies and Residential Child Care Programs (Group Homes)

[2] Policy: SSA 21-09 CW Resource-Parent-Home-Standards;
Public Resource Homes: COMAR 07.02.25 Resource Home Requirements;
Office of Licensing and Monitoring COMAR regulations for Child Placement Agencies (CPA) and Residential Child Care (RCC)

The DHS, OLM monitors Maryland's licensed CPA license, for the recruitment and retention of treatment foster homes. COMAR section 07.05.02, 14.31.06 outlines the requirements for the approval and licensure of foster family homes and childcare institutions. These regulations ensure that standards are applied equally across the State.

Child Placement Agencies and Residential Child Care Programs (RCC) (Group Homes)
DHS's OLM is responsible for ensuring that group homes and child placement agencies are in compliance with licensure of their program and certification of foster parents. There are strict guidelines in place to ensure compliance, and sanctions if the agencies are found to be out of compliance. Regarding OLM monitoring, these requirements are applied equally and there are no instances of exemptions or waivers to the RCC licenses or the CPA home certifications. To ensure uniformity in private resource (CPA) homes, OLM is currently reviewing provider cases on a quarterly basis to ensure that standards are equally applied. As of December 2022, there are approximately 1695 certified CPA homes by child placement agencies. All programs are monitored quarterly by OLM. Private providers must enter required data elements related to RCC staff and CPA home certifications into the CJAMS portal. Quarterly, a random sample (10+10% with max 20) of CPA home records is reviewed by licensing specialists. Calendar year 2022 compliance rates are listed below for RCC programs and CPA homes.

Analysis of Performance:
Tables 32 and 33 provide CY2022 data showing reviews completed to assess program compliance for RCCs and CPAs. OLM consistently applies the regulations when reviewing for compliance and does not let other factors influence the monitoring of programs. Additionally, the data reflects that a thorough and consistent monitoring is occurring in the private provider community.

Table 32: Residential Child Care (RCC) Programs CY2022

# of RCC Providers	# of Site Visits	# of Site Visits that Met Requirements	# of Site Visits that Resulted in a CAP
26 (DHS)	119	25 (21%)	98 (79%)

There is a high amount of non-compliance for RCC's because every type of COMAR deficiency is included in this review. Most of these deficiencies are related to the physical plant. In the future, with the development of CJAMS SSA will be able to determine the breakdown of deficiencies by type. Non-compliant RCC programs are required to submit a Corrective Action Plan (CAP) to DHS/OLM to correct the areas of non-compliance. The Licensing Specialist reviews the CAP response and confirms the CAP implementation during a follow up visit. As of 2022 a new process of identifying COMAR deficiencies that are safety related has been implemented. Providers are not able to renew their agency's license if any safety related deficiencies are outstanding. If the non-compliant items are not corrected and require further action then a moratorium, suspension, or revocation of the RCC license is completed. There were no facilities that required these actions during CY2022.

Table 33: Child Placement Agencies (CPA) homes CY2022

# of CPA Home Records Reviewed	# Met Requirements	# Needed CAP
371	333 (90%)	38 (10%)

CPA providers are required to submit monthly safety reports to OLM, documenting the status of all certified treatment foster parents which includes all aspects of the home study process and the date of treatment foster parent certification and recertification.

All programs are monitored quarterly by DHS/OLM. Documentation must be in each treatment foster parent's record, demonstrating that the initial certification and recertification requirements were met. As part of the monitoring process, licensing specialists interview a random sample of certified treatment foster parents on various subjects, including certification requirements. They are questioned as to whether they have received the necessary training to care for the youth in their home, and whether they felt that the training was useful. Programs that have not provided the required elements of the foster home certification are cited and must complete a CAP.

OLM has revised the meeting format and will now be conducting supportive technical assistance meetings with the provider community every other month. Following the meeting, guidance is distributed to the providers with information and expectations for the COMAR regulation to be found in compliance.

Strengths:
Quarterly monitoring of providers continues to allow OLM to inspect private provider facilities four times a year. OLM also performs periodic site visits to ensure corrective action plans are implemented prior to OLM approval. Additionally, bimonthly technical assistance meetings allow private providers to ask questions and receive guidance on the interpretation of regulations.

Concerns:
Only 21% of the RCC providers were able to be in total compliance during the last year. OLM completes a thorough assessment of compliance with COMAR regulations. It is very rare that deficiencies related to physical plants (i.e., dirty vent, broken furniture, etc.) aren't found. OLM will need to complete a data analysis of residential childcare programs COMAR violations by type, to see those areas that need to be addressed and develop a comprehensive plan to ensure COMAR compliance in the residential childcare provider community. This is a data report being developed in CJAMS as mentioned in the Plans for Improvement. The timeline for completion is dependent on the MD THINK team and their prioritization of system development. OLM is hopeful that this will be completed by July 2024.

Activities to Improve Performance:
OLM continues to work on development and enhancements to CJAMS. Private providers are required to enter in all employee and foster parent records. In addition, when it is time for relicensure private providers must upload all required documents for review. OLM will be reviewing this information in order to license the provider. Monthly training is currently being developed to assist the providers with using CJAMS. Many areas continue to be addressed to

improve the ability to obtain data from the system. As these areas are addressed, the goal is to utilize the system to gather more data that will support the work of OLM.

Item 34 - Criminal Background Checks

Public Homes

Analysis of Performance:

Criminal Background Checks continue to be a mandated COMAR[3] tool to solicit additional information to identify issues for discussion with prospective resource parents or which would eliminate those prospects entirely from approval as resource parents. In order to document compliance with state regulation and policy, there continues to be a field in CJAMS to enter the date the criminal background check was completed for required individuals in the resource home. In addition, when a new resource home was licensed SSA reviewed the data entry into CJAMS as well as uploaded documents. Following this review, any missing information was noted, and the local department was contacted to make the corrections.

COMAR[4] states the Director of LDSS has the authority to deny, suspend, or revoke resource home approvals based on the criminal backgrounds. The Director can also grant a waiver after reviewing the background checks if there are compelling reasons such as the charge was prior to five years before the application to become a licensed resource parent. As the state has continued to enhance its new child welfare data system, challenges were experienced in extracting data and determining its accuracy from CJAMS. There were challenges related to having staff enter the background clearance information due to statewide staffing shortages and timely entry into CJAMS making it difficult to monitor criminal background checks related to licensing or approving foster care and adoptive placements. The LDSS continued to address the safety of children in foster care and pre adoptive placements by getting updates and alerts through the statewide Criminal Justice Information System (CJIS). If the individual (applicant) accrues a new charge, a notification is sent to the local who requested the initial criminal background. This is completed through CJIS, and the reports are maintained locally.

The current report that SSA receives from the local has the updated information from the CPS investigation and any pending charges. The CJIS report is received if the charges filed are prosecuted. SSA utilized this data to provide additional technical assistance to the LDSS when there was an indicated finding to ensure there was corrective action taken against the resource parent when applicable.

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[3] 07.02.25.04 Technical Requirements for Resource Home Approval and Reapproval
E. Criminal and Protective Services Background Checks.
(1) Before a resource home may be approved, an applicant and all household members 18 years old and older shall apply for a State and federal criminal background investigation.

[4] 07.02.25.04 Technical Requirements for Resource Home Approval and Reapproval
E Criminal and Protective Services Background Checks.
(4) The local director: (a) Shall review charges, investigations, convictions, or findings related to any other crimes of any household member, to determine: (i) The possible effect on the applicant's ability to execute the responsibilities of a resource parent; (ii) The ability of the local department to achieve its goals in providing services to children in care; and (iii) The possible effect on or the safety of children in out-of-home care.

Policy dictates that when a LDSS receives a placement provider involved concern the LDSS would then notify SSA via a document referred to as a 1080. This document provides a background on the alleged victim as well as the alleged maltreater. It also gives SSA a snapshot of the concerns and what the agency has done to ensure the child's safety. Within this form, there is the necessary information if needed, SSA can complete a deep dive into the history and current investigation of maltreatment. SSA regularly partners with the LDSS by either attending rapid response review team meetings or participating in separate consultations. Upon completion of the investigation, the LDSS forwards information related to the finding and any action taken by the agency as it pertains to the future of the placement provider.

Historically there was an attempt to have SSA capture a manual data count of provider-related maltreatment. However, human error and staffing shortages have led to these attempts being incomplete. In response, SSA has moved to a process where the information captured in the 1080 form is input directly into the electronic record system. This should be incorporated in the 2023 CJAMS development schedule. The LDSS will be required to notify SSA in the same manner and SSA will provide support to the LDSS. By putting the data directly into the system, SSA will ensure that more accurate data is captured for broader assessment in the future.

Strengths:
SSA has worked to manually keep track of the maltreatment reports and findings in agency approved resource homes this reporting period, however once the information is added into CJAMS tracking will become more accurate. The state has also been able to staff cases with the locals regarding maltreatment findings. SSA will be able to pull accurate background information from CJAMS as it is input by the local jurisdictions.

Concerns:
SSA continued to be unable to provide an analysis of the data for this reporting period due to data and report limitations for CJAMS. In addition, due to resource home staff shortages, SSA was unable to oversee the monitoring and provide technical assistance for the provider's criminal background requirement. The state is still pending development of a maltreatment finding tickler within CJAMS.

The tracking of background clearances may be a moving target as individuals in the home who are not considered providers may turn 18 or already be 18 requiring an additional background check that would not be reflective of provider numbers. COMAR[5] states that once a resource home is approved, if any new members are 18 years old (or older) or if any household members become 18 years old, the local will complete the criminal background check within 30 days. This requires communication between the local and the resource parents. This is also reviewed during the annual reconsideration.

Activities to Improve Performance:

[5] 07.02.25.04 E (2) Once the resource home is approved, if any new members 18 years old or older join the household, or if any household members become 18 years old, they shall apply for a criminal background investigation within 30 days of their 18th birthday or of moving into the household.

In the future SSA would like to incorporate tracking of the background clearances in the ACQI unit dashboard provided to local jurisdictions to ensure they are in compliance with respect to background clearances on file for provider homes and individuals over the age of 18 in the home who may not be included in the provider count. This would also include an update to the provider milestone in CJAMS to track residents in the home that are 18 years or older and if the criminal background check was completed and added to the provider record.

Child Placement Agencies and Residential Child Care Programs (Group Home)
Analysis of Performance:
All RCCs and CPAs are required to receive and review state and federal criminal background checks according to COMAR. Maryland is in compliance with the federal requirements for receiving criminal background checks. RCC providers must be in compliance with COMAR. 14.31.06.05 D (7) and COMAR 14.31.06.05 E (1)(e). CPA providers are required to be in compliance with COMAR 07.05.02.11 B (7)(a) . RCC personnel records must contain documentation of the criminal background check request and a copy of the initial outcome and any periodic updates. Per the FFPSA, all adults working in the RCC facility must have criminal background checks. CPAs are required to receive the results of the criminal background check before an employee, volunteer, or governing board member who has close proximity to children, are approved for employment or volunteer work. In addition, CPAs are required to receive and review the criminal background check results before a CPA home can be certified. When a household member turns 18 years of age, prior to the next annual certification, criminal background checks are required. OLM has developed a process in CJAMS to assist with maintaining compliance on criminal background checks of household members turning 18. A notification is sent to the CPA provider 30 days prior to the youth turning 18, stating that the criminal background check must be completed. OLM monitors compliance with this COMAR requirement by completing review of the CPA home.

Quarterly monitoring of providers allows OLM to inspect staff and foster parent records for compliance with this standard four times a year. Quarterly Provider Meetings allows private providers to ask questions and inform OLM of issues with completing criminal background checks and the home study elements. OLM staff provides technical assistance with any issues that may arise and interpretation of COMAR.

Incidents of alleged maltreatment occurring in a CPA or group home are reported to the LDSS/CPS unit, OLM, and private provider agency. CPA homes are placed on hold pending the investigation and youth are removed, if warranted. The decision to remove the youth from the home is made in conjunction with the local department placement worker, the investigation worker and the CPA provider. However, the ultimate decision is made by the LDSS placement worker. DHS/OLM receives the reports when there is an indicated maltreatment finding to ensure that the CPA provider has taken appropriate action, if necessary, with the CPA home. Regarding group homes, the private provider agency provides an initial and final written plan to DHS/OLM regarding the circumstances, actions taken to ensure safety of youth (to include removal of staff, if necessary) and potential corrective action to be taken for compliance. OLM reviews all CPS Alerts to determine if the CPS Alert is a complaint that should be investigated by OLM. The Licensing Specialist responds to the complaint within 24 hours of receipt. Investigations may require the Licensing Specialist to provide technical assistance and/or impose a sanction.

CPAs and RCC providers are required to submit a Uniform Incident Report via CJAMS. CJAMS is monitored daily by a program manager, who processes all reports as part of coverage responsibilities. CJAMS also sends a copy of the uniform incident reports to the Licensing Specialist for further review and follow up. Additional screening tools utilized by CPA and RCC providers to maintain compliance with federal and Maryland regulations include the Maryland Sex Offender Registry, the Motor Vehicle Administration driving record, child support clearance and the Maryland Judiciary Case Search.

A sample of youth, foster parent and staff records are required each quarterly review. The sample size annually is based on the census of youth, foster parents and staff associated with the agency. Sample records reviewed should be equal to or greater than 10+ 10% of the average census for the quarterly licensure period. A random sample of interviews with youth, foster parents and staff are also required quarterly.

Analysis of Data:
Listed in Tables 34 and 35 below is the CY2022 federal clearance compliance data for Residential Child Care Programs and CPA Homes.

Table 34: Residential Child Care Programs CY2022

# of RCC employee records reviewed	Compliant for Federal Clearance	Non-Compliant for Federal Clearance
367*	358 (98%)	9 (2%)

**As of December 2022, there are 801 group home employees.*

Table 35: CPA homes CY2022

# of CPA home records reviewed	Compliant for Federal Clearance	Non-Compliant for Federal Clearance
371	345(93%)	26(7%)

**As of December 2022, there are 1,695 CPA homes.*

Strengths:
The OLM has been complying with federal requirements for completing federal background checks in RCCs as reflected in the 98% compliance rate.

Concerns:
The CPA providers had a 7% non-compliance rate which will need to be addressed with the CPA providers through technical assistance and provider meetings.

Activities to Improve Performance:

Currently Licensing Specialists are able to determine which monitoring activity is completed at each review. However, in FY2023 Licensing Specialists were required to complete each monitoring activity at each quarterly review. This will include reviews of employee records, youth records, foster home records, and interviews of youth, staff, and foster parents. This will increase oversight so that the provider maintains compliance on a more consistent basis.

As of 2023 OLM has revised the meeting format and will now be conducting supportive technical assistance meetings with the provider community every other month. Following the meeting, guidance is distributed to the providers with information and expectations for the COMAR regulation to be found in compliance.

Item 35 - Diligent Recruitment

Foster family recruitment is vital to ensuring a wide pool of placement options for youth in care. Innovative programs are finding a variety of creative ways to successfully recruit new foster families that meet the needs of children in care. The 24 LDSSs continue to be responsible for diligent recruitment. The foster parent cash award incentive continues to be awarded to utilize existing foster parents as part of the Foster Parent Recruitment and Retention Team. The current foster parent/families receive $500.00 for referring others to become foster parents.

When reviewing race and ethnicity data for youth in foster care and resource parents, in comparison to 2021, Maryland has remained stagnant with respect to resource parent racial composition which is consistent with the number of youths in care. The data outlined in Table 36 below continues to reflect consistency in all racial compositions from 2021-2022. Maryland has a comparable number of Asian youth (.63%) to Asian resource parents) (0.60%). Maryland also has a slightly disproportionate number of Hispanic youth (9%) to Hispanic resource parents (8.05%). In December 2021 (62%) of youth in care were African American, which has shown a reduction to (55%) in the December 2022 data while the African American provider numbers remain consistent at (58.95%) up from (58.3%) in 2021. There was a slight decrease in White providers (29.48%) and White youth in care (26%) in 2022. While the number of missing/unknown youth stayed the same (112) there was a slight percentage increase from (2.6%) in 2021 to (2.83%) in 2022 likely due to the decrease in the total number of children in care from 2021.

Table 36: Racial Composition of Youth in Care and Placement Providers

Race	Youth in care				Placement Providers			
	Dec. 31, 2019	Dec. 31, 2020	Dec. 31, 2021	Dec. 31, 2022	Dec. 31, 2019	Dec. 31, 2020	Dec. 31, 2021	Dec. 31, 2022
Black	2,574 (57.1%)	2,699 (57.1%)	2,628 (62.0%)	2,175 (55%)	628 (28.4%)	1,670 (56.0%)	2,008 (58.3%)	2058 (58.95%)
White	1,228 (27.2%)	1,110 (25%)	1,126 (26.4%)	1,044 (26%)	533 (24.1%)	927 (31.0%)	1,082 (31.4%)	1029 (29.48%)
Hispanic	314	344	355	348	50	210	247	281

Race	Youth in care				Placement Providers			
	Dec. 31, 2019	Dec. 31, 2020	Dec. 31, 2021	Dec. 31, 2022	Dec. 31, 2019	Dec. 31, 2020	Dec. 31, 2021	Dec. 31, 2022
	(7.0%)	(8.0%)	(8.3%)	(9%)	(2.3%)	(7.0%)	(7.2%)	(8.05%)
Asian	33 (1.0%)	30 (1.0%)	25 (1.0%)	25 (.63%)	40 (0.2%)	21 (0.7%)	19 (0.55%)	21 (.60%)
American Indian/Native Hawaiian Pacific	8 (0.25%)	8 (0.18%)	10 (0.23%)	14 (.35%)	5 (0.2%)	3 (0.10%)	10 (0.29%)	7 (.20%)
All others (Refused, Unable to Determine)*	50 (1,1%)	3 (0.07%)	7 (0.16%)	5 (.13%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0%)
Missing/Unknown**	302 (6,7%)	288 (6.4%)	112 (2.6%)	112 (2.83%)	90 (4.5%)	158 (5.25%)	78 (2.3%)	0 (0%)
Total	4,509 (100%)	4,482 (100%)	4,509 (100%)	3,964 (100%)	2,210 (100%)	2,988 (100%)	3,444 (100.0%)	3491 (100%)

Data Source: CJAMS
*Refused, Unable to Determine is utilized if an individual doesn't want to indicate race or does not identify with the options provided.
**Missing/Unknown data indicates that data has not been entered. SSA is working to reduce these numbers by ensuring workers work to obtain racial demographics and inputting the information into the system.

Strengths:
Maryland has seen a decrease in Black youth in care and a slight increase in available Black resource parents in accordance with the chart above.

With the use of CJAMS, there was a positive increase in the numbers to show the race of the resource providers. In 2021 there were 78 (2.3%) providers with missing/unknown race. In 2022, there were zero providers whose race was missing or unknown.

The Child Welfare League of America (CWLA) provided the "PRIDE, The New Generation" training to DSS staff and private providers in August of 2022. This was a weeklong training and14 DSS staff were trained, and three private providers were trained. The attendees are able to teach PRIDE to potential resource parents after the completion of the training.

AdoptUSKids (AUK) in collaboration with the Children's Bureau and the Ad Council wanted to harness the power of programmatic media to target prospective adoptive black families for youth in Maryland awaiting adoption. The creative messaging came in the form of web banners that drove the audience to either the AUK website, or AUK's podcast landing page.

The AUK website is a place for inquiring families to learn more about adopting from foster care, as well as how to get started with state specific information. In August 2022, AUK completed an ad campaign with the goal being to create awareness of the need for foster and adoptive families for teens and youth waiting in foster care. Maryland as well as nine other selected states participated in a targeted media outreach effort with AUK in collaboration with the Children's Bureau and the Ad Council. This media opportunity harnessed the power of programmatic advertising to help raise awareness among a key audience, prospective adoptive black families. Programmatic advertising uses an automated process to purchase online media space using data and algorithms to showcase key messages to desired audiences. The web banners directed the audience to either the AUK website, or AUK's podcast landing page.

The target was for Black families/parents between the ages of 35-60. If a person clicked on the ad or banner, it directed them to the AUK website. AUK was able to evaluate the effectiveness of the media outreach by how many people click on the banner. This initiative combined (including all 10 states) achieved 7.8 million impressions and 5,000 clicks in its effort to reach a narrow but important audience-perspective black parents in states identified as having the greatest need for recruitment. It's important to note that during this same time a national programmatic campaign was also running and directed audiences to either the AUK website, or AUK's podcast landing page.

Results from both the national and local efforts indicate, a total of 943 users with Maryland IP addresses clicked the banners driving them to either the AUK website, or AUK's podcast landing page. A portion of these users also clicked on the state information landing page which features Maryland's adoption and foster care information including: contact information, foster care and adoption licensing requirements, agency contact and support information, post adoption services, and information on Maryland's children. While specific data around raising awareness are challenging to measure directly, the combined results are impressive, directing viewers to the AUK website for more information, and specifically a portion of these viewers connected with the Maryland information page.

Activities to Improve Performance:
SSA will continue to utilize AUK to educate families about foster care and adoption and give child welfare professionals information and support to help them improve their services. AUK also maintains the nation's only federally funded photolisting service that connects waiting children with families. The local 24 jurisdiction can add a youth to the photolisting for child specific recruitment. This will continue for the next reporting period. AUK will continue to send weekly requests to SSA for families interested in becoming a foster parent or adopting. SSA received 120 referrals from AUK from January 1 – June 30, 2022. This information is forwarded to LDSS recruiters on a weekly basis for follow-up. SSA received 96 referrals from AUK from July 1 – December 31, 2022. SSA designated staff sends the interested party information to the local jurisdiction for follow up.

Data between this reporting period reflects two new children that have been added to the photo listing, 92 child inquiries, 0 children placed, 5 new families, and demographics settings that reports the majority age group to be between 6-8 and 15-18 and African American youths. See Table 37 below for additional activities to improve performance.

Table 37: Activities to Improve Performance

Resource Parent Recruitment and Retention	
Utilize the Maryland Resource Parent Association (MRPA), Foster Parent Ombudsman and State Youth Advisory Board (SYAB) to assist LDSS with targeted recruitment efforts to increase resource homes for African American, Asian, and Hispanic youth in care.	**Semi-Annually**
Implementation Status: In Progress 2022 Progress: ● The Foster Parent ombudsman is exploring an updated foster parent curriculum that is more culturally competent and marketable to the State's need to target recruitment of African American, Asian, and Hispanic foster parents. MRPA will continue to support and increase outreach efforts to the Baltimore County Department of Social Services foster parent association.	
Meet with the Maryland's Commission on Indian Affairs to speak about child-specific recruitment for this population.	**2020**
Implementation Status: In Progress 2022 Progress: ● Meetings resumed with the Governor's Office of Community Initiatives (GOCI) in September 2022. The initial focus was regarding ICWA and reviewing current policy in place to ensure it was still active. ● Data was shared with the GOCI representative regarding children in care identifying as Native American/American Indian in the Maryland foster care system. ● Presentations were set up for the GOCI representative to present on Indian Affairs in Maryland to stakeholders, Independent Living Coordinators in 2023. ● A recommendation for a permanency presentation for 2023 to speak with the Maryland Commission on Indian Affairs was requested.	
Adoption Call to Action	
Monitor and track LDSS utilization of AUK website for photo listing of legally free and eligible for adoption to obtain increased adoption finalization.	**Quarterly**
Implementation Status: Delayed 2022 Progress: ● SSA reviews the AUK website photo listing of legally free and eligible for adoption as needed. AUK sends weekly emails to designated staff at SSA for those that have visited the AUK website and relay that they are interested in more information about adoption. The designated staff sends the information to the LDSS for follow up. This work will continue in the upcoming year.	
Work with AUK to implement a work plan to improve adoption practice and outcomes.	**2019**
Implementation Status: Delayed 2022 Progress: ● SSA and LDSS are continuing to work with AUK to update the profiles on the photo listing site. ● We have not yet established a work plan with AUK due to changes in staffing and high level of staffing vacancies in permanency at SSA. The work plan will begin in 2023.	
Include cultural competency as a component in the adoption competency training as well as in the recruitment efforts for additional resource homes.	**2020**

Implementation Status: Delayed 2022 Progress: ● AUK in collaboration with the Children's Bureau and the Ad Council worked to harness the power of programmatic media to target prospective adoptive black families for youth in Maryland awaiting adoption. Messaging was developed in the form of web banners that drove the audience to the AUK website. ● SSA began to explore alternative foster parent training curricula that are more culturally competent. There is a pilot planned in Washington County in 2023 to begin using the alternative training.	
Explore with jurisdictions and AUK, issuance of LDSS adoptive parents open to attending matching events to obtain cross jurisdictional adoptive resources.	**2020/annually**
Implementation Status: Delayed 2022 Progress: ● DHS SSA has engaged in 2022 with the AGO, LDSS (i.e., Washington Co. DSS) and Contracts unit discussions regarding funding needed for AUK. ● SSA issued the updated Adoption Assistance policy 22-07 in December 2022. The policy is in line with the state plan and includes State and IV-E funded adoptions.	

Item 36 - Cross-Jurisdictional Resources
Analysis of Performance:
As seen below in Table 38, the percentage of Interstate Compact on the Placement of Children (ICPC) home studies used in cross jurisdictional cases and completed within or under 60 days is 57% (181 out of 315), an increase of 7% from CY2021. The percentage of ICPC home studies completed beyond 60 days remained at 43% (134). When Maryland receives an incoming National Electronic Interstate Compact Enterprise (NEICE) or e-mailed home study request within 1-3 business days the MD-ICPC State Central Office sends the request to the LDSS. The LDSS is informed of the required 60-day response time-frame consistent with Pub.L. 109-239. MD-ICPC also provides the LDSS with a monthly report of pending or overdue home studies. The improved completion percentage for CY2022 was due to ensuring that there wasn't missing data or time frames that could not be calculated.

Maryland submitted 312 ICPC referrals to other states. Maryland utilizes concurrent permanency planning which at times means a placement resource (most usually a family member or person familiar with the child and interested in caring for the child) may be located outside of Maryland. When this occurs the ICPC Compact is utilized to study the prospective placement resource and obtain approval for placement if it's in the best interest of the child. If the child is placed, the receiving state provides post-placement services until the child is reunified or permanency is achieved with the out-of-state resource. Typically, other states are not able to respond within 60 days unless it is a parent or relative placement resource (not requiring "licensing" factors, pre-service foster parent training, home lead and asbestos inspections) and not a foster or adoption home study referral. While the data exists to discern the placement rate and outcomes of the 312 homes, it is not data readily available for analysis. When the NEICE-CCWIS-Interface is completed in November 2023, that analysis may be practical.

Table 38: Home Studies Completed within 60 Days in CY2019 - 2022

	Home study not completed within 60 days				Home study completed within 60 days			
	CY2019	CY2020	CY2021	CY2022	CY2019	CY2020	CY2021	CY2022
Number of children	468	474	239	134	181	216	277	181
Percent	72%	69%	43%	43%	28%	31%	50%	57%

Data Source: ICPC Compact - NEICE

State Use of Cross-Jurisdictional Resources for Permanency Placements

DHS/SSA continues to support youth being placed outside of Maryland and within Maryland by other states, working collaboratively with the local departments to ensure home studies are completed timely. Each of the 24 LDSS designated ICPC Liaisons were notified by email with NEICE reports of "pending/overdue home studies and the safe and timely due date" (if any) on a monthly basis. Support was provided to clarify and resolve technical questions related to referrals and next steps to ensure cases could be completed. Tetrus/NEICE continued to be utilized although monthly meetings occurred through CY2022 with DHS/SSA, MD THINK and Tetrus/APHSA to incorporate functionality with Maryland's CCWIS (CJAMS) to allow for interface with NEICE which is anticipated to be implemented later in 2023.

An MOU exists between Washington, D.C. and Maryland and continues to be used primarily by D.C. to place approximately 300 children per month during CY2022 in Maryland jurisdictions. Maryland does not need or require the agreement, using typical ICPC process to place children in private or public agency placements in D.C. This border agreement is due to be renewed in June 2023 and meetings will occur with the pertinent individuals to ensure that it continues to meet the needs of both parties.

AdoptUSKids (AUK)

In conjunction with cross-jurisdictional resources to support timely permanency, Maryland has continued to use AUK which helps families throughout the foster or adoption process from receiving a child to accessing supportive services. DHS/SSA has a policy that establishes guidance to the LDSS regarding children waiting for adoption. These children are to be profiled on AUK website if appropriate. The central office, working with AUK liaison, facilitates youth profiles being available on the AUK website. A small number of Maryland LDSS jurisdictions have identified placement resources for special needs youth. The LDSS are not currently able to make referrals for placements outside of Maryland if the identified family is licensed by a private licensing agency. This is mainly due to not having contracts with the out of state private agencies.

Strengths:

As noted above, DHS/SSA has made improvements with regards to the completion of home studies within the 60-day period. Communication with the local departments has ensured that those home studies approaching the deadline are identified as well as development of the NEICE integration into CJAMS which will allow for better monitoring of timeliness and reduce the redundancy of working in two separate systems.

Concerns:

There are still difficulties in meeting the 60-day mandated time frame for the completion of home studies for cross jurisdictional purposes. The greatest challenge, as reported by local departments, is the ability to have prospective resource parents complete the initial resource parent training in the initial 60-day period. Even though it is allowable for this training to occur after the initial 60 days, if the date for initiation and expected completion is communicated with the rest of the home assessment, most jurisdictions do not understand this. Inspections conducted by other agencies for fire, home health, and others outside of the control of the local department can take time to schedule, which might be outside of the initial 60 days, delaying completion of the home assessment. LDSS staff report that this occurs across the state and is the primary factor is non-compliance with 60-day home study completions needed per Pub.L. 109-239.

There is currently no standard way to easily track the number of children who were placed across jurisdictions in relation to the number of home studies completed. Once the interface of NEICE with CJAMS is completed in November 2023, the department will have a mechanism to track this information via the Milestone Report.

With regards to AUK, there have been challenges with management of the listings, resulting in listings that are not current, missing photos and inability to know if follow up regarding inquiries has occurred. There has been substantial staff turnover which could also result in notifications from AUK not reaching the appropriate individuals to provide updates or responses.

Table 39: Activities to Improve Performance

Current or planned Activity to improve performance	Target completion date
Resource Home Monitoring	
Follow-up with LDSS acknowledgement of ICPC cases to ensure compliance and provide technical assistance to eliminate barriers.	**Monthly**
Implementation Status: In Progress 2022 Progress: ● Monthly throughout 2022: SSA provided each of the 24 Maryland LDSS with a LDSS-specific pending and/or overdue home study list and invitation to report, update and/or collaborate, problem solve, as needed. Same will occur in 2023. ● For approved ICPC homes with children placed in them in Maryland, the Maryland LDSS send quarterly reports via the NEICE (detailing monthly contacts) summarizing post-placement services provided, assessments made, and overall progress assessed and pertaining to continued placement and readiness for permanency in Maryland should it be needed. Same will occur in 2023.	
Track/Monitor resource home study completion for 120-day compliance initial certification and 60-day ICPC completion.	**Quarterly**
Implementation Status: In Progress 2022 Progress: ● Monthly throughout 2022: SSA provided each of the 24 Maryland LDSS with a LDSS-specific pending and/or overdue home study list and invitation to report, update and/or collaborate, problem solve, as needed. Utilized automated "alert notifications" sent 10 days before home study is due to assist with tracking the completion of home studies.	

Current or planned Activity to improve performance	Target completion date
● Plans are underway to Interface NEICE with Maryland's CCWIS and the Go-Live date is set for November 2023. The interfacing of the NEICE with CJAMS will allow more efficient monitoring and tracking of ICPC cases in CJAMS.	
Provide technical assistance to jurisdictions that indicate barriers to completion according to the milestone report.	**Quarterly**
Implementation Status: In Progress 2022 Progress: ● Monthly throughout 2022: SSA provided each of the 24 Maryland LDSS with a LDSS-specific pending and/or overdue home study list and invitation to report, update and/or collaborate, problem solve, as needed. This process will continue during 2023.	
Continue to conduct random samples of public provider cases as a monitoring tool to ensure compliance with completion of home study for resource homes.	**Quarterly**
Implementation Status: In Progress 2022 Progress: ● Monthly throughout 2022: SSA provided each of the 24 Maryland LDSS with a LDSS-specific pending and/or overdue home study list and invitation to report, update and/or collaborate, problem solve, as needed. Same will occur in 2023.	
Provide technical assistance to the LDSS to ensure compliance and clarify any questions.	**Quarterly**
Implementation Status: In Progress 2022 Progress: ● Monthly throughout 2022: SSA provided each of the 24 Maryland LDSS with a LDSS-specific pending and/or overdue home study list and invitation to report, update and/or collaborate, problem solve, as needed. Same will occur in 2023. ● Approximately 50 additional staff were trained to use the NEICE (approx. 450 users now Statewide)	
Create and issue a memorandum regarding ICPC compliance to LDSS.	**Annually**
Implementation Status: In Progress 2022 Progress: ● Monthly throughout 2022: SSA provided each of the 24 Maryland LDSS with a LDSS-specific pending and/or overdue home study list and invitation to report, update and/or collaborate, problem solve, as needed. This process will continue in 2023.	
Develop the Resource Home Milestone Report to LDSS Monthly as a monitoring tool to ensure compliance with completion of home study for resource homes.	**2020**
Implementation Status: In Progress 2022 Progress: ● NEICE ICPC Compact cases have no representation in the Milestone Report and require DHS SSA staff to work with LDSS via the NEICE electronic case management system as was done monthly in 2022. In 2023, a report showing ICPC resource providers will also be developed. ● The milestone continued as a work in progress in 2022. The team worked diligently to get the milestone completed in 2022. Full production to occur in February 2023.	

Current or planned Activity to improve performance	Target completion date
Resource Parent Training	
Explore with jurisdictions and MRPA, issuance of LDSS training calendars to ensure statewide training calendar distribution for resource parent accessibility with compliance with home studies.	**2019**
Implementation Status: In Progress 2022 Progress: ● The quarterly training calendar continues to be posted on the MRPA website to ensure resource parents have another means of accessing resource parent training. The trainings can also be found on the Institutes dashboard for resource parents to register. ● The CWA shares the prospective quarterly calendar with SSA prior to production of the schedule. This will continue in 2023.	
Re-institute the Quarterly Resource Home regional meetings to ensure communication from State level to LDSS is consistent	**2019/Quarterly**
Implementation Status: Delayed 2022 Progress: ● This meeting has been discontinued and replaced by the monthly DHS Resource Parent Ombudsman's grassroots meeting. SSA staff attend and present as needed. The 24 LDSS are able to participate in monthly grass roots meetings hosted by the Foster Parent ombuds. The group identifies the topics for the agenda.	
Criminal Background Checks	
Explore options to get Live Scan electronic criminal history fingerprinting and Criminal Justice Information Services (CJIS) clearances at each Maryland LDSS or in an adjacent LDSS location to assist with 60-day home study requirement.	**2020**
Implementation Status: Delayed 2022 Progress: ● SSA has not been able to coordinate with CJIS regarding live scanning. Due to administrative staffing shortages, this activity will be explored, and progress reported during the next reporting period. ● ICPC Compact work requires Maryland-CJIS and FBI-CJS with all public and private home studies. and continues to receive these. Clarification from the Attorney General's Office (AGO) requested in August 2022 raised by one LDSS as to their ability to share the actual CJIS results on home studies with DHS, SSA, Maryland-ICPC as they traditionally always have. This will continue to be explored during 2023.	
Cross-Jurisdictional Resources for Permanency Placements	
Review NEICE to determine best methods to complete home studies in 60 days.	**Quarterly**
Implementation Status: In Progress 2022 Progress: ● The NEICE continues to be the sole electronic case management system in Maryland to perform ICPC Compact work. ● Monthly in 2022, SSA utilized the NEICE along with all 24 Maryland LDSS and private parties for all ICPC Compact referral work. ● Clarification to be issued in 2023 regarding the ability for home assessments to be determined to be complete (and IVE-E compliant) if the foster parent pre-service training is not yet complete and if the	

Current or planned Activity to improve performance	Target completion date
date for the completion of the training within the next 60 days is committed to and provided at the same time.	
CJAMS will replace Maryland CHESSIE, and SSA plans to integrate NEICE with CJAMS.	**2020**
Implementation Status: In Progress 2022 Progress: ● Continued meetings between MD THINK and LDSS to work on incorporating the NEICE features into CJAMS. Final implementation is planned for late 2023. ● New tentative Go-Live date for NEICE interface with CJAMS is November 2023.	

Section 4: Update to the Plan for Enacting the State's Vision and Progress Made to Improve Outcomes

Goal 1: Increase families of origin and youth voice in their child welfare experiences to improve safety, permanency, and well-being outcomes (PIP Goal)

Assessment of Performance:

Child and Family Services Reviews (CFSR) data in Table 40 has shown improvement in the areas of case reviews related to children being safely maintained in their homes as well as families having enhanced capacity to provide for their children's needs. Family participants in stakeholder focus groups in 2022 indicated that they felt overall that they were included in written case plans. However, the completion of Child and Adolescent Needs & Strengths (CANS) assessments appears to have declined in 2022. SSA has continued to experience some challenges with data accuracy in pulling this information from Child, Juvenile, and Adult Management System (CJAMS) and has planned more customized technical assistance sessions on the CANS and Child and Adolescent Needs & Strengths-Family (CANS-F) around the state, to occur in 2023 particularly once data accuracy issues are resolved related to the CANS-F.

The Family Engagement Specialist, who provides an element of lived experience, continues to work with the Constituent Services Office to track constituent calls, emails and texts related to concerns they have with the child welfare system. The calls are tracked in a system called Constituent Referral Management system (CRM), as well as a google document. Data collected continues to inform SSA about trends that develop around families' needs, concerns, and barriers to improve practice for all families. Constituent feedback was incorporated into the agenda for the screening learning circle that took place in 2022. Some examples of feedback provided include individuals not understanding the process once a Child Protective Services (CPS) case is open, often having questions about next steps or why a case would or would not be investigated. Feedback has been provided regarding the need for additional supportive services if the incident does not meet neglect or abuse criteria. This feedback was shared with screeners to help them

improve practice. Additionally, feedback from callers about the hotline have been utilized to improve the end users experience during a hotline call.

Another element of family of origin work is the Parent Partner Program. This program was relaunched in Washington County in November after a hiring difficulty with SSA's partner agency – Maryland Coalition of Families (MCF). This program involves offering parents who are currently working with the child welfare agency the opportunity to have support from a parent who has been through the child welfare process. The program is designed to increase authentic partnerships with families that increase families' ability to navigate the child welfare system and engage in services. The long-term goals of the program are to improve safety, permanency, and well-being outcomes by empowering the families served. DHS/SSA selected the Iowa Parent Partner Program Model for pilot implementation and contracted with MCF to hire a parent partner/peer support for parents. DHS/SSA also partnered with the Capacity Building Center for States (CBCS) to help in building, preparing for, launching, and evaluation of the project.

The purpose of this evaluation is to monitor the Parent Partner pilot implementation, track services, assess fidelity, identify challenges, and determine the impact of a parent partner program on improving outcomes for families, including safety, permanency, and well-being.

CBCS was very supportive in helping to produce materials such as process maps and PowerPoints, assisted in ensuring that this project was representing and building authentic partnering, assisted in measuring successes and assessing barriers along the way with each step of the process. CBCS co-developed the pilot evaluation plan, began supporting and monitoring evaluation and analyzing fidelity and outcome data during the first pilot run of the Parent Partner Program before it was abruptly paused due to the Parent Partner leaving her position and difficulty hiring another. CBCS also summarized results with the team often. CBCS was also instrumental in the relaunch of the program in November 2022.

Table 40: Goal 1 5-Year Monitoring Targets

5-Year Monitoring Targets:	Baseline CY2018	2021 APSR CY2019	2022 APSR CY2020	2023 APSR CY2021	2024 APSR CY2022	2025 APSR CY2023
The percentage of cases rated as a strength during CFSR Progress Improvement Plan (PIP) monitoring case reviews related to children being safely maintained in their homes whenever possible and appropriate will increase to 79% or higher by the conclusion of conclusion of the Child and Family Services Plan (CFSP) period (Safety 2)	69%	63%	76%	83%	88%	

5-Year Monitoring Targets:	Baseline CY2018	2021 APSR CY2019	2022 APSR CY2020	2023 APSR CY2021	2024 APSR CY2022	2025 APSR CY2023
The percentage of cases rated as a strength during CFSR PIP monitoring case reviews related to families having enhanced capacity to provide for their children's' needs will increase to 41% or higher by the conclusion of the conclusion of the CFSP period (Well-being 1)	31%	22%	39%	48%	44%	
CANS compliance rate will increase to 80% or higher by the conclusion of the CFSP period	61%	53%	Not Available*	29%	26%	
For CANS-F completed with families served in Consolidated Services, Services to Families-Intake, Interagency Family Preservation, and Risk of Harm, the compliance rate will increase to 80% or higher by the conclusion of the CFSP period	77%	80%	Not Available*	62%	*	

*Maryland's current data system is unable to extract and analyze CANS-F data correctly. This issue is expected to be resolved later in 2023.

Table 41: Goal 1 Objective 1:1 Measures

Goal 1 Objective 1.1: Revise process for collaborative assessments and developing service plans to facilitate partnership with families, including consistently identifying & engaging the family/youth's chosen supports.
Measure for Objective 1.1: 10% decrease in CANS and CANS-F assessments completed with "no needs" (CY2019 data = 48% CANS-F and 24% CANS) and a 20% increase in strengths recorded on completed CANS-F assessments (CY2019 data = 47% CANS-F)

Rationale for Objective Selection:
• Maryland CFSR Final Report results indicated that the State was not in substantial conformity for the following items:
  ○ Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate, 69%
  ○ Well-being 1: Families have enhanced capacity to provide for children's needs, 31%
  ○ Well-being 2: Children receive appropriate services to meet their educational needs,79%
  ○ Well-being 3: Children receive adequate services to meet their physical and mental health needs, 58%
• CANS and CANS-F (Functional collaborative assessments to identify strengths and needs of children and families) compliance data shows:
  ○ CANS-F: Statewide compliance rate was 77% at the end of December 2018
  ○ CANS: Statewide compliance rate was 61% at the end of December 2018
  ○ Data shows challenges with meaningful use of these assessments:

Goal 1 Objective 1.1: Revise process for collaborative assessments and developing service plans to facilitate partnership with families, including consistently identifying & engaging the family/youth's chosen supports.
Measure for Objective 1.1: 10% decrease in CANS and CANS-F assessments completed with "no needs" (CY2019 data = 48% CANS-F and 24% CANS) and a 20% increase in strengths recorded on completed CANS-F assessments (CY2019 data = 47% CANS-F)
▪ CANS-F: strengths and needs tend to be under assessed (57% of families assessed had no needs identified and 56% had no strengths identified) ▪ CANS: Strengths tend to be over assessed (64% of youth assessed had 10-15 useful strengths identified) • Technical assistance sessions with LDSS to understand compliance and meaningful use data revealed: o Confusion related to correctly scoring items o Difficulty in incorporating the CANS/CANS-F assessment into the development of action-oriented goals in the current Service/Case plan design in Maryland Child Electronic System Information Exchange (CHESSIE) (CJAMS)

Table 42: Goal 1 Assessment of Performance

Key Activities	Benchmarks for Completion
Implement collaborative assessment and planning approach as part of the IPM to support child welfare to authentically partner with families and youth to co-create assessments and plans.	**2019**
Implementation Status: In Progress 2022 Progress: ● January-December: Annual technical assistance (TA), coaching, and CANS certification sessions implemented in each county that incorporates collaborative assessment approach and co-designed with parents with lived experience to highlight means of teaming. ● June 2022: A companion webinar on the teaming policy specific to Maryland's court partners was released. Activities to improve performance: ● In 2023 the agency intends to issue a comprehensive collaborative assessment policy that will supersede previous policies issued and train child welfare staff on appropriate and effective use of these tools. Policy and training will focus on appropriately engaging and partnering with families to assess risk and needs and utilizing this information to develop safety and service plans with families and youth.	
Strengthen the technical assistance provided to LDSS staff to support the effective implementation and meaningful use of collaborative assessments.	**2019**
Implementation Status: Completed 2022 Progress: ● January-December: Annual TA, Coaching and CANS certification sessions implemented in each county that incorporates collaborative assessment approach and co-designed with parents with lived experience to highlight means of teaming. 2023 Activities to improve performance:	

Key Activities	Benchmarks for Completion
● In 2023 the agency intends to issue a comprehensive collaborative assessment policy that will supersede previous policies issued and train child welfare staff on appropriate and effective use of these tools.	
Improve utilization of collaborative assessment data at State and local level to design and provide individualized, tailored technical assistance plans for LDSS.	**2020**
Implementation Status: In Progress 2022 Progress: ● August 2022: Data scrubbed for accuracy and used in pilot TA session with Queen Anne's County to improve use of CANS in service planning. ● September-December 2022: Began using more customized, accurate data in collaborative TA sessions. However, data accuracy was still problematic in some instances due to untimely data entry. 2023 Planned Activities: ● Agency will continue CQI efforts to identify and address barriers to meaningful use of collaborative assessments. This includes deeper analysis of data, identifying LDSS that may be outliers and those that are successful.	
Strengthen supervisor's skills to provide coaching to case workers to support skills and competencies in authentic partnership, collaborative assessments, and developing family/youth driven plans.	**2020**
Implementation Status: In Progress 2022 Progress: ● January-December 2022: Coach Approach model and corresponding learning circles were offered to supervisors across the State. By December 128 supervisors and SSA central staff had been trained; 20 coach mentors were identified representing 12 counties across the state. 2023: Planned Activities: ● Continue teaming with Chapin Hall in providing support on CANS and CANS-F certification annually, it is stressed in these trainings that engagement and teaming with the family is an essential piece of assessment. ● In SSA training sessions and TA given to locals regarding any assessments, teaming with the family is also reinforced and will be reinforced. ● SSA holds quarterly Family Team Decision Making meetings (FTDM) in which family teaming is discussed with facilitators of FTDMs. In 2023, additional lunch and learns or mini sessions have been discussed to ensure consistency of policy across the state. ● SSA will continue to provide technical assistance (TA) and coaching to jurisdictions on an as-needed basis to ensure use of the Integrated Practice Model which reinforces engagement and teaming with families as core practices. ● Coach Approach training will continue to be offered along with the coach mentor program.	
Continue monitoring meaningful use of collaborative assessments.	**2021-2024**
Implementation Status: In Progress 2022 Progress: ● Research was conducted to begin drafting a collaborative assessment policy along with companion practice guidance that will incorporate all assessments, including risk, safety and functional needs assessment. This is a significant policy revision that will require extensive work in 2023. 2023 Activities planned to improve performance: ● In 2023 the agency intends to issue a comprehensive collaborative assessment policy that will supersede previous policies issued and train child welfare staff on appropriate and effective use of these tools. Policy and training will focus on appropriately engaging and partnering with families to assess risk and needs and utilizing this information to develop safety and service plans with families and youth.	

Goal 2: Strengthen workforce knowledge and skills to support the full implementation of Maryland's Integrated Practice Model (IPM) (Progress Improvement Plan Goal)

Assessment of Performance:

In 2022, implementation of Maryland's practice model continued to be sustained through professional development offerings of the coach approach model that were offered to 153 supervisors, local departments of social services (LDSS), and central office leadership throughout the year. A coach mentor certification was offered in an effort to have coach mentors trained throughout the system in order to continue to build and sustain a community of practice that upholds the core values, practices and principles of the model. Trainings took place in January, March, April, June, and October. Learning circles have been offered monthly to sustain the coaching skills learned in the training. Learning circles have been developed for staff at the central office to be able to use the model in offering technical assistance and with screening staff around the state. Seventeen counties now have trained coaches and 12 of those counties have coach mentors that are being trained to sustain learning circles and mentoring of staff in the model.

Table 43: Goal 2 5-Year Monitoring Targets

5-Year Monitoring Targets:	Baseline CY2018	2021 APSR CY2019	2022 APSR CY2020	2023 APSR CY2021	2024 APSR CY2022	2024 APSR CY2023
The percentage of cases rated as a strength during CFSR PIP monitoring case reviews related to children being safely maintained safely in their homes whenever possible if appropriate will increase to 79% or higher by the conclusion of the conclusion of the CFSP period. (Safety 2)	69%	63%	76%	83%	88%	
The percentage of cases rated as a strength during CFSR PIP monitoring case reviews related to families having enhanced capacity to provide for their children's needs will increase to 41% or higher by the conclusion of the CFSP period. (Well-being 1)	31%	22%	39%	48%	43.9%	
*Reentry rate from all types of permanency will decrease to 8% or lower by the conclusion of the CFSP period. (Permanency Headline Indicator)	14%	10%	10%	9%	NA	
*Recurrence of maltreatment rate will decrease to 9% or lower by the	12%	9%	7%	7%	NA	

5-Year Monitoring Targets:	Baseline CY2018	2021 APSR CY2019	2022 APSR CY2020	2023 APSR CY2021	2024 APSR CY2022	2024 APSR CY2023
conclusion of the CFSP period. (Permanency Headline Indicator)						
The percentage of Foster Parents completing required ongoing training will increase to 95% or higher by the end of the CFSP period.	75%	82%	86%	92%	99.8%	
*Data Source: CJAMS 2022 (CYs 2018-CY2022 Headline Indicators revised due to previous data issues)						

Table 44: Goal 2 Objective 2:2 Measures

Goal 2 Objective 2.2: Implement revised pre-service and ongoing trainings for child welfare workers to align and focus on the principles, practices, and values of IPM and include coaching and TOL approaches to improve staff skill and competencies. (PIP Strategy)
Measure for Objective 2.2: Revised pre-service and ongoing training framework and curricula. Implementation plan outlining piloting and full implementation of revised training
Rationale for Objective Selection: • Implementing IPM necessitates training changes. In addition, Maryland CFSR Final Report indicated that current training system was not in substantial conformity for the following items: o Systemic Factors Initial Staff Training (26), Ongoing Staff Training (27), and Foster and Adoptive Parent Training (28). o Feedback concerning pre-service training focused on quality and concerns that workers are not adequately prepared for the work they are expected to do. Variation in training statewide exists because of regional needs and concerns. Additionally, on the job training to integrate classroom learning was identified as a necessary component that is consistently provided. o Feedback regarding ongoing training included lack of standard training hours and content expectations annually, delays in class openings, insufficient training for experienced workers/supervisors, inconsistency of requirements across jurisdictions. • Despite the initial and ongoing staff training systems were not in substantial conformity, evaluations of trainings completed at the end of each training have shown o For pre-service training: 92% (N=188) strongly agreed that what they learned in training was applicable to their job, 91% (N=188) strongly agreed that what they learned would make them a more effective worker or supervisor, and 93% (N=188) rated overall pre-service training as excellent or good. o For ongoing training: 93% (N=3354) "agreed" or "strongly agreed" that training was applicable to their current job, 92% (N=3372) believed training provided useful tools/strategies that would make them a more effective worker or supervisor, and 95% (N=949) "agreed" or "strongly agreed" they are committed to applying what they learned, feel confident in their ability to apply what they learned, and believe they will see a positive impact if they apply the learning consistently. Data source: SFY2018 Child Welfare Academy (CWA) data • The discrepancy between the evaluations completed at the time of training and stakeholder interviews included in Maryland CFSR Final Report suggest the need to examine the current staff training system in order to strengthen long-term TOL and skill for staff and on-going coaching strategies to better enhance knowledge and skill development of staff.

Table 45: Goal 2 Objective 2.2 Assessment of Performance

Key Activities	Benchmarks for Completion
Provide guidance for supervisors to build TOL opportunities into ongoing structured supervision.	**2020-2024**
Implementation Status: In Progress 2022 Progress: ● Coach Approach Training was offered to LDSS leadership staff. After completing the Coach Approach training follow up learning circles were offered to promote TOL on the model. The model supports supervisors in building TOL of the IPM into structured supervision. ● Coaching is an IPM principle in action to ensure a Safe, Engaged and Well-Prepared Professional Workforce. "Coaching Intensives" continued in 2022 allowing 21 of 24 jurisdictions to complete the coaching intensives by the end of 2022. ● In 2023 Coach Approach training will continue to be offered to support supervisors in building TOL of the IPM into structured supervision.	
Assess coaching model to inform an adaptation to develop the capacity of supervisors to integrate coaching into ongoing supervision with staff. (PIP Activity)	**2021-2024**
Implementation Status: Completed 2022 Progress: ● January- December 2022, 14 LDSSs had completed their IPM coaching intensives, bringing the total to 21 LDSSs who had finished their coaching intensives. These intensives were designed to support TOL of the integrated practice model. As these coaching intensives were initiated throughout the year, SSA began adapting the use of the Coach Approach in providing technical assistance and meeting formats in order to operationalize the IPM. This model is intended to promote critical thinking. ● In January, the Coach Approach model began to be offered to supervisors and LDSS leadership as a professional development training. In April, those who had been trained were offered the opportunity to further their skill development to become coach mentors. The intention is to provide each region of the state coach mentors to support this model and sustain the implementation of the IPM. As of December 2022, 17 of 24 jurisdictions had supervisors trained in the Coach Approach model and SSA had 25 staff trained in the model. In addition, 20 trained staff were on track to become coach mentors, representing 12 counties across the state. After completing the Coach Approach training follow up learning circles were offered to promote TOL on the model. The model supports supervisors to coach workers to empower workers to solve problems with support from the supervisor. ● It is anticipated that additional Coach Approach training will be made available in 2023 to train supervisors. Also to continue with the coach mentor program. This will allow certified coach mentors to support peer learning circles across the state to continue to embed and sustain the IPM in practice.	
Revise pre-service and ongoing training curricula to align with and support implementation of the IPM (PIP Activity).	**2019**
Implementation Status: Completed & Ongoing 2022 Progress: ● The core values, principles and practices of the IPM are now fully infused and thread throughout the redesigned preservice training program, as well as any foundation track and in-service courses developed and facilitated by the CWA Training Team. Curriculum review and enhancement is an	

Key Activities	Benchmarks for Completion
ongoing process to ensure continuous quality improvement. Any revisions or additions to preservice training curricula and materials are made in alignment with the IPM in support of Maryland's child welfare transformation efforts. ● All new in-service training topics are selected and offered in collaboration with SSA with the primary goal of supporting IPM implementation and actualization of IPM core values, principles, and practices into daily work. ● The in-service training catalog inclusive of on-going and newly added courses continued to be reviewed to align with IPM core values/practices and language and as well Family First core values. Outside contractors who facilitate in-service training courses have been provided with clear instructions and guidelines regarding the incorporation of IPM core values, principles and practices, and all materials are reviewed by the CWA Team prior to being delivered to the child welfare workforce to ensure IPM alignment. This review includes course descriptions, learning objectives, core competencies and language. ● In 2023 newly added courses will be reviewed to align with IPM core values, practices, language and Family First core values.	
Implement surveys immediately after pre-service and ongoing training and at 3 months follow up as well as focus groups to assess the effectiveness of learning opportunities in preparing staff to prepare staff to do their job.	**2020 - Ongoing**
Implementation Status: In Progress 2022 Progress: ● January-December 2022: The Workforce Development Network (WDN) in partnership with CWA worked to complete the development of the Post Training Evaluation Plan. This has been an ongoing task for over two years. The evaluation plan was vetted and approved by SSA Executive Leadership, the Outcomes Improvement Steering Committee (OISC) and the LDSS Affiliates (Assistant Directors) in December 2022 with a projected implementation date of January-February 2023. Post Training Evaluation Surveys will be administered at two- and six-month intervals and will use a Likert rating scale to monitor/evaluate the following: o As a new worker, pre-service provided me with a solid foundation of relevant knowledge and skills o Pre-service training is an important component in preparing new child welfare workers for their job o What I have learned from pre-service has made me a more effective worker o I have been able to successfully apply what I have learned in pre-service to my work o I believe I will see a positive impact when I apply what I have learned in pre-service training o The family engagement, interviewing and court simulations have prepared me to do my job more effectively o The opportunity to participate in field experiences during pre-service allowed me to apply newly learned and information and skills o What I learned in training is still valid and beneficial to my current work duties ● In 2023 SSA plans to request a quarterly IOTTA survey to cover Pre-Service, In-Service, and Resource Parent training. SSA will also begin drafting a new scope of work for FY25 to include strong evaluation requirements.	
Develop and implement a professional development module for supervisors on how to coach workers through supervision.	**2020**
Implementation Status: Completed 2022 Progress:	

Key Activities	Benchmarks for Completion
• January- December 2022, 14 LDSSs had completed their IPM coaching intensives, bringing the total to 21 LDSSs who had finished their coaching intensives. These intensives were designed to support TOL of the integrated practice model. As these coaching intensives were initiated throughout the year, SSA began adapting the use of the Coach Approach in providing technical assistance and meeting formats in order to operationalize the IPM. This model is intended to promote critical thinking. • In January, the Coach Approach model began to be offered to supervisors and LDSS leadership as a professional development training. In April, those who had been trained were offered the opportunity to further their skill development to become coach mentors. The intention is to provide each region of the State coach mentors to support this model and sustain the implementation of the Integrated Practice Model. As of December 2022, 17 of 24 jurisdictions had supervisors trained in the Coach Approach model and SSA had 25 staff trained in the model. In addition, 20 trained staff were on track to become coach mentors, representing 12 counties across the state. After completing the Coach Approach training follow up learning circles were offered to promote TOL on the model. The model supports supervisors to coach workers to empower workers to solve problems with support from the supervisor. • It is anticipated that additional Coach Approach training will be made available in 2023 to train supervisors. Also, to continue with the coach mentor program. This will allow certified coach mentors to support peer learning circles across the state to continue to embed and sustain the IPM in practice.	
Integrate innovative TOL activities into all pre-service and ongoing learning opportunities to support learning and adoption of IPM.	**2020-2024**
Implementation Status: Completed & Ongoing 2022 Progress: • January 2022-December 2022 This is an on-going activity. E-learning, simulations and field experience assignments continue to be interwoven into pre-service training activities. In-service training catalog, course reviews and learning objectives continue to be reviewed to identify opportunities to incorporate TOL opportunities to reinforce IPM. • One opportunity was the enhancement of the family engagement simulation activities to better assist staff with honing their interpersonal, assessment, motivational interviewing, communication, and case planning skills. Structured debriefing sessions between actors and participants also allows for direct feedback regarding skill development. • Based on participant, supervisor and trainer feedback, modifications to the preservice simulations (court and interviewing skills) and field experiences are continuously made to best ensure TOL and IPM implementation following preservice completion.	
Integrate the IPM within Bachelor of Social Work (BSW) and Master of Social Work (MSW) programs at local universities (Renegotiated activity from CFSR PIP)	**2024**
Implementation Status: In Progress 2022 Progress: • A sub-committee of the WDN was formed to develop a plan for the integration of the IPM within BSW and MSW programs at local universities, preliminary plans were discussed, and Morgan State was identified as a possible pilot site. Currently, this has been implemented within a sub-contract for Bowie State University (BSU). SSA continues to entertain the option of other Maryland Universities. • This process is continuing in 2023 with Bowie State University. The sub-committee of the WDN will continue to meet and analyze the options of other Maryland Universities	

2.3 IPM information is included in the Scope of Works for residential childcare (RCC) and child placement agency (CPA) provider Contracts.

Table 46: Goal 2 Objective 2.3 Objective Measures

Goal 2 Objective 2.3: Integrate IPM language into provider contracts
Measure for Objective 2.3*:* Integrate language into 100% of the Provider Contracts

Rationale for Objective Selection:
• Headline data shows:
  ○ Maryland's placement stability has fluctuated and as of CY2018, was at 4.38 moves per 1000 days in care, exceeding the target of 4.12
  ○ Maltreatment in care for CY2018 is 11.4 as opposed to the target of 8.5.
• Maryland CFSR Final Report results indicated that the State was not in substantial conformity on Permanency Outcome 1 Item 6 achieving reunification, guardianship, adoption, or other planned permanent living arrangement, 50%
• During Maryland's PIP convening, stakeholder feedback included:
  ○ The needs of families are broad and the challenges they face are often complex, beyond the limited resources of any Local Departments of Social Services or the Social Services Administration.
  ○ Maryland family and child serving agencies and organizations often work in silos, within their own mandates and perceived parameters of confidentiality.
  ○ These silos mean that agencies have limited understanding of what other agencies can offer a family and families too often receive basic referrals versus facilitated referrals (e.g., warm handoffs) and coordinated services.
  ○ Families report going through multiple systems in search of the support they need, becoming increasingly frustrated and disempowered by the difficulty they experience navigating systems, in addition to meeting their own needs as well as those of their family.
  ○ There is a lack of shared accountability among family and child serving agencies and organizations on behalf of child-welfare involved families, in part driven by the lack of a holistic vision that Maryland values safe, healthy, and self-sufficient families.
  ○ A shared vision is a foundational element for bringing together system partners to form partnerships and work collaboratively to share resources and remove barriers in support of families.

Table 47: Goal 2 Objective 2.3 Assessment of Progress

Key Activities	**Benchmarks for Completion**
Develop a common glossary of terms to include in solicitations.	**2020**
Implementation Status: In Progress 2022 Progress: ● Terminology related to the Integrated Practice Model was included in the Provider Questionnaire for FY2023 ● In 2023, a review of the definitions of terms will be completed in preparation of the FY2024 Provider Program Questionnaire. ● The Provider Program Questionnaire will be added to CJAMS in 2023, to include the glossary of terms	
Partner with Provider Advisory Council to clarify terminology and strategies for the IPM.	**2020-2024**
Implementation Status: In Progress 2022 Progress:	

● The Provider Advisory Council (PAC) was reinstituted in August 2022 and updates concerning the IPM implementation, SSA's implementation structure and discussions around the integration of the IPM in provider practices were discussed and were included in the meeting agendas. ● In 2023 the IPM will be implemented with PAC in the development of provider relations and reinforcement of collaboration and teaming strategies.	
Review and develop standard compliance reporting methods that align with the IPM.	**2021**
Implementation Status: In Progress 2022 Progress: ● The Provider Questionnaire and the Annual Report language were both revised and aligned with each other as well as revised to align with the IPM model. Because it was noted that the alignment between these two documents was needed, draft revisions for both were developed in November 2022. ● In 2023 the FY2024 Provider Program Questionnaire will be reviewed and vetted to ensure consistency in terminology prior to its release to providers for completion and submission. ●	
Customize technical assistance for providers based on need.	**2021-2024**
Implementation Status: In Progress 2022 Progress: ● Began to meet proactively with providers to prevent placement disruptions and operationalize IPM practices and principles with teaming to include family and youth teams and LDSS. ● In 2023 efforts to team, collaborate and implement IPM in practice will continue through expanded technical assistance to include other subject matter experts, such as education specialist, medical director and hospital liaison.	

Goal 3: Strengthen Maryland's CQI processes to understand safety, permanency, and well-being outcomes

During the calendar year, DHS/SSA utilized the State and Local Continuous Quality Improvement (CQI) Cycle to strengthen Maryland's CQI processes to understand safety, permanency, and well-being outcomes. The use of the CQI cycles allowed for regular sharing of CFSR and Headline Indicator data performance with internal and external stakeholders through the DHS/SSA Implementation Structure, SSA Advisory Committee, and Foster Care Court Improvement Program (FCCIP). DHS/SSA Implementation Structure groups actively participated in the CQI cycle, facilitated by the CQI Unit, by discussing performance data, considering qualitative data gathered for additional context, and identifying areas needing improvement to be further analyzed and addressed through small tests of change and improvement strategies. As reflected in table 48 below, during CY2022 Maryland achieved goals in Educational Needs of the Child (Item 16), Physical Health of the Child (Item 17), Families have enhanced capacity to provide for their Children's Needs (Well-being Outcome 1) and Services to Family to Protect Child in the Home and Prevent Removal or Re-entry into Foster Care (Safety Outcome 2). For Achieving Reunification, Guardianship, Adoption, or Other Planned Permanency Living Arrangement (Item 6), the goal was not achieved, and there was a decrease in performance for this item.

In order to support continued improvement on Achieving Reunification, Guardianship, Adoption, or Other Planned Living Arrangement (Item 6), DHS/SSA has implemented several targeted approaches to increase performance on permanency outcomes throughout the past year. In partnership with Chapin Hall and University of Maryland, School of Social Work (UMSSW) and through ongoing discussions with internal and external stakeholders, DHS/SSA has collaboratively conducted root cause analyses to identify barriers to achieving permanency outcomes and practice and systemic challenges contributing to delays in the timely achievement of permanency. The identified areas for improvement were shared with the LDSSs for further insight that contributed to the identification of targeted strategies for increasing performance on permanency outcomes. Such efforts include continuing to partner with legal stakeholders via the Implementation Structure to address barriers related to effective collaboration between the LDSSs and courts and providing technical assistance to LDSSs with upcoming Child and Family Services Reviews (CFSRs) to support the achievement of permanency for children and youth with open foster care case, especially in for children and youth with a goal of guardianship.

DHS/SSA continues to implement the IPMl in order to sustain outcomes and improve the outcome yet to be achieved. In addition to understanding performance on key measures, IPM training, IPM Coaching Intensives, Coach Approach Model training and learning collaboratives are integrating opportunities to adjust continuous support of sustainable skill building related to authentic partnership and engagement, teaming, assessing, planning, monitoring, and adapting goals of families, children, and youth with the ultimate goal of transitioning them out of our system. Feedback obtained from participants was immediately incorporated into the training curriculum and learning collaborative sessions to enhance skills directly related to the CFSR items outlined in table 48 below.

Table 48: Goal 3 5-Year Monitoring Targets

5-Year Measures of Progress:	Baseline CY2018	2021 APSR CY2019	2022 APSR CY2020	2023 APSR CY2021	2024 APSR CY2022	2024 APSR CY2023
The percentage of cases rated as a strength during CFSR PIP monitoring case reviews related to children being safely maintained in their homes whenever possible will increase to 79% or higher by the conclusion of the CFSP period. (Safety 2)	69%	63%	76%	83%	88%	

The percentage of cases rated as a strength during CFSR PIP monitoring case reviews related to achieving reunification, guardianship, adoption, or other planned permanent living arrangement will increase to 60% or higher by the conclusion of the of the CFSP period (Item 6)	50%	23%	16%	34%	31%	
The percentage of cases rated as a strength during CFSR PIP monitoring case reviews related to families having enhanced capacity to provide for their children's needs will increase to 41% or higher by the conclusion of the CFSP period. (Well-being 1)	31%	22%	39%	48%	44%	
The percentage of cases rated as a strength during CFSR PIP monitoring case reviews related to children receiving appropriate services to meet their education needs will increase to 89% or higher by the conclusion of the CFSP period. (Item 16)	79%	88%	94%	95%	100%	
The percentage of cases rated as a strength during CFSR PIP monitoring case reviews related to children receiving adequate services to meet their physical and mental health will increase to 68% or higher by the conclusion of the CFSP period. (Well-being 3)	58%	81%	90%	86%	88%	

Table 49: Goal 3 Objective 3.1 Measures

Goal 3 Objective 3.1: Monitor fidelity, quality, and impact of IPM implementation through CQI that consistently engages key stakeholders to share in decision-making and that leads to strategy adjustments when warranted (PIP Strategy)
Measure for Objective 3.1: Focus groups will be conducted as an addition to CQI processes to collect qualitative data. Results will measure the fidelity, quality, and impact of the IPM. Evaluations after training, TOL, and coaching will also assist in measuring this objective.

Rationale for Objective Selection:

The IPM has recently been developed and launched, an evaluation plan has not yet been developed and integration with CQI has not been planned. An evaluation plan allows the State to:

- Post research questions in order to understand quality, fidelity, and outcomes
- Empirically gauge progress on IPM implementation and outcomes
- Monitor, understand, and refine the IPM implementation
- Maximize child and family outcomes through the impact of the IPM on case practice.

Table 50: Goal 3 Objective 3.1 Assessment of Performance

Key Activity	Benchmarks for Completion
Based on lessons learned, refine evaluation plan & practice.	**2021-2024**
Implementation Status: In Progress 2022 Progress: ● May – October 2022: CFSR Focus Group data concludes that SSA is making progress, according to parent and youth feedback, in teaming with them. However, feedback from the courts, resource parents, and attorneys reflect a need for a better collective understanding of concurrent planning and application of the concept in improving outcomes for permanency. The webinar on teaming with court partners was successfully launched in June 2022. ● A similar training format is planned to be launched in 2023 to improve permanency outcomes. The training is aimed at training court partners and staff across the state. Additionally, in 2023, SSA will work with local departments to connect them to their permanency liaisons to support court partnerships and have ongoing robust conversations with the courts about achieving permanency and the use of concurrent planning. Two concurrent planning trainings will be held in-person in July 2023 with the local departments. The trainings will be recorded to ensure that all child welfare staff have access to the training.	
CQI to improve implementation and outcomes of the IPM.	**2021-2024**

Implementation Status: In Progress
2022 Progress:

- January – December 2022: The CQI unit continues to discuss the IPM in the Orientation and Practical Data meetings with the LDSSs to understand how the LDSSs are implementing the core IPM principles and practices in their work with families in order to support the safety, permanency, and well-being of children. The CQI unit provides feedback on the LDSS's use of the IPM principles and practices in the context of their CFSR review through the CFSR Results Report, which is shared during CIP meetings and used to develop the objectives and strategies outlined on their CIP. The CQI unit encourages open and honest conversations about barriers to implementing the IPM and the resources and initiatives the LDSS is utilizing to support teaming efforts with families, within their agency, and with community partners.

- After reviewing the reports from the focus groups conducted in April 2022 and October 2022, there was considerable overlap noted in the main themes identified as it relates to engaging and teaming with families. In April, transparency and consistency in teaming by the LDSS was critical to families reporting positive teaming experiences with the LDSS. In October, transparency, in the form of honest and open communication, was highlighted as an important aspect of building trust with families and, regarding consistency, youth and biological parents reported mixed experiences with the frequency of engagement and contact with the LDSS throughout the case. Furthermore, in the October focus groups, workers discussed their process for preparing families for FTDMs and ensuring that the families' support system is invited to formal team meetings.

Table 51: Goal 3 Objective 3.2 Measures

Goal 3 Objective 3.2: Strengthen data and CQI tools to increase consistent implementation and utilization of the State's CQI cycle
Measure for Objective 3.2 Annually reviews the State CQI cycle utilized within the OISC and development of action steps for improvement if needed.
Rationale for Objective Selection: ● The Maryland CFSR final report results indicated the Quality Assurance Systems were not in substantial conformity. ● The Office of Legislative Audits report results found Maryland to not be in compliance with 14 child welfare outcomes including a systematic approach to quality assurance.

Table 52: Goal 3 Objective 3.2 Assessment of Performance

Key Activity	Benchmarks for Completion
Continue to refine and enhance Headline Indicator and the CFSR results dashboards to support utilization of data by state and local staff.	**2019**

Implementation Status: In Progress
2022 Progress:

- The CFSR Performance Report continues to be posted to the internal and external DHS platforms. The results were shared and discussed with the Implementation Teams, Outcomes Improvement Steering Committee, FCCIP, and SSA Advisory Board. Updated Headline Indicator data was posted to the internal DHS platform and emailed to each of the LDSSs on a quarterly basis. Headline Indicator dashboards continue to be produced for each of the LDSSs prior to CFSR Orientation and Practical Data Meetings, Continuous Improvement Plan (CIP) Meetings, and CIP Monitoring Meetings so that they can compare their outcomes and progress with their trend data. CFSR Results Reports that are provided to LDSSs following CFSR case reviews continue to include data around Integrated Practice Model (IPM) practices, principles, and values observed. To align the Headline Indicators with the CFSR round 4 statewide data indications, revisions to the Headline Indicators were made in 2022. The LDSS were notified of the changes, which included changing time frames from quarterly to annual, removing all youth over the age of 18 for permanency and placement stability measures, and including the Trial Home Visits timeframe to permanency in 12 months for entry. Storyline indicators regarding timeliness of initial F2F are still in progress but should be available during CY2023. Also added to the Headline Indicators were storylines for all permanency and placement stability measures regarding race/ethnicity, age, and circumstances of removal. Storylines were also added for entry rate regarding circumstances of removal and age.
- In 2023, the CFSR Performance Report will be reviewed and modified to account for the upcoming CFSR Round 4.

Provide ongoing presentations to LDSSs to enhance the quality of the data and the capacity of staff to use it effectively.	**2019 and annually**

Implementation Status: In Progress
2022 Progress:

- January – December 2022: SSA data analytics leadership provides regular data presentations on various aspects of agency performance in Maryland on safety, permanency, and well-being outcomes. This has included presentations on CFSR performance to LDSSs throughout the year to enhance data quality and the capacity of staff to use it effectively in improvement planning. During CFSR Orientation and Practical Data Meetings, Continuous Improvement Plan (CIP) Meetings, and CIP Monitoring Meetings with LDSSs, DHS/SSA reviews and explains the local Headline Indicator data related to safety, permanency, and well-being as well as CFSR case review qualitative data to identify practice strengths and areas needing improvement. These meetings include participation by LDSS leadership and staff to increase their understanding and capacity to utilize data for practice improvement. DHS/SSA encouraged LDSS leadership and staff to identify the stories behind the data to translate the data into lessons learned that can support meaningful changes to practice. Moreover, the data analytics team provides agency-wide trainings to LDSS staff on data literacy to support their ability to understand quarterly Headline Indicator dashboards.
- In 2023, SSA data analytics leadership will continue to provide technical assistance to the local departments as needed through means that best support their understanding of the Headline Indicator data.

Increase statewide accessibility of Headline Indicators and the CFSR results dashboards.	**2020**

Implementation Status: In Progress
2022 Progress:

- January – December 2022: The CQI Unit routinely reviews and discusses the most recent LDSS Headline Indicators with each LDSS bi-annually during their CFSR CIP Monitoring meetings. Following each LDSS CFSR case review, the CQI Unit reviews the CFSR findings in comparison with the LDSS Headline Indicator data with the LDSS leadership, staff, and external stakeholders in a CIP Meeting and provides the LDSS with a CFSR Results Report outlining the strengths, areas needing improvement, and recommendations. The SSA Headline Indicator dashboard and CFSR results continue to be reviewed regularly in a variety of internal and external stakeholder meetings, and leadership and staff are actively aware of agency performance trends. Case review narratives were analyzed as it relates to the timely achievement of permanency to understand the root causes of key practice issues. Results were provided by DHS/SSA to implementation teams in order to provide additional context for CFSR and Headline Indicator performance. These summary analyses continue to be particularly useful in providing actionable insights, especially related to permanency planning, family engagement, service provision, and teaming practices with families and the court, thus equipping LDSSs with the knowledge needed to develop targeted strategies for improvement.
- The CQI Unit will continue to share the CFSR Results Report and the Headline Indicator dashboard with the local departments at regular intervals and continue to discuss qualitative and quantitative data with internal and external stakeholders during various meetings in 2023. Additionally, the CQI Unit will continue to monitor agency performance trends as it relates to the timely achievement of permanency and the results of this ongoing analysis will be provided to the local departments.

Develop and implement a local quality assurance process to monitor compliance with state and federal regulations.	**2020 and biannually**

Implementation Status: In Progress
2022 Progress:

- Maryland has continued to utilize a Quality Assurance (QA) Review process with LDSSs with CPS reviewed quarterly and the remaining service areas reviewed semi-annually. These QA Reviews allow each LDSS to critically assess the quality of practice and local-level processes. Included are case-level and resource provider level reviews to support an ongoing understanding of LDSS performance related to national and statewide standards. These efforts are informing opportunities to improve practice and ensure quality service delivery for children and families receiving in-home and out-of-home services. In addition, these reviews facilitate targeted course corrections where needed in local jurisdictions. The LDSS QA Reviews occur in parallel with the statewide DHS/SSA Administration QA Reviews and aid the state in identifying statewide versus local trends in practice and understanding which additional resources, training, technical assistance, or other supports are needed to address gaps and areas needing improvement. Through these reviews, LDSSs can elevate local insights on performance for SSA to review cumulatively in addition to other evidence and data gathered on statewide performance across CFSRs and safety, permanency, and well-being indicators in addition to program improvement measures. Insights and trends noted through QA Reviews are leveraged for statewide policy and program decision-making while also enabling LDSSs to monitor their own performance to guide locally driven improvement efforts.
- The QA Reviews will continue to be utilized alongside the CFSR on-site reviews to drive policy and practice reform in 2023.

Enhance state CQI cycle to support regular reviews of progress, identify areas of growth, and test out small measures of change.	**2020-2021**

Implementation Status: In Progress
2022 Progress:

- January – December 2022: Qualitative data collected through the state CFSR case review process using the narrative summaries from the On-Site Review Instrument (OSRI) continues to inform practice improvements related to permanency and well-being. The CQI Unit in partnership with Implementation Teams within the DHS/SSA Implementation Structure and local jurisdictions have used this information to identify areas of growth to improve teaming efforts between the agency, court, and families. Through the existing CQI process, stakeholders were engaged in LDSS convenings. In addition, each jurisdiction receives targeted assistance and facilitation from the CQI Unit following their site's CFSR case reviews to construct a data-driven, comprehensive continuous improvement plan that is tailored to address opportunities for improvement illuminated during the on-site review process. This process will continue to be utilized throughout 2023.

Monitor implementation of CQI cycle and local quality assurance process, making adjustments as needed.	**2021-2024**

Implementation Status: In Progress
2022 Progress:

- January – December 2022: The CQI Unit continued to monitor implementation of Maryland's State CQI cycle. This has included regular review and discussion of outcomes data to identify performance improvement opportunities, prioritize performance issues, conduct root cause analyses, and develop strategies to address the priority areas needing improvement. CFSR and Headline Indicator performance data were regularly reviewed with key internal and external stakeholders through the DHS/SSA Implementation Structure. These groups were actively involved in a variety of root cause analyses related to improving performance on OSRI items assessed through the CFSR process. Specifically, the DHS/SSA Service Array Implementation Team's Health Workgroup identified improving coordination of health care services to support timely completion of required health exams and preventive health services including behavioral health as key improvement areas to address.
- In 2023, the CQI Unit will continue to involve key internal and external stakeholders in conducting root cause analyses as needed in an effort to understand performance outcomes and develop strategies to improve practice.

Goal 4: Improve workforce wellness to reduce the impact of secondary traumatic stress and decrease turnover rates

The issue of Secondary Traumatic Stress (STS) remains a priority for SSA. Attention has been given to ensure that STS trainings are offered throughout the training system to support worker wellness and foster Safety Culture. New staff are introduced to issues related to child welfare trauma in pre-service module one: Foundations of Child Welfare Practice. This is followed by Trauma Responsive Casework in module two: Complicating Factors Impacting Child Abuse and Neglect. Modules one and two first discuss client related trauma and then STS more generally; concentrating on the definition and common factors that contribute to STS. Module six: Family Driven Planning, Intervening and Monitoring has several sections devoted to the actualization of the IPM which looks at STS with a more impactful lens and focuses on issues of self-awareness, burnout, compassion fatigue, DSM-V-Acute Stress Disorder, resilience, and post traumatic growth. These topics are also covered and reinforced in Foundations and in-service with even more concentration on the emotional, physiological, behavioral, interpersonal, and cognitive elements of STS. In these full day sessions staff are involved in developing a "Self-Resiliency Plan" which identifies professional strategies and self-care practices to address STS.

The CY2022 retention rate percentage decreased slightly from the prior year. This decrease is reflective of the struggles that the Department has experienced with the staff turnover following the pandemic. As a result, SSA is also beginning to collect the turnover rate among child welfare caseworkers - 15.75% in CY2022. Our retention rate is important to identify the experience and knowledge for the agency and it is also important to see the overall turnover of staff from year to year. Our retention rate provides valuable information on the experience and knowledge of agency staff, but SSA has been seeking more data on the overall turnover of staff from year to year. We expect to see this number decrease over the next year as the fluctuations in the labor force stabilizes. Due to a transition in data collection between our contract with the Child Welfare Academy and the DHS Learning office, SSA is unable to quantify the percentage of new staff completing the STS and Safety Culture trainings. DHS/SSA is working to consolidate this data to be able to effectively report on this metric. DHS/SSA remains committed to introducing the Safety Culture concepts to SSA Leadership, Directors, Program Managers, and Supervisors as well as maintaining the training as part of the ongoing curriculum.

Table 53: Goal 4 5-Year Monitoring Targets

5-Year Measures of Progress:	Baseline CY2018	2021 APSR CY2019	2022 APSR CY2020	2023 APSR CY2021	2024 APSR CY2022	2024 APSR CY2023
NEW MEASURE: Increase percentage of new staff completing trainings on STS and Safety Culture included in Foundations training within one year of joining the workforce by 6% (2% per year) over the CFSP period. **Due to a transition in data collection between our contract with the Child Welfare Academy and the DHS Learning office, SSA is unable to quantify the percentage of new staff completing the STS and Safety Culture trainings in CY2022.*	47%	67%	58%	48%	*Not Available	
NEW MEASURE: There will be an increase in new child welfare caseworker staff 5-year retention rates by 10% (2% per year) over the CFSP period	41%	43%	49.62%	49.3%	46.3%	

Table 54: Goal 4 Objective 4.1 Measures

Goal 4 Objective 4.1: NEW OBJECTIVE CY2020: Incorporate worker wellness and safety culture into pre-service and in-service training to raise awareness of and mitigate STS.
Measure for Objective 4.1*:* NEW MEASURE: Percentage of new staff completing training on STS and safety culture within one year of joining the workforce.

- Please see the chart above. Due to a transition in data collection between our contract with the Child Welfare Academy and the DHS Learning office, we are unable to quantify the percentage of new staff completing the STS and Safety Culture trainings in CY2022.
- New staff are introduced to issues related to child welfare trauma as a mandatory part of pre-service.
- In 2023 the Coach Approach training will continue to incorporate secondary trauma and psychological safety.

Table 55: Goal 4 Objective 4.1 Assessment of Progress

Key Activities	Benchmarks for Completion
Provide technical assistance and support to LDSS as they participate in and complete STS-BCS, monitor and track data related to turnover, STS, Burnout, and Safety Culture.	**2020-2024**
Implementation Status: Complete 2022 Progress: ● This goal was not continued as it was determined that there were not enough funds to pursue implementation.	

Goal 5: Strengthen system partnerships to improve safety, permanency, and well-being of youth and families as well as build a prevention service array to support children and families in their homes and community

During this reporting period, SSA engaged in interviews with LDSS to learn more about successful interventions and partnerships with service agencies and how to close service gaps that are impacting serving families. This includes learning more about key components with partners such as Developmental Disabilities, Department of Juvenile Services (DJS), Local Housing Programs, Hospitals, and services for Unaccompanied Homeless Youth. With the support of the Service Array Implementation Team members, the agency was able to collect materials for a partnership toolkit of essential materials for partnership building and lessons learned document that highlights Best Practice Strategies for successful partnership and service coordination with various service providers. The team also developed a set of recommendations from interviews that will assist the agency in strategic planning around enhancing partnership in targeted service provider areas.

SSA continues to strengthen system partnerships to improve safety, permanency, and well-being of youth and families through the Family First Prevention Services Act implementation. This includes building partnerships with agencies to provide services to families. Currently there are 17 out of 24 LDSS participating in evidence based programs through FFPSA. Prevention services that are currently part of Maryland's Family First plan are: Family Functional Therapy (FFT), Multisystemic Therapy (MST), Parent Child Interaction Therapy (PCIT), and HFA Healthy Families America (HFA). Nurse Family Partnership (NFP) is also part of Maryland's plan but is only available in one jurisdiction which has not been trained in Family First Prevention Services Act (FFPSA) yet. Sobriety Treatment and Recovery Teams (START)
and Family Centered Treatment (FCT) are part of Maryland's plan but due to their status of Supported vs. Well-supported an evaluation is needed to include these two EBPs in FFPSA reimbursement claiming.

Monthly check-in meetings are held with LDSSs to discuss with the counties how implementation is progressing and barriers. A barriers and strategies document using PDSA is being built to establish strategies to work through the barriers that the state is facing. Some of the barriers that have been brought up with the counties center around family engagement, how to talk with families about imminent risk, and how to know what evidence-based practice will work best and how to explain these to families.

On July 27, 2022, the Institute (School of Social Work) virtually hosted DHS and DJS holding a "Quality Improvement: DJS/DHS Quarterly Collaborative" focusing on best practices for referrals and MST/FFT services; it was received positively. During this collaborative, one-pagers that had been created for these services were added as handouts that could be used for talking through with and giving to families that may benefit from the Evidence-Based Programs (EBPs). On October 26, 2022, another MST/FFT collaborative meeting was hosted by the Institute at the School of Social Work with DJS and DHS which focused on engagement with the families and barriers to services. This one was also received well.

In addition to these collaboratives, the Communication Team at SSA created a tip sheet "Tips for Talking with Families About Prevention." This worksheet was disseminated to caseworkers for help with difficult discussions. It focused on engaging the families in discussions about safety concerns, planning together, and offering resources as well as how to respond when families get angry or upset during the discussion.

SSA also meets with various counties and EBP (Evidenced-Based providers) to discuss their concerns with data collections, referrals, and claiming issues. In December, Phase III of Implementation began with training the final 7 counties in what the Family First Prevention Services Act of 2018 is and how it will change their work with families.

Data charts for FFPSA prevention EBP outcomes were tracked by University of Maryland School of Social Work for PCIT, MST, and FFT. See the charts below for Utilization and outcomes for FY2022.

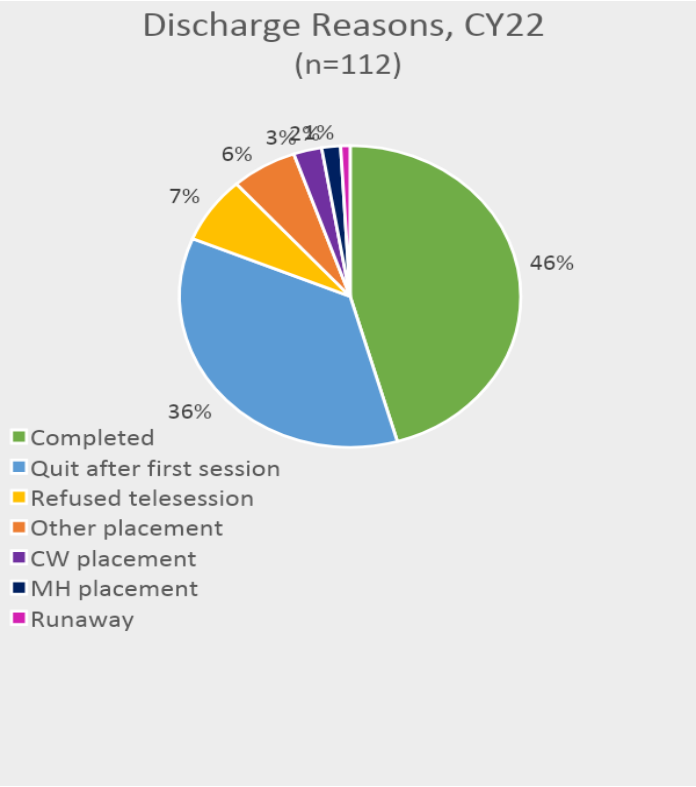
The chart below shows the number served by evidence-based practices and inclusive of families who started treatment as well as those who were discharged during this period. HFA counts per child; 39 children were served through HFA during calendar year 2022. Each of the other evidence-based practices listed counts by family. 12 families served through PCIT, 176 families were served through FFT, and 49 families were served through MST.

Table 56: FFPSA EBPs

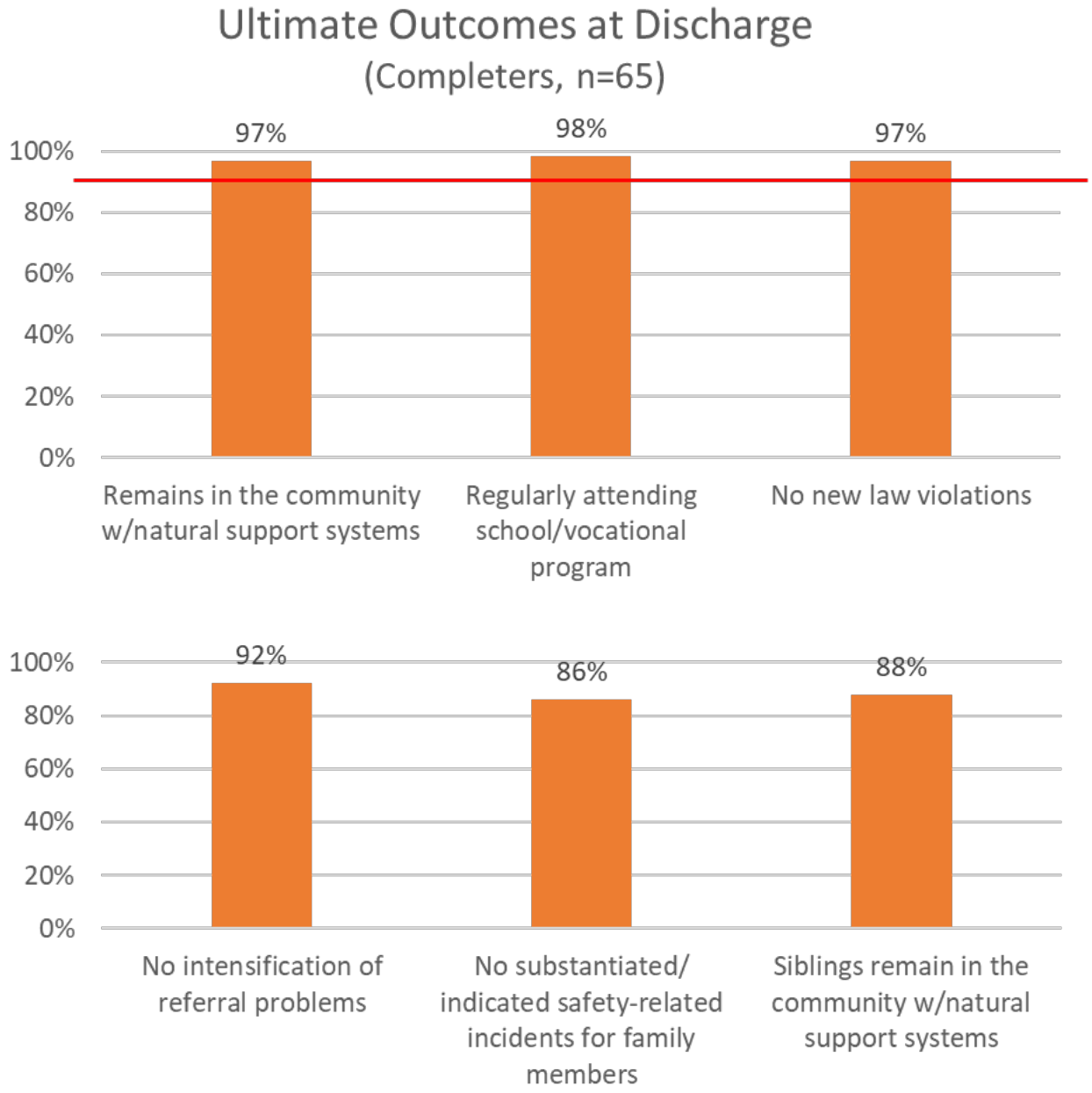
Maryland's FFPSA Evidence Based Practice	# Served CY2022
Healthy Families America	39 children
Parent-Child Interaction Therapy	12

Family Functional Therapy	176
Multisystemic Therapy	49
Data Source: The Institute for Innovation and Implementation, 2022	

The pie graph below shows the reasons for discharge of families from FFT for those that were discharged during 2022. It is unsettling that 36% of families quit after one session; however, the state is working on this issue through PDSA and improvements have been made since the previous data that showed 44% of families quit after one session. There have also been improvements in completion rate up from 39% at previous data to this pie graph showing 46% of families completing treatment. The outcomes of FFT include children remaining in the community, attending school, not receiving new law violations, siblings remaining in community with natural support, no substantiated or indicated safety-related incidents for family members, and no intensification of referral problems all exceeded the target level of 80% for those families that completed FFT.

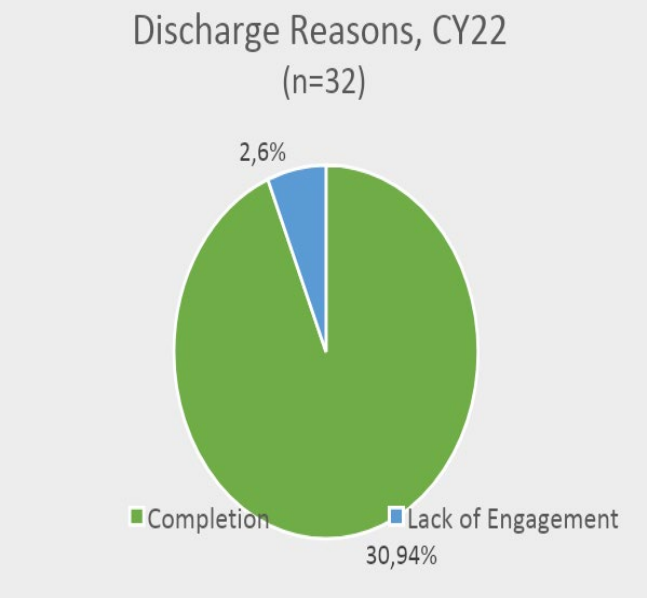


Data Source: The Institute for Innovation and Implementation, 2022

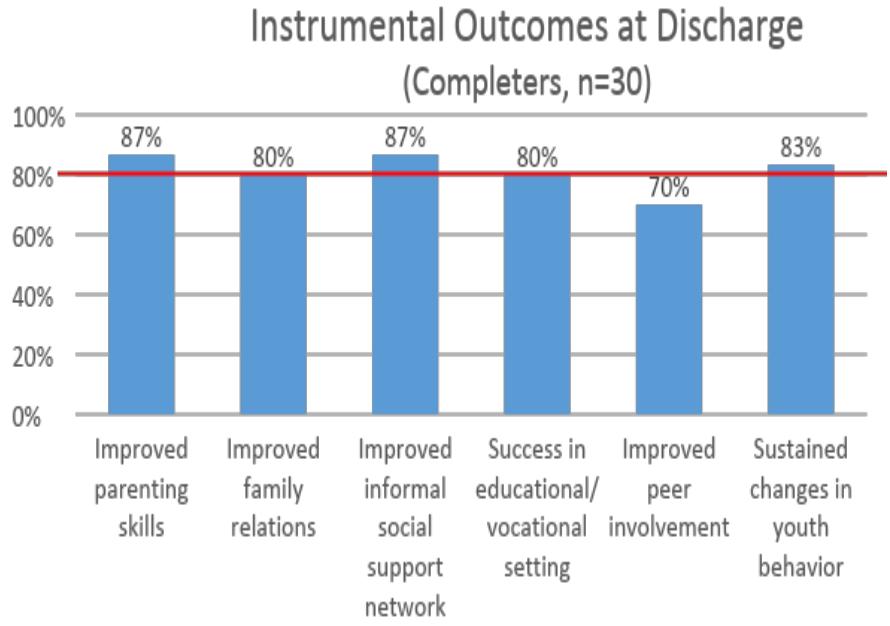


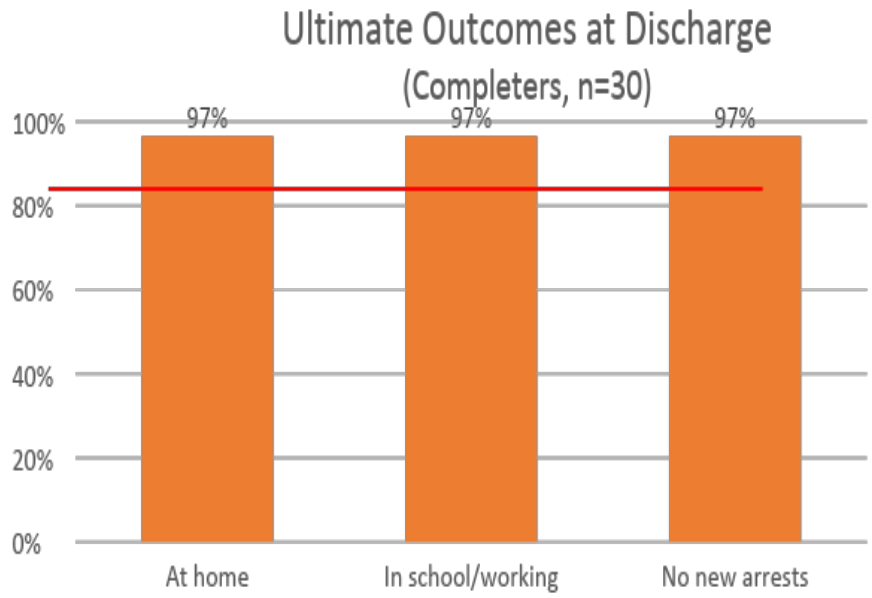
Data Source: The Institute for Innovation and Implementation, 2022

During CY2022, 94% of families who participated in MST completed the service. The bar graphs show that for all families that completed MST outcomes were met or exceeded in the following categories: improved parenting skills, improved family relations, improved informal social supports, success in educational/vocational setting, sustained changed in behavior during the program, the youth stayed at home, was in school or work, and had no new arrests. The one area that was a little below target was improved peer involvement but that was still 70%; the target is 80%.



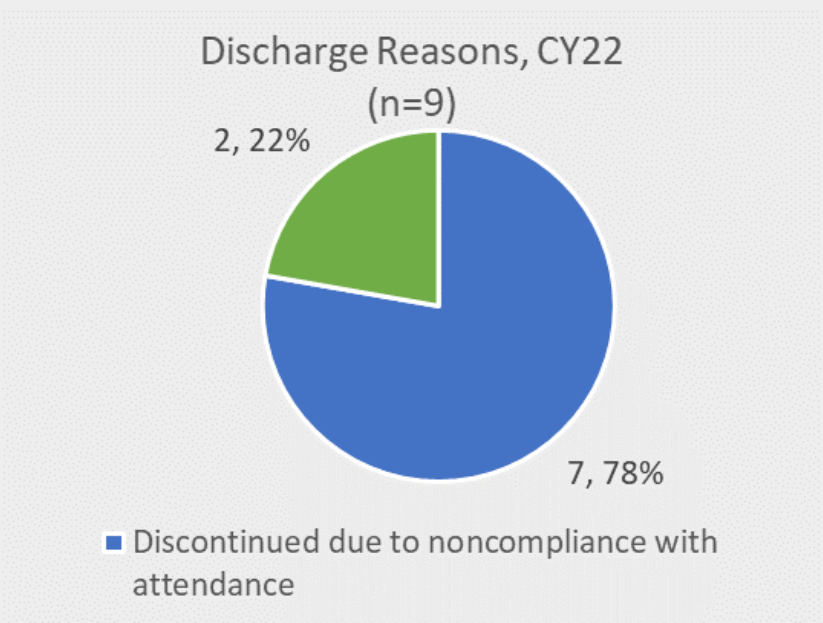
Data Source: The Institute for Innovation and Implementation, 2022





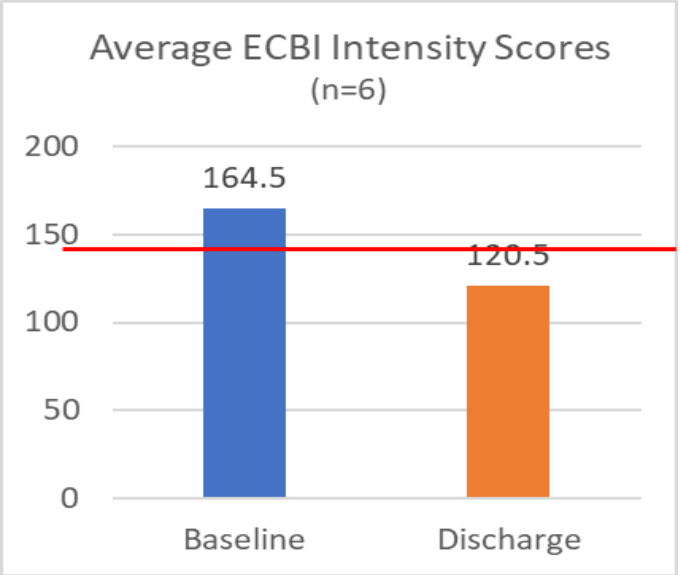
Data Source: The Institute for Innovation and Implementation, 2022

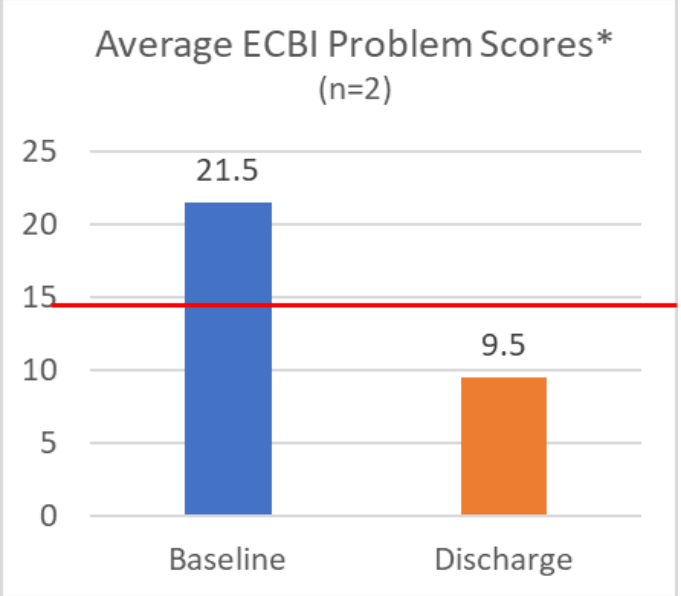
The pie graph below shows that only 22% of the 9 families who were discharged from PCIT in 2022 completed treatment (or “met PCIT graduation criteria"). Research has shown that community based PCIT can high dropout rates (e.g., Lyon & Budd, 2010), but that even small doses of PCIT (i.e., 3-4 sessions) can result in improvements in parenting skills (e.g., Hakman et al., 2009) and children's behavior (Lieneman et al., 2019). Although 78% of families did not complete PCIT, those 7 families attended 8 sessions on average, suggesting they likely still benefited from treatment.



Data Source: The Institute for Innovation and Implementation, 2022

Further, outcome data collected as part of PCIT implementation indicates that DSS families are benefiting from the program (see charts below). The Eyberg Child Behavior Inventory (ECBI) is administered with caregivers during the course of PCIT and measures the intensity, or frequency, of the child's problem behaviors as well as how problematic the caregiver perceives their child's behaviors (note: the Intensity Scale is collected at each session and the *Problem Score is only completed with families who completed both phases of PCIT and graduated). The chart on the left shows: Of all families who were discharged from PCIT and completed the Intensity Scales, the average score decreased from 164.5 at baseline to 120.5—below the clinical cutoff—as of discharge. The chart on the right shows: Of those who graduated from PCIT (n=2), the average Problem Score declined from 21.5 at baseline to 9.5—again, below the clinical cutoff—as of discharge.





Data Source: The Institute for Innovation and Implementation, 2022

SSA has a contract with Advance Metrics that is to start next year for HFA data purposes. Advance Metrics will teach LDSSs how to use their data collecting program and they will be able to track outcomes through there.

Implementation & Program Supports

Data Systems

During 2022, technical assistance and support to case workers was provided through a variety of processes. Most surrounded improving performance of CJAMS for case workers although training around utilization of the Headline Indicator Dashboard and program Milestone continued to be provided to supervisors and managers as requested.

Data Reports

During 2022, the focus was on data integrity and the stability of the current milestone reports in Qlik (CJAMS Reports). This was a collaborative process with the LDSS and Maryland Total Human-services Integrated NetworK (MD THINK) and included developing a better understanding of where the data was found in the application, ensuring the report logic was accurate, and supporting data entry into the system. Data validation of the milestone reports occurs three times per week, ensuring that they maintain a high degree of stability and accuracy for the LDSSs.

The report development team also focused on crucial application fixes to ensure proper data flow to the QLIK reports. This group met weekly to review reports already in production and deploy any needed fixes, as well as to discuss the prioritization and development of other child welfare and provider reports needed to support case management and program processes.

Throughout 2022 there was a concerted effort to review both report functionality and the way users interact with the reports on a regular basis. Research and Evaluation continues to partner with MD THINK to design and construct reports to be both user-friendly and to provide a clear and effective visualization of the data.

Baltimore City Consent Decree Reports

In 2022, Research and Evaluation focused heavily on providing support to Baltimore City in the development, testing, and implementation of over 60 reports for the consent decree. These reports have eliminated the need for hand counts for all of the required data, and they can be validated with other QLIK reports derived from the same CJAMS elements. Thanks to the work completed in 2021, this group met at least twice per week to develop the Business Specifications, review and test the newly created reports, and approve these reports for deployment into production in CJAMS. By the end of 2022, 53 of these reports were fully deployed to production and 11 more were in development or partial production.

During this same time frame, increased attention was paid to aligning business specifications and policy, creating and implementing application enhancements, and identifying and carrying out user training. Most of the reports focus on elements of foster care and the work completed by the case workers. All reports were developed such that they will meet the needs of the consent decree, but also be more broadly usable by every jurisdiction statewide. Research and Evaluation's focus on these reports will lessen once they have all been moved into production, though modifications

and changes will be made as needed to ensure the accuracy and usability of these reports over time.

CJAMS Support & Enhancement
Systems Management provided coordinator groups to discuss challenges and concerns with CJAMS functionality and to help troubleshoot issues, initially meeting twice per week and eventually reducing the frequency to once every two weeks. Representatives from all LDSSs, DHS/SSA, and MD THINK applications participated in these meetings. The focus was to ensure that caseworkers can document information about their children and families accurately, efficiently, and effectively, and to support the overall case management process. Additionally, bi-weekly calls are held with CJAMS Child Welfare Coordinators to cover agenda items such upcoming demos, how-to guides, user training, questions on CJAMS functionality, and outstanding CJAMS ticket issues.

Over the course of the year there were also several work groups focusing on the creation of stories to enhance CJAMS, which eventually consolidated into a single, larger meeting. This group outlined needed modifications, enhancements, and new features to be included in CJAMS to improve both the user experience and data quality management. The membership of the group included a DHS/SSA systems development team member whose focus was on the application and the training needs for the enhancement being requested. This group also participated in viewing demonstrations and testing these enhancements, asking questions about their applicability and scope. This helped to ensure that any enhancement would work for the end user as well as support reporting requirements.

Adoption and Foster Care Analysis and Report System (AFCARS) Updates
The revised Adoption and Foster Care Analysis and Report System (AFCARS 2.0) went into effect in October 2022, and much of the year was spent on the development and implementation of these new requirements in our applications. Research and Evaluation focused on writing stories that would identify necessary modifications and enhancements to CJAMS in an effort to collect the required data elements. After creating application stories, groups consisting of data analysts, end users, data administrators, DHS/SSA leadership, program staff, and MD THINK staff convened to ensure proper functionality. Prior to the start of the October review period, training sessions were held that included all LDSSs to go over the updated AFCARS measures and show all new elements in the CJAMS application. The Research and Evaluation Team continues to review this data regularly and communicates with the LDSSs on any needed updates to ensure that Maryland is able to meet the federal reporting requirements. In the coming months, there will be a QLIK report available to all LDSS to allow for periodic checks of their AFCARS compliance, prior to the report submission deadlines.

Section 5: Quality Assurance System

Maryland continues to grow and leverage its Quality Assurance/Continuous Quality Improvement (QA/CQI) System to implement improvement activities outlined in the 2020-2024 Child and Family Services Plan (CFSP).

Foundational Administrative Structure

The CQI/QA unit at SSA oversees the Quality Assurance (QA) System and local CQI processes in the state of Maryland. The CQI/QA unit provides Child and Family Services Review (CFSR) peer reviewer training and quality assurance training throughout the year to SSA staff, volunteers from local departments, and partners at Chapin Hall and the University of Maryland School of Social Work. This training consists of applying the federal Onsite Review Instrument (OSRI), reinforcing high quality reviews, reviewing written CQI policies and procedures, and building capacity of newer staff. Staff also receive training in understanding Maryland's Headline Indicator dashboard performance. Staff meet with external reviewers on an ongoing basis to assess overall trends towards improving outcomes and discuss the overall quality of the reviews to promote fidelity to the CFSR review process.

Maryland continues to build capacity to enhance its current CQI/QA system by working closely with Chapin Hall and the University of Maryland School of Social Work. Through these partnerships, DHS/SSA can anticipate and plan for staff attrition and maintain a highly functional CQI/QA system. Over the past year, for example, the CQI/QA unit was not fully staffed and lost a CQI supervisor, but SSA was able to leverage these partnerships to fill key gaps until SSA was able to hire another CQI analyst and a CQI supervisor. Additionally, on a yearly basis, the CQI/QA team works closely with Chapin Hall to build additional capacity in understanding performance by implementing a more rigorous root cause analysis (RCA) approach to enhance Maryland's performance in achieving improved outcomes for children and families. The RCA is based on the Capacity Building Center for States approach and consists of developing guiding research questions, developing a data plan, developing a theory of change to address root causes in the barriers to achieving outcomes for children and families. During CY2022, the CQI/QA team and Chapin Hall implemented the RCA to support timely face-to-face contact with victim children and their families after a maltreatment report is accepted (Item 1) and the timely achievement of permanency outcomes (Item 6). This work will be further used to inform Maryland's Statewide Assessment for CFSR round 4.

Quality Data Collection

The Maryland CFSR is conducted using the federal OSRI, which assesses the quality of practice and service delivery to children, youth, and families. Through Maryland's CQI/QA System process, DHS/SSA identifies practice strengths and needs of the service delivery system using data extracted from reports within the federal Online Monitoring System (OMS). This information is combined with the Headline Indicator dashboard performance, which utilizes data extracted from CJAMS (i.e., CCWIS).

In 2021, Maryland initiated the implementation of a local QA review process designed to assess compliance with key child welfare activities. Through the use of a standardized tool, these QA reviews allow each LDSS to critically assess the quality of practice and local level processes. Included are case-level and resource-provider level reviews to support an ongoing understanding of LDSS performance related to national and statewide standards. These efforts are informing opportunities to improve practice and ensure quality service delivery for children and families receiving in-home and out-of-home services. In addition, these reviews facilitate targeted course

corrections where needed in local jurisdictions. Over the past year, the QA review tools have been revised as needed in order to increase validity.

In addition to these quantitative measures, stakeholder focus groups were held in April 2022 and October 2022. The results of the focus groups were shared with DHS/SSA leadership and will be presented to the Outcomes Improvement Steering Committee in the Spring of 2023. The focus groups provide an opportunity for the families, youth, and professionals involved in the child welfare system to inform SSA's understanding of Maryland performance on systemic factors, the IPM, and other strategies to improve practice.

Case Record Review Data and Process

Maryland's CQI/QA System supports local jurisdictions through the completion of ongoing case reviews, utilizing administrative and case-review data, to assess and understand progress towards achieving positive outcomes for children and families. Maryland conducts monthly state-led reviews of the 24 local departments over the course of six 6-month periods. Each period, two large jurisdictions (including Baltimore City, the state's largest metropolitan region), one medium jurisdiction, and two small jurisdictions are reviewed, with the sample of cases selected proportional to the size of the jurisdiction. The reviews use a random sampling methodology to ensure comparability between review periods. In 2022, nine local departments were reviewed spanning three review periods: Baltimore County, Worcester, St. Mary's, Baltimore City, Frederick, Montgomery, Garrett, Wicomico, and Howard.

Case reviews are led by the CQI/QA unit and supported by volunteers from other units at SSA, child welfare staff from jurisdictions other than the one under review, and partners from Chapin Hall and the University of Maryland School of Social Work, all of whom undergo a formal peer reviewer training process. Reviewers utilize information provided in the case record and interviews of key participants to understand the quality of services provided, the local department's assessment process, and progress toward case goals. With written manuals and instructions provided by the Children's Bureau (CB) for support, cases are entered into the federal OMS and the validity of the ratings are reviewed through a three-tiered QA process. Because of our current infrastructure and ongoing relationship with our partners, SSA intends to conduct a state-led review for CFSR round 4.

When further information is needed regarding specific domains related to the CQI/QA process, program managers at SSA partner with the local departments to conduct deeper analysis and provide targeted technical assistance as needed. For instance, in 2022, the CQI/QA unit supported local departments in analyzing trends in the timely achievement of permanency outcomes (Item 6) using the CFSR data from OMS to understand contributing factors to a rating of Area Needing Improvement (ANI) for Item 6.

Analysis and Dissemination of Quality Data

Maryland's CQI/QA system can evaluate the quality of services using administrative data pulled from CJAMS (i.e., CCWIS) to track progress across sixteen key outcomes that measure safety, permanency, and well-being through the Headline Indicators dashboard. DHS/SSA distributes Headline Indicators on a quarterly cycle statewide to all the local departments. The data show

statewide and individual jurisdiction level progress towards achieving outcomes. To ensure meaningful application of the Headline Indicators dashboard to each local department, storylines were added to the dashboards in 2022 as a way to compare jurisdiction trends to state-wide trends, consider racial disparities, and explore child-level factors associated with performance outcomes. Additionally, statewide CFSR results are disseminated to local departments and to internal and external stakeholders every 6-months. The CFSR Results Report is a summary analysis of local CFSR performance following each CFSR onsite case review. This report outlines the aggregated findings of the LDSS onsite case review, including trends around their practice areas of strength and areas needing improvement. The report then summarizes the overall CFSR performance trends in comparison to the local Headline Indicator data and provides recommendations for practice improvement.

DHS/SSA continues to regularly review and discuss aggregate CFSR performance data with external and internal stakeholders at a variety of venues within the DHS/SSA Implementation Structure (see Collaboration and Feedback Loops section for additional information). These discussions focus on identifying trends across program and service areas, assessing strengths and barriers, and identifying potential root causes impacting performance. SSA is committed to improving the CQI/QA system by amplifying family voice and the voices of those with lived experience by creating spaces alongside other stakeholders for ongoing discussions around the data and eliciting feedback to make substantive changes to practice.

Feedback to Stakeholders and Decision-makers and Adjustment to Program and Process

The CQI/QA unit reviews the CFSR Results Report with the local departments following the on-site review to ensure understanding of the data analysis and collaborate with the local department to develop strategies to implement recommendations for practice improvement and navigate identified barriers. CQI/QA unit provides the LDSS targeted assistance to construct a data-driven, comprehensive Continuous Improvement Plan (CIP) to leverage their strengths and develop strategies to address areas needing improvement. Such strategies include, but are not limited to, bolstering training, forming and strengthening community partnerships, and providing technical assistance to translate policy to practice. The CIP is then monitored on an ongoing basis bi-annually through meetings between the CQI/QA unit and the local department until the LDSS restarts the cycle.

The CFSR process is reflected upon on an ongoing basis to determine its successes and areas needing adjustment. The CQI/QA unit elicits feedback on the CFSR process by surveying first-time CFSR peer reviewer volunteers and by having open and honest discussions with the local department during the exit debrief following the on-site review. Additionally, QA huddles are held each review to discuss the process in real time. In combination, these multiple avenues of obtaining feedback on the CFSR process aid the CQI/QA unit in determining additional training and guidance needed to adequately support the efficacy of the CFSR process.

The LDSS QA reviews occur in parallel with the statewide CFSR reviews and aid the state in identifying statewide versus local trends in practice and understanding which additional resources, training, technical assistance, or other supports are needed to address gaps and areas needing improvement. Through these reviews, LDSS can elevate local insights on performance for DHS/SSA to review cumulatively in tandem with other evidence and data gathered on

statewide performance. Insights and trends noted through QA reviews are leveraged for statewide policy and program decision-making while also enabling LDSS to monitor their own performance to guide locally driven and developed improvement efforts.

Maryland has also implemented bi-annual focus groups that offer an opportunity for families, youth and professionals who are involved in the system to inform our understanding of Maryland performance on the systemic factors, the IPM, and other strategies to improve practice. To increase youth and biological parent voice, the focus groups will be held on an annual basis, starting in the coming year, and recruitment efforts will be reviewed and enhanced to improve overall participation rate.

Section 6: Update on Service Descriptions

Stephanie Tubbs Jones Child Welfare Services Program

Below is a list of all services currently provided by Maryland Department of Human Services/Social Services Administration (DHS/SSA) which have not changed since the submission of DHS/SSA's Child and Family Services Plan (CFSP). For a full description of services please refer to DHS/SSA's
CFSP.

- Child Protective Services
- Alternative Response
- Family Preservation Services
- Kinship Navigation
- Placement and Permanency
- Adoption Assistance Program
- Mutual Consent Voluntary Adoption Registry
- Adoption Search, Contact and Reunion Services
- Ready By 21
- Guardianship Assistance Program

The estimated number of individuals and families to be served (the number of individuals and families to be served by service/activity with the total estimated funding indicated); the population(s) to be served (the population that has been targeted for the designated services); and the geographic areas where the services will be available is reported in Appendix A: Maryland FY2024 CFS-101s.

Services for Children Adopted from Other Countries

Maryland does not provide any specific programs targeted to children adopted from other countries. If children enter care post adoption, they receive the same services as those provided to children born in this country, aimed at reunifying the family as soon as possible. Prior to removal, the family would need to access family preservation services in attempts to preserve the adoption. At the time of removal, families are eligible to receive post adoption support.

All adoptive families can receive post adoption therapeutic services through two sole source contracts. Adoptions Together and Center for Adoption Support and Education (CASE) provide pre and post adoption services in Maryland regardless of the type of adoption.

When a child enters foster care, the electronic system has a "person" tab that helps identify if the youth has been previously adopted. It asks, "Has the child ever been legally adopted?" If it is marked yes, it asks for a prior adoption date and was the prior adoption intercountry. This was part of the Adoption and Foster Care Analysis and Reporting System (AFCARS) 2.0 update in August 2022 that was implemented in October 2022.

Services for Children Under 5

As indicated in Table 57, in CY2022, 21.6% of children under the age of 5 that came into care had a length of stay of 11 months or less. This is an increase from the 2021, which was at 17.9%. A little more than half (55.7%) of children under five had a length of stay of 12 months or more in CY2022. In 2022, children under 1 years old made up 20% of the entries into care and children ages 1 through 4 years old made up 21% of the entries into care.

Table 57: Children Under Age Five Length of Stay CY2022

Social Services Administration: Children Under Age Five in Foster Care, Length of Stay (LOS)				
LOS in Care (In Months) of Children Under Five in Out-of-Home				
Calendar Year	**6 months or less**	**7-12 months**	**12 months or more**	**Total**
2022	248	236	609	1093
Percentage of population	22.7%	21.6%	55.7%	100%
Percentage Point Change: 2021 to 2022	-.09%	3.7%	-2.7%	
2021	278	211	687	1,176
Percentage of population	23.6%	17.9%	58.4%	100%
Percentage Point Change: 2019 to 2020	3.3%	-1.9%	-1.5%	
2020	259	252	763	1,274
Percentage of population	20.3%	19.8%	58.9%	100%
Percentage Point Change: 2018 to 2019	-8.1%	-1.5%	9.4%	
The goal is for 80% of the children 0-5 will have a length of stay of 11 months or less by 2024.				
Source: Child, Juvenile, and Adult Management System (CJAMS)				

The agency continues to shift to a focus on prevention, during this reporting period, the agency continued with its implementation of the Family First Prevention Services Act (FFPSA) and the five identified prevention evidence-based practices. The agency continued to offer workforce

development training to the child welfare workforce focused on engaging families, assessing needs, appropriate service matching, and coordinating with service providers to ensure service plan goals were being met.

Through Maryland's FFPSA plan, the agency currently supports and collaborates to implement several evidence-based interventions for young children and their families. These interventions include:

- Parent Child Interactive Therapy (PCIT) which is an evidenced-based mental health intervention designed for children aged two - seven and their families. This intervention is currently being implemented in Anne Arundel, Carroll, and Allegany counties. There are other jurisdictions that would like to include PCIT in their plan also. 12 families received this Evidence-Based Program (EBP) in 2022.
- Healthy Families America (HFA) is an evidence-based home visiting program designed for pregnant mothers and parents with children up to 24 months of age. It is being implemented in seven jurisdictions. This intervention allows for expansion to other jurisdictions in coming years as well. 39 families utilized this EBP in 2022.

Maryland also has several programs that increase recovery from substance use disorders, encourage retention in treatment, increase parenting skills and capacity and coping skills, and enhance child well-being which can support in reducing lengths of stays for children. These services include:

- Safe Babies Court Team Approach (SBCT) (Frederick County)
- Peer Recovery Coaches (Harford County)
- Judy Centers (Various counties)
- Family Recovery Courts (5 Jurisdictions)
- Sobriety Treatment and Recovery Teams (10 jurisdictions)
- Nurturing Parenting Program (NPP) is a promising parent-education program that is being implemented in two jurisdictions, but it is not part of the FFPSA.

Since the submission of the 2023 APSR, the state has undertaken numerous activities and initiatives to reduce the length of stay, addressing the developmental needs for children under 5 in foster care as well as for those served in-home and, in a community-based setting. The state is partnered with the Maryland Family Network (MFN) to collaboratively support efforts around the prevention of child maltreatment. The Community-Based Child Abuse Prevention (CBCAP) work that MFN directly leads as well as our Family Support Center and Early Head Start Networks, for which MFN provides administrative oversight and funding. These initiatives and programs are prevention-focused, and SSA applies a Strengthening Families approach to promote families' and communities' protective factors. And, as part of the CBCAP portfolio SSA is focusing on building collaborations between public-private, local, and state organizations in the service of amplifying prevention-focused impacts. MFN presented their Strengthening Families CBCAP model during the implementation team meeting that resulted in a robust conversation about community pathways to prevention and opportunities to collaborate with the department, community providers, and partners.

As reported in the 2021 APSR, the state continues to address system infrastructure related to childhood development and Maryland is currently the recipient of the Pritzker Family Foundation

Prenatal-to-Age-Three State Grant also known as the Building Better Beginnings (B3) initiative. DHS continues to serve as a key leader on the B3 initiative. B3 focuses on expansion of high-quality services available for expectant families and families with children from birth to age 3 who are living at or below 200% of the federal poverty level. The initiative focuses on increasing receipt of services in three broad areas: high-quality prenatal and early childhood care and services to support health and development (Healthy Beginnings); comprehensive services that promote maternal health, infant and toddler development, and family well-being (Supported Families); and high quality, affordable infant-toddler childcare, and early learning experiences (High-Quality Early Care and Learning). The agency spent 2021 as a key collaborator on the B3 initiative to develop the state's inaugural Prenatal-to-Three Equity Report which is essential to promoting equity in the three broad domains and in addressing the developmental needs of all vulnerable children aged 3 including children in foster care, as well as those served in Family Preservation and within community-based agencies. During this reporting period, Maryland continues to support this work by working with partners to identify reasons families are having issues finding childcare for children under 2, supporting increasing the number of slots for infants and toddlers including children in foster care.

Lastly, as previously reported, DHS/SSA restructured to create a Child Welfare Early Childhood specialist position focused on children aged 0-5. This position was designed to enhance coordination of services and identify opportunities to further strengthen collaborations in effort to reduce the occurrence of child abuse and maltreatment and ensure safety permanency and well-being. The position was recently vacated, and the agency is working aggressively to fill the position including sharing the post with community partners.

Efforts to Track and Prevent Child Maltreatment Deaths

In 2022 the updated Child Fatality/Serious Physical Injury/Critical Incident Policy was released which included updates to the form used to capture fatality data. Currently, DHS/SSA receives information about child deaths from LDSS at the time of the fatality when they submit the completed form previously mentioned. DHS/SSA utilizes those forms to track all reports of fatalities and serious physical injuries that could result in fatality. The forms are submitted by all 24 jurisdictions to DHS/SSA. Throughout 2022 DHS/SSA experienced barriers with obtaining access to Redcap. Redcap is a more advanced tracking system than what is currently in use. SSA worked with the Office of Technology for Human Services (OTHS) to try to resolve issues with access to RedCap. In May SSA staff got access to RedCap through the University of Maryland. Unfortunately, there were unforeseen barriers to being able to use RedCap through University of Maryland Virtual Private Network (VPN) access. SSA worked with the University of Kentucky to explore possible solutions to the barriers. SSA, University of Kentucky and OTHS met to explore other possibilities. OTHS worked with the University of Kentucky technical team to gather the necessary documentation to explore the possible solutions to said barriers. Despite this a solution was not found as the VPN systems between the University of Maryland and SSA were not compatible. This led to the need for a new approach.

In 2023, fatality reporting forms will be updated to allow for future enhancements in the way track and store fatality data including incorporating the form into CJAMS. This will allow local jurisdictions to enter information directly into the system for more timely notification. DHS/SSA would have access to an accompanying report that would capture data elements directly from the

system. This will improve Maryland's ability to monitor trends and provide any necessary guidance, technical assistance, or training to staff. This will also ensure more accurate data reported to National Child Abuse and Neglect Data System (NCANDS) as the system will verify the information against all areas and there will be less opportunities for human error.

SSA attends rapid response review team meetings facilitated by the local jurisdictions following the report of a child fatality where maltreatment could be a contributing factor. SSA works with the LDSS to address next steps in the investigation, child safety and ensure a full family assessment is completed. This also assists SSA in gathering trends outside of data tracking. In June 2022 SSA started to contact medical examiners in DC and DE to get information regarding fatalities that cross State lines.

SSA was able to fully implement the Child Maltreatment Fatality Review (CMFR) statewide in 2022. SSA team members were trained in use of Safe Systems Improvement Tool and shadowed CMFR debrief conversations with front line staff and supervisors. Each chosen fatality case is examined on a worker and supervisor level to learn system wide improvement opportunities that could reduce child mortality. As an extension of the CMFR SSA recruited a multi-disciplinary team and held the first fatality related mapping session in 2022. Mapping is a process that identifies what SSA can do as a child welfare agency to reduce child mortality while at the same time encouraging collaboration across ranks and disciplines to seek solutions to problems. In bringing together outside agencies SSA is encouraging them to commit resources to safety concerns. Feedback from CMFR lead to meetings with workforce development, Child Welfare Academy (CWA) and Maryland Child Abuse Medical Providers (CHAMP) to enhance training for Child Protective Services (CPS) staff around children experiencing medical neglect.

In May of 2022 SSA released a Safe Sleep Guidance intended to support staff in using best practice to engage families, manage risk and safety related to sleep practices of infants and children. SSA also participates in the State Child Fatality Review Team. As part of this team, SSA contributes data and expertise to the State's combined efforts to reduce child mortality. See Appendix B: Updated State Plan.

Promoting Safe and Stable Families (PSSF)

Service Decision-Making Process for Family Support Services

Please refer to the Child and Family Services Plan (CFSP) and previous Annual Progress and Services Report (APSRs) for background information on the PSSF grant. The PSSF grant is used to help LDSSs fund services to help families and children in the following categories: family preservation, family support, family reunification, and adoption promotion and support services. These funds are allocated to the LDSS for contracting with local community-based organizations to provide these services to families and children within their local jurisdiction. In 2022, Maryland allocated PSSF funds to all 24 jurisdictions utilizing at least 20 percent of the PSSF grant in each of the service categories; approximately 10 percent of the grant was administration and discretionary spending. There were no changes or additions in services or program design during this reporting period. Estimated expenditures for the described services are provided on the CFS-101, Part I.

Division X Supplemental Funding from the Supporting Foster Youth and Families Through the Pandemic Act

DHS/SSA allocated to local departments the emergency funding for the Mary Lee Allen Promoting Safe and Stable Families (PSSF) to be utilized to support families by facilitating reunification of youth who are placed in out of home care, support and prevent entry into care and promote and support adoption finalization and remove barriers for those youth who have a goal of adoption. The LDSS were also provided with a tip sheet and guidance for use of the funds and tracking expenditures on a quarterly basis. Through September 2022, DHS/SSA has spent approximately $1,104, 067 on various activities and items including tutoring services to children in adoptive homes during distance learning, daycare services for foster care children, purchasing of furniture for children in care and covering medical, dental, and pre-adoptive expenses for children and families seeking to be foster parents. In addition to providing funding to families in care, PSSF funds also allowed social workers to attend virtual conferences and trainings throughout the year. DHS/SSA noted in 2021, that there was limited spending of the Division X PSSF funds by local departments that may have resulted from barriers such as a lack of clear guidance on the utilization of the funding in conjunction with their standard PSSF allocation as well as managing state timelines regarding the procurement of services. To support spending of these funds by September 2022, the state further explored with LDSS the barriers to spending and provided technical assistance around appropriate uses of these funds.

Family Reunification Services

Approximately 429 families and 475 children were served in SFY2022. Family Reunification services provided by the LDSSs have been tailored to the individual family and have addressed the issues that brought the family into the child welfare system. Family Reunification services support Safety Outcome two (2) in the CFSR that children are safely maintained in their home when possible and support Permanency outcome one (1) in the CFSR that children have permanency and stability in their living situation. These Family Reunification services that are provided by the LDSSs help achieve both reunification and prevent re-entry in the foster care system.

The types of services provided include:

- Individual, group and family counseling
- Mental health services (i.e., trauma therapy)
- Parenting classes
- Parent mentors
- Sibling visitation
- Family bonding activities
- Therapy not covered under Medical Assistance
- Tutoring assistance
- Drug screenings
- Childcare services

Family Preservation and Family Support Services

Family Preservation and Support Service Funds help local jurisdictions to fill in service gaps. Each jurisdiction is different, and these funds allow for individualized planning based on the needs in the respective jurisdiction. Family preservation and/or family support funds through PSSF were allocated to all twenty-four (24) LDSS in Maryland in 2022 resulting in approximately 5,565 families and 11,440 children being served in 2022. This was an increase from the 5,188 families and 10,734 served in FY2021. Family Preservation are service programs designed to promote the safety and well-being of children and their families, enhance a parent's ability to create a safe and stable home environment, and maintain permanency while preserving family unity. Family Preservation Services programs are designed to enable a child to remain safely at home while receiving intervention services. Since 2018, on average 96.4% of the children served through Family Preservation were able to remain with their families during the time of their service.

Most of the LDSS operate specific programs with their allocated Family Preservation and Family Support funds that provide family visiting, counseling, or evidenced-based services. The LDSSs that were not allocated funds for a specific program received "flex funds" that are used to pay for a variety of supportive services for families receiving Family Preservation services. The amount of the "flex funds" allocation depends on the caseload for In-Home services.

Some of the services paid for through "flex funds" include community-based parent education programs and structured parenting classes that are an essential part of child welfare services; some of these programs offer parenting development opportunities such as vocational training as well. In addition, home visiting services were also provided, which served families with children ages 4 months to 5 years old. These "flex funds" achieve program goals by providing services to families to preserve and strengthen families and to prevent children's entry into foster care. A strength of the PSSF family preservation and support service programs is that the local jurisdictions help to develop an adequate service array throughout the State by filling service gaps. All the family preservation and support programs are different and are based on the needs in the respective jurisdiction.

Adoption Promotion and Support Services

Approximately 397 families and 397 children were served in SFY2022. The 24 LDSS offer adoption promotion and supportive services in order to assist families during the adoption process, encourage more adoptions for those youth seeking permanency and finalize adoptions. For the SFY2022 funds, the allocation for each LDSS is based on the number of children with a goal of adoption. The LDSS are required to submit a plan each year that describes how they will spend their allocation.

The types of services provided include:

- Respite and childcare
- Adoption recognition and celebration gifts
- Recruitment advertisement (radio, billboards)
- Recruitment advertising campaign with the local movie theater
- CPR/PRIDE trainings for families

- Monthly parent support groups facilitated by a specialist
- National Adoption Month gifts
- Deposits for adoption celebrations
- SAFE Home Study Trainings
- Support staff de-escalation trainings
- Family-Centered practice trainings
- Safety & well-being coaching
- Adoption books & folders for Adoptive
- National Council for Adoption Conference for staff
- Fingerprinting and physical/TB test reimbursement for potential adoptive/foster parents
- Specialized medical equipment to prevent injuries for clients
- TPR mediation & attorney fees
- Consultation, education, and counseling services to include individual and family therapy and evaluations to help families and children working towards adoption
- Legal advertising for petition for guardianship to support adoption & the purchase of a biological parent's death certificate to support pre-adoptive needs.
- Phone cards to support pre-adoptive children & families contact with their biological families, tablets to support educational needs, school supplies and clothing to support pre-adoptive children.

Populations at Greatest Risk of Maltreatment

Substance Exposed Newborns (SENs) are considered as a population at greatest risk of maltreatment because of the age and risk involved with prenatal substance exposure. While the agency considers all children engaged or receiving state services vulnerable to maltreatment, SENs may suffer from long term adverse effects that may impact their health and well-being as well as the parent's inability to properly care or protect the SEN due to unhealthy decisions and behaviors associated with the parent's substance abuse/use. The agency recognizes that a collaborative approach with health care and service providers for a comprehensive assessment of the SEN, parent/caregiver, and other family is necessary to effectively support the well-being and safety of the SEN and other family members.

Assessment of Data

The state's SEN data in Table 58 "Total SEN Notifications Categorized by the Following Substances" below, shows a fluctuating pattern that has been reoccurring the past several years. For CY2022, there were 2,119 SEN cases served by the agency reflecting at least a 10% decrease from 2021. The agency's data migration (CJAMS transition 2019) and system enhancements continue as an area of focus to review and validate SEN data to identify trends and inform the agency's decisions to support the SEN population and programmatic needs. The SEN data fluctuations may be attributed to and impacted by various factors. There is a distinction between "reporting" and "notification" as the former is associated with Child Protection Services (CPS) maltreatment allegations whereas the agency identifies "notification" as alerting the agency to conduct and complete a service assessment. The agency acknowledged a language change was necessary to shift mindsets that reflect prevention-focused programming, policy, and practice for SENs. Across the state child welfare staff and health care practitioners understanding of the SEN definition, the SEN notification exemption, and Maryland's current cannabis use law may be the most notable factors. Maryland's Family Law Article § 5-704.2. requires a notification to be made

when newborn under the age of 30 days, 1. displays a positive toxicology for a controlled substance after birth, 2. shows some effects of controlled substance use or withdrawal resulting from prenatal substance exposure as determined by a medical staff, or 3. displays signs of a Fetal Alcohol Spectrum Disorder (FASD). In addition, the law affords a mother who is legally using a substance as prescribed that a notification to the LDSS is not warranted solely based on the newborn's positive toxicology. There must be some effect on the baby which is determined by the health care practitioner at the time of delivery per Family Law Article § 5-704.2.

Within Maryland there are over 30 birthing hospitals each with their own set of established procedures and processes related to universal screening and testing, as well as criteria for determining when a newborn is affected due to effects of controlled substance use or withdrawal resulting from prenatal substance exposure. A controlled drug/substance is a substance included under Maryland's Criminal Law Article § 5-404. Cannabis is a Schedule 1 drug/substance under the United States Controlled Substance Act and Maryland's Criminal Law Article § 5-404. A written certification for its use does not make it a prescribed controlled drug/substance under Family Law Article, § 5-704.2.(e)(2)(i). Therefore, a notification to LDSS is required for a newborn with a positive toxicology or displaying some effects or withdrawal of Cannabis from prenatal substance exposure. Neither Maryland's Family Law Article § 5-704.2. or the Code of Maryland Regulations (COMAR) 07.02.08 Substance Exposed Newborn Safe Care Plan includes criteria for determining when a newborn is affected due to effects of controlled substance use or withdrawal resulting from prenatal substance exposure or an exception for a written cannabis written certification. The agency will continue to explore with guidance from SSA's Medical Director, TA from The Institute and Chapin Hall, and meaningful collaborations with key stakeholders to promote consistency and adherence with the SEN law and COMAR. The agency reviewed the COMAR 07.02.08 Substance Exposed Newborn Safe Care Plan and submitted amendments in collaboration with SSA's program staff and DHS Office of Attorney General (OAG) to align with current law, best practices, and policy.

Table 59 Total SEN Removals below provides the total number of SEN cases for calendar years 2020, 2021 and 2022 which resulted in removal of the SEN pursuant to a SEN service case. This table also provides the timeframes (in days) in which a removal occurred from the date when service assessment began. The table indicates that between CY2020 and CY2022, the number of removals declined significantly from 202 to 130 respectively representing a 36% decline. This supports the agency's approach for SENs which is prevention-focused service assessments and intervention focused on keeping families safe, stable, and intact whenever possible. This table reflects during CY2022 most removals (40.8% (n=53)) occurred during the interval from 7 - 30 days. While a case-by-case analysis would be needed to draw more specific conclusions, removals during the 7 - 30-day interval suggest that the LDSS worker, more likely than not, attempted to engage the parent(s) to keep the family intact through a safety assessment and Plan of Safe Care (POSC) at a minimum.

Table 58: Total SEN Notifications Categorized by the Following Substances*

	All SENs	Opiates	Amphetamines	Cocaine	Benzo-diazepines	Marijuana	Alcohol Spectrum Disorder	Prescription Drug	Other
CY2020**	2,134	410	42	111	20	732	3	60	78

CY2021	2,359	612	57	235	44	1,433	2	76	132
CY2022	2,119	549	63	217	32	1,323	3	53	118

Table 59: Total SEN Removals

Child Removals	Total Children	Removals less than 2 days	Removals between 2 and 6 days	Removals between 7 and 30 days	Removals between 31 and 60 days	Removals between 61 and 90 days	Removals at 91 or more days
CY2020	202	8	18	68	16	11	81
CY2021	182	11	20	70	24	7	50
CY2022	130	3	22	53	16	11	25

**The substance categories reflect any substance exposure to the newborn, with some newborns exposed to multiple substances.*

*** CY2020 may contain some data migration issues related to transition from MD CHESSIE to CJAMS*

The most notable CJAMS enhancements for SEN during 2022 were the Plan of Safe Care (POSC) being embedded into the agency's system and the development of the SEN Milestone Report. During September 2022, the POSC was made accessible in CJAMS for child welfare staff to complete all SEN assessments. The agency expects to utilize data from the POSC to go beyond the needs or service referrals for the SEN and parent/caregiver to identifying and examining correlations between services and outcomes i.e., service closure with no SEN reoccurrence, no future maltreatment reports, critical incident, or fatalities. SSA's Well-Being Unit collaborated with MD Think, LDSS staff, and SSA program staff to introduce several SEN enhancements that will improve SEN data reports and inform SSA on any jurisdictional patterns and characteristics data i.e., birthing hospital SEN notification patterns; jurisdictions with the highest number of SENs displaying some effects of controlled substance use due to prenatal substance exposure (Maryland's Family Law Article § 5-704.2. SEN definition) that will support program, service, and training decisions. The SEN Milestone Report serves to assist the agency and the LDSS with compliance and monitoring of activities required for SEN service cases by providing relevant and actionable information. This report runs daily monitoring of when the initial contact was made with the SEN, when the assessments (safety and risk) are completed, POSC completed, how long the SEN case is open and other relevant SEN and family case information. The report is a working document that agency program staff will continue to update to support compliance and program evaluation. SSA program staff will continue to work with MD THINK and the LDSS to identify and develop CJAMS enhancements to inform SEN practice and identify areas of need (technical assistance; training; build service array) to promote healthy outcomes for SENs and families. In addition, the agency will explore how to utilize the POSC, SEN Milestone Report, and additional SEN/SUD ad hoc reports to examine and address disparities and inequities in SEN services and outcomes as the agency at the time of this report has not analyzed data to identify equity issues.

2022 Efforts to Support and Address the Needs of SENs

During 2022 the agency continued to support and address the needs of SENs to support effective implementation of the POSC and adherence to Maryland's Family Law Article § 5-704.2. Technical assistance from The Institute for Innovation and Implementation (The Institute) and Chapin Hall to the LDSS, birthing hospitals, substance use treatment providers, and community

providers to improve practice and cross-system collaboration remained an area of focus to reduce foster care placement and preserve families impacted by parental substance use. SEN activities included workforce development, webinar sessions, targeted TA sessions with LDSS staff, and the state level SUD Workgroup.

The Institute and Chapin Hall's technical assistance (TA) supported FFPSA Substance Use Disorder (SUD) Family Based Residential Treatment planning, TA sessions, and workforce development such as the SEN Birthing Hospital Listening Session and the Medication for Opioid Use Disorder (MOUD)-SEN Fall webinar series.

During the fall of 2022, The Institute and SSA program staff facilitated a statewide POSC training, Integrating the Plan of Safe Care into Child Welfare Practice, as a result of the POSC being embedded in CJAMS and targeted TA sessions with LDSS' program staff (continuation from the 2021 SEN Policy Survey). The training provided a walk-through of the POSC in CJAMS with interactive discussions focused on strategies and workflow for case management and utilizing assessment information to develop the POSC i.e., appropriately organize and manage; service planning; identifying interventions.

The Birthing Hospital Listening Session focused on the completion of the SEN notification form required by Maryland's Family Law § 5-704.2., to ensure a timely notification is made to the LDSS providing relevant and necessary SEN and parent/caregiver information to initiate a SEN service case. Facilitated by SSA's SEN program staff and Chapin Hall, the goals were to understand barriers and challenges related to completing the written notification for the agency to identify actionable items that will support timely completion and submission. The target audience was hospital staff and medical personnel responsible for making SEN notifications to the LDSS. The results of the listening session were:

1. Adherence to the SEN law inconsistent among LDSS'
2. Workforce development and patient education

SSA's SEN program staff will work with The Institute and Chapin Hall to identify actionable items and strategies to address identified barriers.

The agency worked with UMSSW, Ruth Young Center for Families and Children CWA to update and enhance the current SEN training curriculum for child welfare staff. An advanced skills POSC lab with a focus on cannabis use will be introduced early 2023 with plans to offer a 2nd POSC lab focused on MOUD to enhance frontline staff skills to conduct a SEN assessment and utilize information gathered during the SEN assessment including collaborating with service providers to develop the POSC.

To identify areas of needs, adequately address SENs and families impacted by substance use and build feedback loops, the agency continued to facilitate the state level SUD Workgroup monthly meetings. LDSS program staff, state agencies (Maryland Department of Health (MDH), Behavioral Health Administration (BHA) and Maternal & Child Health), local health department staff, birthing hospital staff, and substance, opioid use treatment providers participation helped inform the agency on current practices and resources, challenges, and served as a crucial component to strengthening a prevention-focused service approach for this population. The SUD Workgroup along with the SEN Policy Survey from 2021 and targeted TA sessions held with the

LDSS' informed the Fall 2022 webinar topics. The agency partnered with CWA, University of Maryland School of Medicine Maryland Addiction Consultation Services (MACS), several local community providers, and MDH's BHA, Maternal & Child Health, and Center for Tobacco Prevention and Control. MOUD-SEN Fall 2022 topics to support best practices and harm reduction included 1.) toxicology tests: purpose in treatment, 2.) medical cannabis and mental health, 3.) effects of cannabis use during pregnancy, 4.) value of peer recovery specialists, and 5.) effects of nicotine & vaping. In addition, the impetus for the annual fall webinar series serves to increase staff skills and strengthen collaborative practices that may improve positive outcomes for families impacted by substance use disorder.

The FFPSA SUD Family Based Residential Treatment provision was identified by the agency to address parental substance use and support timely permanency for SENs and children ages 0-5. TA from The Institute and Chapin Hall supported preliminary planning for SSA to determine how to implement the provision and engage partners to support and work towards a late Fall 2023 pilot. Meaningful collaborations were held with state and local agencies (including Optum is the Administrative Services Organization/ASO for Maryland's Public Behavioral Health System), substance treatment providers, LDSS staff, and other partners to develop and consider how best to structure the pilot to promote safety, support positive substance abuse treatment outcomes, and achieve timely permanency. The preliminary planning resulted in 2 substance use treatment providers agreeing to partner with SSA to implement a pilot with monthly meetings held along with engagement of a diverse group of individuals to inform and support shared decision-making on the development and implementation of this provision. SSA plans to continue with meaningful and authentic engagement to understand the challenges and identify solutions that will support successful implementation of the SUD Family Based Residential Treatment provision.

Table 60 Activities to Improve Performance for SENs updated to reflect changes along with progress made to meet identified target dates. The collaborations formed and activities held during the past two years provided SSA with some primary next steps to further explore and consider during 2023 such as implementing an evidence-based SUD screening tool to support practice and healthy outcomes for families impacted by SUD. When SSA's SEN activities are completed, SSA along with collaborative partners and TA provided by The Institute will identify and finalize next steps to include in the agency's next CFSP. SSA, with TA received from Chapin Hall and The Institute, revealed additional exploration is necessary to develop a shared strategic plan with state agencies and community providers which may extend beyond 2024. At the time of this report, SSA discontinued the "*Coordination at the state and local level to serve as a supportive partner with Maryland's state agencies on developing an effective approach to addressing the needs of parents prenatally such as a Prenatal Plan of Care supporting the needs and services for pregnant women affected by substance*" SEN activity and will further explore the agency's approach to supporting a Prenatal Plan of Care.

Table 60: Activities to Improve Performance

Activities to Improve Performance for SENs	Target Date
Enhance cross-system collaboration to support early intervention/prevention services, implementation of the POSC and build SEN Collaborative Teams to improve services for SENs, pregnant women, postpartum women, fathers, and families impacted by substance use.	**June 2024**
Implementation Status: In Progress 2022 Progress: ● The agency continued to collaborate with Multidisciplinary Teams through participation on various committees and workgroups at the local and state level including internal workgroups and peer learning collaboratives that inform service needs and development of strategies to achieve positive outcomes i.e., Maryland State Department of Education (MSDE) State Interagency Coordinating Council; Maryland's Peer Recovery Services; SEN Supervisory Meeting. This activity will continue to support local cross systems collaboration in 2023.	
Develop targeted SEN and substance use trainings and enhance current agency trainings to improve practice to serve SEN, support effective implementation of the POSC, and decrease negative outcomes related to this population e.g., SEN critical incidents; parental overdose or overdose deaths; SEN fatalities.	**December 2024**
Implementation Status: In Progress 2022 Progress: ● SSA and the Child Welfare Academy identified training enhancements and specialized training to assist child welfare staff with engaging families identified with parent substance use. The agency collaborated with several state and local stakeholders to conduct webinars during 2022 to enhance the workforce's knowledge and skills to support positive outcomes for SENs and families with parental substance use. ● Trainings scheduled for 2023 include Maryland's state law related to recreational Cannabis use, adverse health effects associated with cannabis use, cannabis safety and harm reduction, and POSC Lab (focus on cannabis and MOUD).	
Improve the methods by which Maryland monitors SEN cases and improves upon Quality Assurance.	**December 2024**
Implementation Status: In Progress 2022 Progress: ● SSA continues to monitor SEN service cases and provides LDSS with Technical Assistant sessions to support the agency's progress and quality improvement on serving SENs and their families. A milestone for activities is used as a guide for timeliness. SSA continued to look to identify training needs to improve SEN practice, outcomes, and effective implementation of the POSC. This activity will continue in 2023.	

Sleep-related Child Fatalities

In 2022 DHS/SSA presented child fatality data from 2021 to the Secretary's Office, to the OISC and the CPS and Family Preservation Implementation Team. This data review focused on sleep-related fatalities. A safe sleep workgroup was developed to dig deeper into the data. This workgroup met for two months to develop guidance and training for LDSS staff. The workgroup included frontline staff, Maryland Department of Health and community partners that work with families that have lost children from sleep related deaths. Videos from those with lived experience were included in the safe sleep guidance that was released to staff in May. The guidance will be reviewed yearly, and adjustments made to ensure the document remains in compliance with the American Academy of Pediatrics recommendations. Safe sleep training was also incorporated

into pre-service training for LDSS staff. After releasing the Safe Sleep guidance DHS/SSA provided technical assistance to LDSS staff and attended the pilot safe sleep training for pre-service. In June 2022 DHS/SSA presented at the State Fatality Review Team meeting about the Safe Sleep guidance to assist in connecting the work done within each county level fatality review team and at the State level.

Kinship Navigator Funding

In 2022, Maryland continued the development and implementation of the Enhanced Kinship Navigator Pilot Program model to re-design the evaluation process, implement training on the study protocols to the LDSS key staff identified in each jurisdiction, and support each pilot jurisdiction community for the full launch of the program, which occurred in 2022. The Enhanced Navigator Pilot program consists of eight pilot jurisdictions with three Maryland Coalition of Families (MCF) Kinship Navigators that featured a peer-to-peer support model, a comprehensive assessment process, four levels of intensity support, and a single point of access to services through the Family Investment Administration (FIA) and case workers in locals departments of social services (LDSSs). The DHS/SSA Kinship Navigation Administrator held monthly meetings with the LDSS Kinship Navigators and MCF navigators to strengthen targeted outreach, communication with partner agencies, and provide additional resources to support kinship caregivers across the state. Through various workgroups and local huddles, kin voices were integrated into the process of implementation.

During the reporting period, Maryland continued to organize and facilitate professional development training to engage kinship caregivers and identify needed resources. Training programs included in-service training for LDSS staff navigators, enhanced Kinship Navigation Model navigators, FIA staff, community partners, as well as kinship caregivers.

Outreach to bring awareness to the community and especially include kinship caregivers in the Kinship Navigator program and resources in Maryland was enhanced through the LDSS Kinship Navigators, DHS/SSA Kinship Care webpage (which was updated by the Kinship Navigation Program Administrator), collaboration with 211 Maryland (a kinship navigation page was developed with a banner to route families directly to a single point of access), and a kinship subscription was developed and implemented with 211 Maryland, which provided a monthly text message blast to kin caregivers who subscribed to the monthly subscription), and the monthly Kinship Navigator Family First workgroup kinship resources and supports were shared with partner agencies and stakeholders to strengthen outreach to diverse populations. In September 2022, the Kinship Navigation Program Administrator partnered with 211 Maryland Inc. and participated in a podcast to discuss kinship care, kinship navigation in Maryland and the work the state is doing in its pilot program in connection with Family First Prevention Services Act. Through this funding DHS/SSA was able to collaborate with the University of Maryland (UMB)/The Institute, Chapin Hall and MCF to implement and evaluate the Enhanced Kinship Navigator Pilot Program serving kinship caregivers in eight pilot jurisdictions. The institute established an evaluation design to implement Maryland's Enhanced Kinship Navigator Model, provided professional training and support to LDSS staff and SSA to improve Maryland's Kinship Navigation structure, and provided technical assistance to DHS/SSA. Funding was provided to Maryland Coalition of Families for direct kinship services, peer to peer support, and other resources as requested by the kinship caregiver.

DHS/SSA plans to continue evaluation in 2023 through having listening sessions and feedback huddles across the state with kinship navigators and kin caregivers to include kin voices and identify gaps in services, resources available or lack thereof, and additional partnerships needed to strengthen the Kinship Navigator Program statewide and standardize services. At this time, Maryland does not have a timeline to have the program rated by the Title IV-E Prevention Services Clearinghouse, but this has been identified as a goal to achieve in the future.

Guardianship Assistance Program (GAP- 14 recipients CY2022)

- Baltimore County – 12
- Talbot County – 1
- Wicomico County – 1

The GAP information above indicates the number of Kinship caretakers who were TCA recipients and received the Guardianship Assistance Program (GAP) Subsidy in CY22.

Table 61: Temporary Cash Assistance (TCA) Data CY2022

January 2022-December TCA-Non-Needy Caretaker Relative Cases		
Jurisdiction	**Non-Needy Caretaker Relative Cases**	**Needy Caretaker Relative Cases**
Allegany County	63	14
Anne Arundel County	274	24
Baltimore City	859	194
Baltimore County	252	32
Calvert County	27	0
Caroline County	57	7
Carroll County	42	4
Cecil County	138	28

Charles County	80	9
Dorchester County	28	6
Fredrick County	80	7
Garrett County	17	1
Harford County	138	32
Howard County	37	13
Kent County	22	2
Montgomery County	265	21
Prince George's County	327	47
Queen Anne's County	20	5
St. Mary's County	65	7
Somerset County	32	4
Talbot County	28	3
Washington County	147	24
Wicomico County	122	14
Worcester County	51	2
Total	3,171	500

The above table indicates the number of kinship caregivers in each county who were beneficiaries of Temporary Cash Assistance (TCA) TANF benefits in CY2022. Needy caretaker relatives are relatives that are also requesting assistance for themselves. They are included in the TCA household and therefore are counted in the grant. If the relative has any income their income will be counted against the TCA grant. Non-needy caretaker relatives are relatives that are not requesting assistance for themselves. They are not included in the TCA household and therefore not counted in the grant. Their income is not considered, and this is sometimes commonly referred to as relative/child only TCA.

Monthly Caseworker Visit Formula Grants and Standards for Caseworkers

To offer more support to families and improve the quality of caseworker visits, training offered to staff included de-escalation techniques to support staff engagement with families and strengthen understanding of family centered practice as well as exploring decision making and coaching to develop and evaluate safety and well-being. Laptops were also purchased for workers to complete visitation documentation in CJAMS as well as other devices to assist in providing resources to families and workers in hybrid visit settings. In an effort to continue addressing the needs of families, LDSS would like to see more training regarding autism spectrum disorder as well as supplies that will upgrade and enhance observation rooms and visitation rooms, such as toys, books, crafts, and furniture. Local leadership would also like to host more staff appreciation opportunities for their workers. Virtual visits were no longer applicable in CY2022.

Adoption and Legal Guardianship Incentive Payments

Analysis of the Data

Table 62 below outlines the award year, award amount, and amount expended for Adoption and Legal Guardianship Incentive funding.

Table 62: Adoption and Legal Guardianship Incentive Expenditures SFY2022

Award Year	Award Amount	Amount Expended
FFY2018 (10/1/2017 - 9/30/2021)	$619,500	$619,500
FFY2019 (10/1/2018 - 9/30/2022)	$85,000	$28,998
FFY2020 (10/1/2019 - 9/30/2023)	$20,000	TBD
*FFY2021 (10/1/2020 - 9/30/2024)	N/A	N/A
*FFY2022 (10/1/2021 - 9/30/2025)	$228,000	TBD

*Did not receive a grant award for FFY2021

In 2022, the Adoption/Guardianship funds were used to provide adoption incentive funding to LDSSs to incentivize adoptions. Services provided were psycho-educational services, evaluation services, mental health & educational advocacy, trauma informed therapy, summer camp, trauma

focused therapy, neurobehavioral evaluation, tutorial services, installation of a wheelchair ramp, speech and language therapy, travel to visit an adoptee in a residential treatment program and other specialized services. In 2022, SSA approved $123,382.50 in Adoption/Guardianship Incentive funds serving 16 adoptees from 13 families.

In 2023, the state will continue to assess the needs of the families in Maryland by receiving and reviewing requests for Adoption and Guardianship Incentive funds. The requests can include child specific recruitment activities such as photo listing and matching events. The state will also utilize the funds to assist LDSS with stabilizing pre adoptive placements and other direct client services and services for Custody and Guardianship cases.

Adoption Savings

As outlined in the CFSP, DHS/SSA continues to work on utilizing Adoption Savings funds as delineated in the Adoptions Savings Plan to impact the following outcomes: child welfare case worker adoption competencies, increase adoption/guardianship permanency, increase services offered to adoption/guardianship families post adoption finalization, as well as resource parent education. As of October 2022, DHS/SSA was able to spend the following:

- $1,105,161 in Post Adoption
- $547,290 has been obligated in Post Adoption (open purchase orders)
- **Total: $1,652,451.00**

Maryland is not making changes to its Adoption Savings methodology and will continue to utilize the funds to support permanency through guardianship and adoptions.

The state calculates adoptions savings based on the number of finalized Title IV-E adoptions per fiscal year. For FFY, DHS/SSA has a cumulative total (2015-2022) of $2,626,052 unspent funds as of September 2022. Given the federal guidelines for the use of these funds, the following percentages will used to spend the funds by September 30, 2023, on the activities outlined in the plan below: **10% At-Risk ($682,206); 70% IV-B/IV-E ($3,897,060); and 20% post-Adoption ($1,105,161).**

- National Adoption Association Membership $35,000 (2021-2023) executed
- Center for Adoption Support and Education Post Adoption Contract $1,596,788 (2021-2023) executed with a nine- and six-month extension approved. Adoptions Together Post Adoption Contract $1,405,295 (2021-2023) executed with a nine- and six-month extension.
- Maryland Post Adoption and Preservation Services Request for Proposals (RFP) – The state is procuring post adoption and preservation services to offer educational and therapeutic services to youth and families within Maryland's five regions. The RFP is scheduled to be completed by the end of FY23. The contract is a five-year multi-year contract and will run (2023-2028). Total: $1.5 annually ($7,500,000)
- 2022 Resource Parent Training Curriculum – The state is continuing the Maryland Resource Parent training contract with the Child Welfare League of America. The contract is set to be a multi-year and will run from (2023-2024). Total: $285,660

Strengths:

The current adoption support programs served over 180 families this past fiscal year 2022 as well as, engaged all 24 jurisdictions to provide post adoption services. One provider has provided 59 support groups, more than 577 hours of therapy while the other provider has 13 families engaged in their second round of services. Interracial Adoption parent and child support groups are also provided to families yielding 37 participants (17 parents and 10 children) during the 2022 fiscal year.

Concerns:
Due to staff turnover, the post adoption RFP was not completed during 2022 however, is expected to be posted in 2023. The state continues to struggle to spend Post Adoption funding and continues to be in an annual surplus of Adoption Savings. It is the hope of the state that the execution of this RFP and contract will aid in spending those funds by serving families, children and youth with their post adoption needs.

Family First Prevention Services Act Transition Grants
DHS/SSA made no changes to the proposed uses of the FFPSA Transition Act Grant funds outlined in the 2023 APSR. A large portion of the Transition Act Grant supports Maryland's infrastructure to implement Evidence Based Practices. Listed below are the activities from 2022:

Support residential placement providers to improve quality and better meet the needs of child welfare-involved families
In 2021, DHS/SSA developed and implemented an application process for designating interested placement providers as Qualified Residential Treatment Providers (QRTPs). Included in the application process was the opportunity to request funds to support placement providers in obtaining or maintaining accreditation by an independent, not-for-profit organization. By December 2021 DHS/SSA received thirteen applications and selected seven for a full review. In 2022, the FFPSA Transition Act funds were used as DHS/SSA worked with 5 of the placement providers to assist them in maintaining or meeting the requirements needed to become fully accredited with the FFPSA requirements for full designation as a QRTP. In the residential placement area of FFPSA, these funds were not used for direct service to families and children in 2022.

Develop a rigorous evaluation strategy for certain evidence-based programs
This activity is targeted to provide funding to support the development of evaluation plans for Family Centered Treatment (FCT) and START that were included in Maryland's original Prevention Plan submission. To date, DHS/SSA has not added either intervention to its prevention plan although both were approved by the Title IV-E Prevention Clearinghouse and rated as [promising/supported]. DHS/SSA focused its efforts in 2022 on continuing to train staff and stand up EBPs currently approved in Maryland's Prevention Plan that are well-supported. As these EBPs are fully implemented in identified jurisdictions, DHS/SSA will explore opportunities to add the evaluation to the Prevention Plan to include FCT and START.

Support building the evidence for certain interventions previously funded under Families Blossom (Title IV-E waiver)
During the reporting period DHS/SSA has continued state level funding for several promising programs that were funded under Families Blossom, Maryland's title IV-E Waiver that may be

potentially viable for FFPSA funding with support to build demonstrable evidence required by FFPSA. During 2021 DHS/SSA drafted a scope of work to support the development and implementation of an evaluation plan that aligns with FFPSA requirements for two interventions funded under Families Blossom, Maryland's title IV-E Waiver: Community of Hope (COH) being implemented in Washington County and Partnering for Success (PfS) being implemented in Baltimore County. DHS/SSA worked on an agreement to be in place by 2022, but with delays now expects an agreement to be in place in 2023. The Partnering for Success and Bester Community of Hope are two interventions being implemented in Baltimore County and Washington County, respectively, for which DHS/SSA is looking to build evidence around their effectiveness. The interventions collaborative framework plan to improve cross systems partnerships with the integration of evidence-based treatments in order to meet the behavioral needs of children, youth, and caregivers with the goal to maintain a place where children are safe, and caregivers are supported to prevent maltreatment from occurring in the first place and prevent further maltreatment.

Support for existing providers implementing EBPs included in Maryland's Prevention Plan and expansion of providers able to implement EBPs in Maryland's Prevention Plan
The EBPs in Maryland's Prevention Plan are programs that are already implemented in several localities across the State. The plan is to increase the reach of these interventions, either by expanding in the current jurisdiction with existing providers or by installing in new sites with. During 2021 DHS/SSA worked with local jurisdictions to identify which EBPs each jurisdiction wanted to expand or install. Using this information DHS/SSA developed an expansion and installation plan that included proposed numbers to be served, start-up and implementation costs for SFY22 and 23, potential vendors to provide services and any needed collaborations between jurisdictions and other state agencies in order to have sufficient capacity to support EBP implementation. During 2022, DHS/SSA began utilizing these funds to support expansion and/or installation in some of the identified jurisdictions.

The families that are served through the evidence-based programs (EBPs) that are in Maryland's Title IV-E Prevention Plan are families with youth in the home from prenatal to age 17. The families that have utilized the EBPs the most are those families with youth between ages 14 years and 17 years old; 55% of the youth were in this age range. The next highest population was families with youth aged 11 -13 years old; 34% of the youth were in this age range. Families with 5-10 year olds, families with 1-4 year olds, and then, families with youth under 1 year old followed in how many were served. In terms of race of youth served through EBPs in 2022: 44% were Black/African American, 33% were White/Caucasian, 11% were Biracial, and 12% were Unknown/Other. With regards to ethnicity of youth served through EBPs in 2022: 88% were Not Hispanic/Latino, 12% were Hispanic/Latino, and ethnicity of 2 youth was marked as unknown (this was less than 1%). In reference to the gender of youths served through EBPs in 2022: 58% were female, 40% were male, and 2% were non-binary. The youth that Maryland has identified as "prevention eligible" or that Maryland identifies as candidates for these services are youth from families with one or more specific risk factors that could lead to the removal of a youth from the home if the issue is not addressed. These specific risk factors (listed in order from highest to lowest occurrence among families that used EBPs in Maryland in 2022) are: complex psychological or behavioral needs, prior child welfare experience, risk of harm, substance use

disorder, informal kinship, complex medical needs, unsafe living conditions, DJS involvement, and victims of trafficking.

Support infrastructure for EBP CQI efforts
Family First requires that Maryland monitor the services that families/children are receiving pursuant to child specific prevention plans and collect information and conduct CQI related to fidelity and outcomes. DHS/SSA has worked with the University of Maryland School of Social Work to develop and enhance existing processes to collect needed data. During the reporting period, DHS/SSA has continued its agreements with the University of Maryland and has shifted existing CQI reports to a web-based dashboard format for most of the EBPs that is available to the state and LDSSs of social services. The only EBP that this has not worked for is HFA, but it is expected that funds will be used next reporting period to shift this EBP's reports as well.

Rebrand child welfare services as family support services
DHS/SSA continued to identify opportunities to rebrand messaging related to the services and supports provided by the agency. Efforts have included the initial development of materials providing information related to Maryland's transformation efforts and the implementation of FFPSA. There have been discussions of PSA-type videos and other types of messaging. In addition, DHS/SSA began discussions related to the redesigning of portions of the DHS website to align with efforts to shift from a child welfare system to a system focused on child and family well-being. DHS/SSA hopes that in future reporting periods these funds will be maximized to support these and other efforts.

DHS/SSA also recognizes that the Family First Prevention Services Act Transition Grant is meant for assistance in building up prevention of out of home placements and for shortening the stay in out of home placement when necessary, but is a time-limited grant. Due to this, Maryland will have discussions in Family First Prevention Services Act lead meetings in 2023 and ongoing about how to continue the services that have been expanded and increased after this grant expires in 2025. Maryland plans to discuss grants that may be available, connect with other states that are having similar discussions, and consider changes in current policies for support services or uses of other funds available such as John H. Chaffee funds.

Family First Prevention Services Act Certainty Grants
Maryland was not eligible for the FFPSA Funding Certainty Grant during the reporting period.

John H. Chafee
Assessment of Performance:
The State Youth Advisory Board (SYAB) – This workgroup was relaunched in Spring 2022 in order to engage foster youth from around the state. The purpose of the group is to encourage youth to express their ideas, concerns, and participate in systems change development of initiatives. There are several youths who participate from different local jurisdictions. Efforts have been made to recruit more youth to participate. As part of the collaborative process, youth who participate in the SYAB create surveys for events. They will also facilitate a session in the Emerging Adult Summit scheduled for April 2023. Job descriptions were created for youth who

participate in the SYAB. The descriptions allow youth to understand their role, time commitment, and compensation for participation. DHS was able to secure stipends for participation in the SYAB via the Maryland Coalition of Families, a family advocacy organization.

Emerging Adults Workgroup (EAW) – This workgroup consists of community stakeholders/partners, such as foster parents, DSS workers, independent living coordinators, SSA staff, and other state agencies. Youth are able to attend, but currently there are no active/participating youth. Efforts will be made to include youth once a stipend can be determined. One of the missions of this workgroup is to collaborate with adult services in order to facilitate a smooth transition from child welfare to adult services for youth that need continued support. The Adult Services Team has participated in meetings to help this effort, which remains ongoing. In 2022, community stakeholder Maryland Educational Opportunity Center, gave a presentation on how to assist youth in completing the Free Application for Federal Student Aid (FAFSA) and other educational tasks. This organization is also a resource for former youth in care who need assistance in applying for educational assistance.

The Emerging Adult Workgroup developed a process map for Out-of-Home (OOH) pregnant and parenting youth. It strategically identified pregnant and parenting youth and created a trauma informed intensive process which involves tracking, prevention, and collaboration with family, the local DSS, along with physical and mental health community partners. The document mapped out guided services for the pregnant and parenting teen, caseworker and other supports. The chart process included Eligibility→Assessment→Referral→Monitoring→Feedback→ Closure. The chart expressed the use of engagement strategies, supports and partnerships. It prioritized youth decisions regarding Evidence Based Practices (EBP), community resources, youth feedback, and post EBP support. The workgroup also created questions and ideas to improve future practice. This information was used to develop the Pregnant and Parenting Youth Practice tip sheets, and Documentation tip sheets.

The Emerging Adults Workgroup joined together with Adult Services and plans to develop a collaborative process that will assist vulnerable emerging adults who may benefit from Adult Services. The group plans to implement a standard tool to support and guide the transition.

In 2023, two independent living providers will join the group to strengthen and support them and youth in these programs. These providers serve pregnant and parenting youth. It will give them an opportunity to inform SSA and other group members of the challenges and successes of these programs. These groups will also be utilized in implementing the Family First Prevention Services Act with respect to services for pregnant and parenting youth.

MyLife (Maryland Youth Launching Initiatives for Empowerment) Website – This is a state-maintained website that contains a variety of information for youth in and out of foster care. It is designed to use pop-ups that youth can complete regarding education and other needs they may have. Specifically, there is information on the Ready by 21 Benchmarks, the Maryland Youth Transition Plan, and resources for youth who have left care. This website is a starting point to understand older youth and emerging adult programming in the state of Maryland. It is not only designed for the youth, but also for caseworkers and other local DSS staff, foster parents, and

community members. It contains information on how to contact DHS program staff. For 2022, there were a total of 4,200 users of the website. They viewed a total of 22, 100 pages from the website. The most popular pages were the MyLife homepage, Ansell Casey Life Skills, SYAB, and Advocacy Archives. Most users of the page accessed it from their desktop computer (69.7%), then mobile device (28.9%). The smallest percentage (1.4%) was accessed via a tablet computer. The primary languages usage was English, followed by Spanish and then Korean. There were other languages used as well. The website was most accessed on Mondays. The website continues to be updated on a regular basis. There could be potential growth in the number of website visitors with the use of an app and social media sites.

Technical Assistance and Support – The Older Youth Team continues to support constituents, including former youth, professionals, and community partners by providing resources and consultation. Some inquiries are directed to the team through the Foster Youth Ombudsman. Information and referral are in the areas of education, post foster care support (rent, food), mental health, and housing. This gives the Older Youth Team an opportunity to interact with constituents including former youth in care to assess their continued needs and ways to improve outcomes for youth who exit care. Other professionals working with youth also contact SSA to request information.

The Emerging Adults Executive Internship – The internship was held 8/22/22 – 8/26/22 virtually. DHS/SSA had 35 applicants, and 18 participants. Youth participated in three hours of facilitated group training and time, as well as two hours of one-on-one supervision time daily. Throughout the course of the week, youth received training on: The State Youth Advisory Board, Citizens Review Board, and Strategic Sharing, Vision Boards & How They Create Focus, and Gender Identity & Gender Expression, Contracts & Performance Monitoring, and Resume Building & Interview Success, Exploring Post-Secondary Options, Maryland State Legislative Process & Overview of 2022 Legislative Session, and Youth Role in Social Justice Reform. This week-long internship was supported by five volunteers who implemented a minimum of two hours out of each of their days to support our emerging adults in this program. In addition to the interactive training, participants received a stipend (maximum of $375) dependent upon their attendance and participation in this week-long internship. This incentive was calculated to provide and inspire further professional development in our youth by highlighting both the importance of being paid for your time, and the responsibility to adhere to program and job requirements. On the final day, our emerging adults participated in a farewell video where those who were comfortable expressed their favorite parts of the program.

During the Emerging Adult Executive Internship, the Youth Voice Survey was administered. A total of 18 youths participated in the survey. They were asked to evaluate on 4 topics that affect the emerging adult population in care: The YTP (Youth Transition Plan), Post-Secondary Education, Casey Life Skills, and Suicide Prevention. For the YTP, 73.3% of the youth reported selecting their support team for the YTP meetings; 23.3% selected that they had not. Youth did report areas where they noted changes: attitude toward adulthood improved and their goal achievement improved. The youth noted areas where improvement was needed: having the actual YTP meeting, as some stated they did not have one in the last year. For post-secondary education, 58.3% of youth reported they had no previous knowledge of ETV, whereas 33.3% confirmed they had knowledge and 8.3% reported they had some knowledge of this program. Youth reported they would like more career options other than college and needed help with finding a career

path. With respect to the Casey Life Skills Assessment, 70% of youth rated they felt confident in the assessment areas, whereas 30% felt somewhat confident in these areas. Responses to how youth felt about the assessment: indifferent, good, excited, unsure of the future, and supported. For the Suicide Prevention part of the survey, youth were asked to view the My Life is Worth Living Website and then take the survey. Most of the youth, 73.3% reported having a good support system when feeling low. Some support was reported by 26.7% of the youth. Youth who reported getting no suicide prevention information from school or a caseworker was reported by 53.3% of the youth. The percentage of youth receiving information about suicide prevention information was 46.7%. Youth reported the following helpful supports when feeling low: friends, foster parents, sports/physical activity, therapy/professional intervention, suicide prevention hotline/crisis chat, and youth support group.

The Older Youth team continues to track runaway incidents that occur in jurisdictions across the state. The Runaway Policy, in conjunction with the Sex Trafficking Policy, will be released in 2023. Both policies will be presented in a webinar designed for staff at LDSSs. There will be training for LDSS staff on the new policy, including the provision of guidance and best practices. The Runaway Policy trafficking content will be presented along with the Sex Trafficking Policy in a webinar designed for staff at LDSSs of social services. The policies require use of the Quick Youth Indicators Tracking Tool (QYIT) to identify whether a youth has been a victim of sex trafficking.

2022 Runaway Stats:

Total Number of Runaway Incidents: 323
Assigned Male: 127
Assigned Female: 195
Transgender Identified: 1

Race:
American Indian: 2
Asian: 2
Black/African American: 261
Caucasian: 44
Native Hawaiian/Pacific Islander: 0
Multi Racial: 14

The Semi-Independent Living Arrangements (SILA) program gives youth in care ages 16-20 the opportunity to practice living independently while being supervised by the LDSS. Youth in SILA can live in a variety of settings including renting a room, living in their own apartments, or staying on campus in a dorm. This gives youth the opportunity to learn and practice independent living skills and activities while receiving services from their agencies and other community resources. SILA eligible youth receive a monthly stipend if they meet eligibility requirements by continued enrollment in school/vocational training or employment. In 2022, DHS/SSA disbursed SILA payments to 111 foster youth, for a total of $529,566.83. The SILA funds were used to pay for rental payments/room and board, utilities, education, food, transportation, clothing, and recreation.

SSA continues to secure credit reports for youth ages 14-17 to support the LDSSs with ensuring that the state is in compliance with the Child and Family Services Improvement and Innovation Act (Public Law (P.L.) 112-34). Youth ages 18-21 are responsible for securing their own credit reports but can receive assistance from their case workers. The state maintains contracts with the three major credit bureaus: Experian, TransUnion, and Equifax. There was a total of 955 credit reports retrieved for youth in 2022. Most of the reports were for Baltimore City youth.

Maryland continued to track COVID 19 positivity among children and youth in care throughout 2022. When a child or youth tested positive, the local agency sent a critical incident report to SSA to document the positivity and whether the child was in the hospital or not. A brief narrative of the incident is included in the report about how the infection occurred. In 2022, the Critical Incident policy was updated to include a statewide emergency for COVID and/or Monkeypox. Under the guidance of the DHS Child Welfare Medical Director's office, the process outlined the method to report the exposure or positivity cases for youth in Foster Care.

There were 479 COVID-19 related critical incidents.

- 135 youth were exposed, and 344 tested positive
- 7 youth were hospitalized
- 237 youth assigned as female (49.4%), and 242 youth assigned as male (50.5%) had COVID-19 critical incidents.
- Race:
    - African American 272 (56.7%)
    - Asian 2 (0.41%)
    - Caucasian 157 (32.7)
    - Hispanic/Black 1 (0.20%)
    - Hispanic/White 7 (1.4%)
    - Hispanic/Latino 29 (6.05%)
    - Unknown/Other 11(2.29)

There was one (1) positive Monkeypox case in Baltimore City.

Cohort 5 National Youth in Transition Database (NYTD) data collection began in October 2022. Each state jurisdiction, total of 24, was tasked with collecting surveys from 17-year-olds in care to obtain baseline information. As of December 21, 2022, a total of 18 surveys were collected amongst the jurisdictions. There is a total of 132 due for this cohort. NYTD data collection needs to be strengthened for the 21-year-old cohort, whose survey obtainment is below expectations. Internal efforts will be made to collaborate with the quality assurance and data teams to streamline and assist in improving data collection for this age group. To help increase the participation of eligible youth at the 19 and 21-year-old intervals, the state can do several things: have the survey completed by the LDSS on the 21st birthday, offer financial incentives for participation, ensure there is a valid address at the time of exiting care, and have a dedicated website where youth can complete the survey securely online, which would go directly to SSA.

DHS/SSA continues to partner with Chapin Hall for technical assistance in building capacity for implementing strategies, policies, regulations, outreach, and partnerships impacting emerging adults. Meetings were held weekly to review the need for data, policy, and recommendations. Chapin Hall provided one-on-one support, research, and data to support older youth and Chapin

Hall assisted the Older Youth Team in developing a readiness assessment to determine the strengths, weaknesses, and opportunities in the implementation of FFPSA.

Family First Prevention Services Act (FFPSA) – This legislation has changed the John H. Chafee Foster Care Independence Program to now the John H. Chafee Foster care Program for Successful transition to Adulthood. This reflects the change in focus from independence to transitioning to adulthood. FFPSA calls for changes in programming for older youth in the areas of independent living and pregnant and parenting youth (PPY). The Older Youth Team participated in the Implementation Team process. Data about pregnant and parenting youth will be obtained and incorporated into the implementation plan. EBP providers will be identified that serve youth. In addition, 2023 will focus on the need for CJAMS enhancements regarding documentation in CJAMS of pregnant/parenting youth: pregnancy, status of the youth's child (committed/non-committed, separate notes about this child's functioning, development).

DHS/SSA continues to partner with The Institute for Innovation and Implementation at the University of Maryland School of Social Work to begin the process of developing the Ready by 21 Manual. The manual will incorporate the Integrated Practice Model. It will also reflect the need for increased focus on building relationships with workers/independent living coordinators and youth. Youth ages 14-21 will be required to have transition planning meetings every 6 months at a minimum. The manual will also emphasize the need for the workforce to better prepare youth and their teams for the transition planning meetings. Youth will also be expected to lead their team transition meetings. The manual will provide guidance to the workforce in order to improve outcomes for youth. The prospective due date is June 2023. In addition, The Institute also works as a technical partner in the Enhanced-Youth Transition Plan (E-YTP).

Independent Living Coordinators Meeting (ILC) – This workgroup consists of independent living coordinators from across the state who are the main contacts for guiding emerging adult activities at the local DSS level. This workgroup meets monthly to discuss current issues at the local level that emerging adults are experiencing. It is also the vehicle in which SSA informs the group of policies, clarification of policies, and addressing questions. The group also informs SSA of needed policy changes, systemic barriers, local events, and challenges.

Services and support to LGBTQI+ youth is an area that needs continued strengthening. There were no specific initiatives completed in 2022. For 2023, the plan is to assemble a workgroup to review the state's LGBTQI+ policy to address gender affirmative care and appropriate placement of youth in agencies. The goal is to ensure that the agency clearly communicates to LDSS the need to ensure that LGBTQI+ youth are respected and safe in their placements. In addition, the team will also work to enhance CJAMS in gender identification. Currently, there is only the indication of male and female within the system. There needs to be an update to include other gender identifications, in order to more accurately capture this data.

There are 9 foster youth in Maryland who identify as Native American. In CJAMS, if a child or youth is identified as Native American, a field is populated to request the tribal information. In reviewing CJAMS, most of the youth did not have an indicated tribal affiliation. For those children and youth who had a tribal affiliation, they were identified as belonging to the Piscataway Conoy and Cherokee Nation. Piscatoway is not federally recognized. The Cherokee

Nation is federally recognized. This is an area that needs strengthening for DHS/SSA. Technical assistance will be provided to local departments of social services to ensure tribal information is completed and efforts are made to connect children and youth to their tribe. DHS/SSA will also enhance efforts to connect with tribal leaders through the Maryland Commission on Indian Affairs representative.

Outreach was done to Indian Tribes through community organizations, The Baltimore American Indian Center and Native American LifeLines, and a member of the Piscataway tribe. A representative from the Lumbee Tribe, affiliated with the Baltimore American Indian Center discussed her desire to reach out to Native American youth in foster care to help them reconnect with their heritage. This member provided information on benefits specific to Native Americans that foster youth could receive. She discussed the history of the Lumbee tribe's presence in Baltimore and how they are now scattered throughout the state of Maryland. She also provided some demographic information: the largest tribes in Maryland are the Piscataway, Lumbee, and Cherokee tribes which numbers about 7,000. Native American LifeLines provided information about their health, social, and financial services that would be beneficial to Native youth when they exit care. The Piscataway tribe member provided information about the history around the removal of Native children from their families. He discussed the hesitancy of some individuals not wanting to identify as Native American, which he stated is possibly the reason for the low numbers of youth who identify as such in Maryland's foster care system. Continued efforts to engage the Native American community include having the state representative from the Maryland Indian Commission to attend the ILC meetings and having state representatives participate in community events. Given the few Native American youth identified, those who are transition aged will be identified and outreach to their LDSSs will be done to provide information on the above-mentioned resources.

The Maryland Youth Transitional Plan (Maryland YTP) is a tool created by the Maryland Department of Human Services, used to assist youth in creating a series of steps that will result in the smoothest transition from out-of-home placement to adulthood. By using the plan, youth can organize their thoughts and physically see what goals need to be met to guarantee an effective transition for life events such as: completing school, working in a meaningful career, saving money, safe and stable housing, mental health care, and maintaining relationships. The state's Youth Transition Plan (YTP) was updated and released in 2022. Case workers and supervisors were also trained on how to utilize the new plan. In addition, the document can now be completed in CJAMS and printed for signatures and copies given to the youth. In addition, the Foster Care Verification Letter was also reinstituted. This letter is used for youth who exit care to verify they were in the foster care system.

The Enhanced-Youth Transition Planning (E-YTP) Model is an individualized, youth-driven, strengths-based, comprehensive, and team-based transition planning process that places youth ages 14–21 who are in foster care at the center of their transition planning. E-YTP provides a structured system for a youth-driven transition planning process that honors youth's voice and focuses on a youth's own strengths and goals while supporting the youth in identifying team members who can serve as partners to help meet those goals with success.

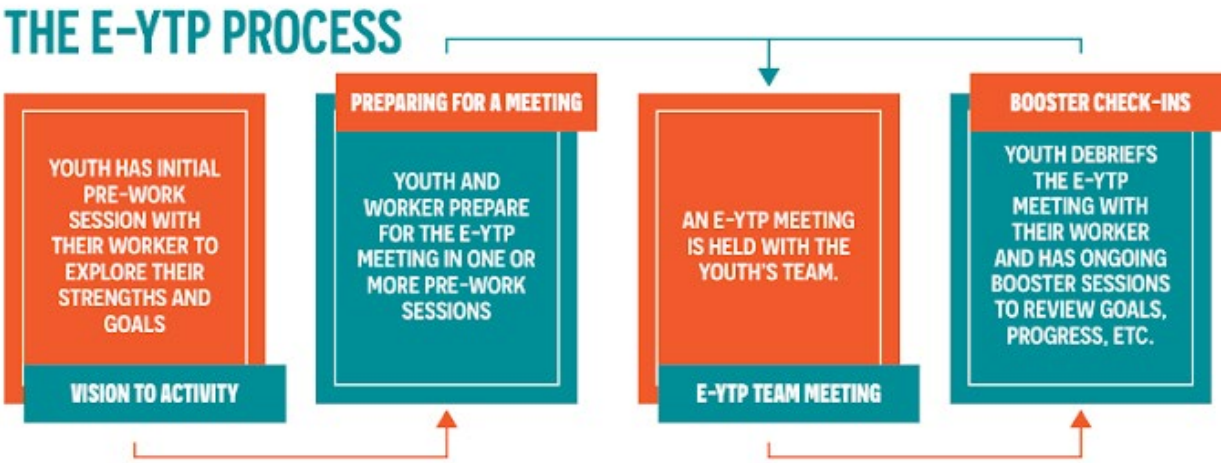
E-YTP was developed with funding from the federal Children's Bureau as part of The Institute for Innovation and Implementation's Youth At-Risk of Homelessness demonstration grant (2013-

2015) and implementation grant (9/2015-9/2020). E-YTP was implemented as a pilot program in five rural counties on Maryland's Eastern Shore (Talbot, Queen Anne's, Kent, Dorchester, and Caroline), but as of spring 2022 the pilot has transitioned to four counties with one opting to discontinue (Dorchester). E-YTP is culturally responsive to the needs of Black, Indigenous People of Color (BIPOC) and LGBTQ+ youth and relevant to both rural and urban communities. E-YTP supports the use of strong, youth engagement skills through the required certification of all foster care supervisors and workers in Achieve My Plan (AMP). The Institute selected AMP as the E-YTP's youth engagement overlay to ensure that workers are engaging with youth by using skills and techniques that support the goals of E-YTP and reduce the risk of young people experiencing homelessness after exiting from foster care. E-YTP is grounded in implementation science. It utilizes skill-based, behavior change coaching with each foster care supervisor to ensure that skills and techniques learned during training are developed further and that they result in high-quality practice. The E-YTP empowers youth and their teams to reach their goals across the designated *Ready By 21* benchmarks: education and employment, financial empowerment, permanent and supportive connections, safe and stable housing, well-being and civic engagement. *(QIC-EY.org, 2023)*

Each month SSA meets with the enrolled LDSSs and The Institute to discuss implementation of the E-YTP process and to address any issues with CJAMS, strengths and challenges with staff implementation, and training needs. At the end of 2022, there were a total of 20 youth who had been involved in the E-YTP process. The program continues to strive toward ensuring that youth who are involved in E-YTP successfully exit care. Areas that need strengthening include understanding how data is collected, aggregated, and presented to SSA on a quarterly basis. On average, 43% of youth had at least one E-YTP meeting. An average of 5.75% of youth had no E-YTP meeting. An average of 32% of youth had pre-work[6] completed, but the target goal is 80%. Each jurisdiction that participates in E-YTP, is making progress in implementing this process. For example, Queen Anne's County has all their team members trained in the AMP module. In Caroline County, the average time between team meetings decreased from an average of 4.2 to 1.7 months in Q2[7] (target is no more than 3 months between meetings). In Talbot County, the percentage of youth who had pre-work completed rose from 25% to 83% during Q2.

[6] Pre-work-youth and caseworker meet to explore goals and direction of the meeting and solicit feedback from the youth

[7] Q2-SFY23 October 1-December 31, 2022



(The Enhanced-Youth Transition Planning (E-YTP) Model, 2021)

The state also tracks the number of youths who apply for disability through its partnership with Maximus. The Maryland Disability Benefits Advocacy Project (DBAP) works to ensure eligible children and youth in care obtain long-term Social Security benefits by working directly with LDSS and Maximus to refer children and youth in care. There are six claim types foster youth could file disability benefits for: initial applications, disabled adult child, Survivor Benefits, Adult Conversion of SSI benefits, representative payee, and placement change. Meetings are held each month with the state's Family Investment Administration (FIA) Department and Maximus to discuss issues with the project. A quarterly meeting is supposed to be held with a larger group that consists of representatives from the Social Security Administration and other state agencies. These meetings have not been as consistent. In 2022, 157 children and youth were referred for SSI claims. The state, in conjunction with Maximus, will conduct a workshop with LDSSs of social service to provide refresher training for caseworkers to help support the process of converting child SSI benefits to adult benefits.

SSA needs to address housing needs of young adults in transition from foster care. Specifically, the state aims to increase the usage of Family Unification Program (FUP) and Foster Youth to Independence (FYI). The project will involve speaking to the independent living coordinators to understand barriers to housing in general. Local housing authorities will be contacted to assess barriers to utilization of FYI and FUP vouchers. Typically, there are jurisdictions (Montgomery, Prince George's, St. Mary's, Calvert, Carroll, and Cecil Counties and Baltimore City) and one state agency -The Maryland Department of Housing and Community Services (MDHC)- that routinely receives FUP vouchers (FUP Awards). There are 24 jurisdictions in Maryland, indicating that this voucher is significantly underutilized in the state. In addition, the agency also needs to increase the utilization of Section 811 vouchers for youth who exit care. There are specific housing programs under this housing voucher that are earmarked for youth exiting care. There has been an identified barrier of the MDHC having difficulty in connecting with ILCs from LDSS to add youth on the waiting list. The goal of 2023 will be to close this barrier by having a system in place to connect youth to being screened and placed on this wait list.

The state updated resources for youth suicide prevention on the MyLife Website in January 2022. The Maryland Commission on Indian Affairs provided the training on mental health

resources to the group. Optum, the state's administrative service provider for mental health, was contacted regarding access to inpatient substance abuse treatment for youth under the age of 18. From this outreach, the state was provided with resources for mental health and substance use providers who serve youth. A mental health database will be devised to share with ILCs. For 2023, the EA and ILC Workgroups, along with the SYAB will incorporate mental health training and resources into its meetings. In addition, SSA will also participate in a statewide Transition Age Youth Mental Health Workgroup.

The state needs to implement a plan to ensure that youth in care understand that they can enroll in Medicaid if they move to another state. An Exit from Care Form will be developed as a tool to be used by caseworkers and youth by the end of CY2023. The form will contain information needed by youth to ensure they have continuity in information they would need immediately upon exiting care: entry and exit date of foster care stay, social security number, Medicaid number and linkage to Maryland Health Connection, along with information about how to access Medicaid in other states, among other needed information and resources. A workshop will be provided in the ILC and EA meetings to update these members about this new requirement.

Education and Training Vouchers (ETV)

The services provided through the ETV Program in CY2022 remain the same. Despite ongoing difficulties due to online schooling and cost inflation, students continue to pursue their higher education, and this is evident by the number of returning students each semester. In addition, as reported by the National Students Clearinghouse in Spring 2022 there were 8 youth that graduated: 2 with an Associate's degree, 5 with a Bachelor's degree, and 1 with a Master's degree (due to youth leaving foster care by age 21 Maryland is not able to confirm graduation). In March 2022, Maryland's ETV Vendor, Foster Care to Success, provided notice that they were ending their contract as of July 1, 2022. SSA was able to negotiate with Foster Care to Success and continue their contract through the next school year. Over the summer SSA began to explore potential ETV vendors both in and out-of-state. A new vendor Foster Success was identified and their proposal for a two-year contract was submitted in December. Foster Care Success plans to increase the number of youths who receive an ETV stipend to 225 youth per year. Foster Care Success services will include a full-time Maryland based ETV coordinator that will meet monthly with all ETV recipients and engage youth in ETV programs and additional support services. The Maryland coordinator will help connect youth to campus services and resources and assist youth in making satisfactory academic progress as needed and provide learning opportunities for ETV-eligible youth to participate in academic and financial support services.

Unduplicated number of ETVs awarded in 2021-2022 (academic year)

In the July 1, 2021- June 30, 2022, academic year there were a total of 145 recipients, 53 new recipients and 92 returning students. During the COVID-19 pandemic the number of new students and total number of recipients decreased, although the number of returning students remained consistent. As reported by Foster Care to Success, in their monthly contacts with students they continued to express challenges due to mental health and being behind academically which could be attributed to the pandemic and difficulty with being isolated and engaging in online schooling. Also returning students were previously connected to ETV Coordinators and understood the ETV application process, while new students may not have understood the

application requirements. During the 2021-2022 school year there were 30 youth who started applications but did not complete or return the necessary financial documents and in the 2022-2023 school year there have been 44 incomplete applications. The largest percentage of ETV funds support youth living expenses (31%), housing (24%), transportation (23%) and school supplies (9%) to support youth while attending school. Living expenses can include on campus food or meal plans, utilities, and personal living expenses. Most students receiving ETV funds are age 21 and older (60%), which is when they need funds the most as at 21, they age out of care and lose other financial aid associated with being in foster care (SILA stipend, etc.).

The below goals were identified for ETV on the CFSP, the baseline data used was the 2018-2019 academic year (highlighted in the chart below) which had 174 total recipients, 70 unduplicated new and 104 returning students (59% of total served):

- **Goal One:** To Increase the Number of new unduplicated student recipients.
    - Measure 1: Increase the number of ETV recipients by 3% annually.
    - Outcome 1: By academic year 2022-2023, Maryland will have a total 78 unduplicated new recipients funded.

- **Goal Two:** To Increase Student Retention Rate
    - Measure 1: Increase returning student rate by 2% annually.
    - Outcome 1: By academic year 2022-2023, 69% of total ETV recipients will return from a previous year.

Table 63: Number of Youth Receiving ETV Funding

Number of Youth Who Received ETV Funding by Academic Year				
Academic Year	**Total**	**Number of Returning Youth**	**Number of New Youth**	**Number of Graduates**
2017-2018	171	103	68	
2018-2019	174	104 (59%)	70	7
2019-2020	155	95 (61%)	60	28
2020-2021	129	89 (69%)	40	8 (not verified by NSC)
2021-2022	145	92 (63%)	53	8
2022-2023*	91	57 (63%)	34	

**2021-2022 includes youth that received Division X funding.*
***2022-2023 School Year Data is current as of 5/24/2023. The decrease in students is due to the shorter contract length of 9 months (October 1, 2022-June 30th, 2023) and there was a matching decrease in funds.*

Due to the COVID-19 pandemic, many youths' educational plans were disrupted and there was a decrease in youth that received ETV funds starting in 2020. In the 2020-2021 academic year there were 89 returning students which was 69% of the total ETV recipients, meeting goal two for that

academic year. But the number of new youths accessing ETV funds declined in the 2019-2020 and 2020-2021 academic years and Goal 1 has not been met.

Standard services provided through the current ETV program are:
ETV Awards: Direct payments made to full time students of up to $5,000.00 for college and vocational training. Part time students may be eligible for up to $2,500 annually. On average students received $3,000 during the academic year. All applications were reviewed per the state's ETV program plan, with a goal of fully funding those with the greatest need, students who are progressing, and those soon to graduate.

Academic Success Program (ASP): ASP provides age-appropriate information to students who are in different academic and social stages of young adulthood. First-year students need basic information and encouragement, while upperclassmen need to focus on academic progression. All students are enrolled in ASP once they are funded. Students who are pregnant and parenting receive more intensive ASP support with phone calls that focus on helping them realistically plan on how giving birth and/or parenting affects their post-secondary plans.

Financial Literacy, Budgeting and School Choice: Prior to being funded for the semester, each student must meet with their ETV coordinator to discuss financial aid and classes. Foster Care to Success (FC2S) helps students develop budgets based on each semester's combined funding and explains how Maryland ETV students can pay for school without incurring excessive debt.

Mentoring/Coaching: Maryland ETV students are offered a mentor who makes a one-year commitment to the student. These well-trained and supported volunteers communicate with the student throughout the school year, at least two times a week, via phone calls and text messaging, email, and Facebook. This is a strategic coaching model, designed to meet the individual student's academic and social/emotional development needs. Mentors encourage and offer guidance on issues such as: communicating with instructors, graduation requirements, career planning and employment skills and etiquette.

ETV Division X Funding
DHS/SSA was awarded $449,718 in Division X additional ETV funding. The agency utilized the Division X ETV funding to assist youth who had been on track to attend or were attending post-secondary institutions or programs but had their education interrupted due to the COVID-19 pandemic and public health emergency and youth who applied for ETV funding with identified needs as a result of the pandemic. In January to June 2022 a total of 76 students received Division X ETV funding for a total of $136,712.75. All funds were expended during the 2021-2022 school year. Division X funds were focused on the priority populations of older youth, youth who experienced housing instability, youth who experienced job loss and youth who were pregnant or parenting. During the 2021-2022 school year a total of 142 students received Division X funding, 32% were parenting or pregnant, 23% were aged 26 or older, 82% identified as female, and 30% were from Baltimore City. The funded students identified 3.5% as Asian-American, 6% as Latino, 15% as Caucasian, and 65% as African American.

Chafee Training
Throughout 2022 a total of 6 full-day training sessions were offered for LGBTQIA+ competency training for all child welfare staff statewide, with 104 staff served in total. These trainings are delivered by qualified facilitators who have undergone facilitation training through The Human Rights Campaign. The LGBTQIA+ competency training addresses: pronouns; best practice language; early messaging; the lack of LGBTQIA+ resources for foster youth; youth coming-out experiences; and insight on how agencies can become more affirming organizations. In 2023, SSA is looking to expand our LGBTQIA+ training to include resource families and placement agencies, as supporting Maryland's LGBTQIA+ youth is a collaborative effort. In addition to incorporating placement organizations in our training efforts, SSA will be updating the LGBTQIA+ policy in 2023 to expand definitions and clarify placement requirements and best practices for LGBTQIA+ youth. The update of the LGBTQIA+ policy has been identified as an area of focus as 8 placement organizations do not serve LGBTQIA+ youth, and only 79 serve transgender and gender non-conforming youth.

Consultation with Tribes
See Consultation and Coordination with States and Tribes Section, below, for the response to this section.

Section 7: Consultation and Coordination Between States and Tribes

There are no federally recognized tribes in Maryland. However, in June of 2022 DHS began efforts to collaborate with the Governor's Office of Community Initiative (GOIC) to better support the Indian Child Welfare Act (ICWA). Beginning in September of 2022, DHS and the GOIC set up a bimonthly meeting to review current SSA policy on Native Americans Family and Children (SSA/CW 16-05). There were no noted changes needed after the review.

The state re-engaged the Director of Ethnic Commissions in September of 2022. The director serves as the coordinator for the Commission on Indian Affairs and is also a representative of the Native American community who meets with SSA Permanency staff every other month.

As of December 2022, DHS has 9 youth in foster care that identify as Native American. During bimonthly meetings, the state presents data to the GOIC on the number of youths who identify as Native American and review if the education, medical and placement needs are being addressed. There is a presentation and request for participation scheduled for the spring of 2023 to meet with the Maryland Commission on Indian Affairs. Please see additional information on DHS efforts to consult and coordinate with tribes in Section 6, John Chaffee.

As part of Adoption and Foster Care Analysis and Reporting System (AFCARS) 2.0 there are now questions in CJAMS related to ICWA. When information about a child is entered in CJAMS, the persons tab has a section that asks about ICWA status inquiry. There are now dropdowns options in CJAMS regarding ICWA status inquiry. The dropdown options address if the youth is a current member or eligible for membership, the name of the federally recognized tribe, and whether legal notice was sent to the tribe. There is also an information icon to assist with identifying the Tribal Identification code. DHS will now be able to accurately collect data for youth that identify as Native American through the electronic record. With the assistance of the

new AFCARS questions the state will be able to identify if there are any youth that identify with federally recognized tribes that have been established in other states.

Section 8: CAPTA State Plan Requirements and Updates

There have been no significant changes to Maryland's laws, regulations, previously approved CAPTA plan that would impact the state's eligibility for CAPTA. Maryland continues to utilize CAPTA funding to support child abuse and neglect prevention activities. This includes supporting community-based programs that provide an array of case management services for children and families focused on child maltreatment prevention. CAPTA funding supports the investigation of reports of child sexual abuse through a grant to the Center for Hope (formerly Baltimore Child Abuse Center (BCAC). The Center for Hope provides forensic interview services to support investigations involving primary and precautionary cases of child sexual abuse and assault, child witnesses to domestic violence and homicide, and cases of human trafficking and cybercrime.

The State successfully renegotiated and entered into two contracts for child maltreatment prevention services: Family Connections Program (FCP) and prevention services provided by The Family Tree. The first contract, with the University of Maryland's School of Social Work's Ruth Young Center for Family Connections Program (FCP), Grandparent Connections, continues to work with grandparents who are raising their grandchildren while focusing on preventing child maltreatment and contact with the child welfare system. This program also provides a learning experience for master's level social work graduate students who are employed as family case managers. This contract is awarded annually in the amount of $200,000.00. The vendor for the service will remain the same for 2024 and 2025.

In 2022, the FCP provided services to a total of 91 families including 221 children. During this time frame, 145 referrals were received, and 74 new cases were opened. Services included assessment, planning, and referrals to services and/or resources; individual, conjoint, family and group counseling; case management; trauma-adapted family connections (TA-FC); provision of concrete resources; and advocacy. Service locations included the client's homes, teleconferencing, community agencies and sites (schools, legal services, mental health centers, LDSS offices, parks, stores, and playgrounds), and the Family Connections site.

FCP has made a significant impact in helping families achieve positive outcomes while contributing to research and the implementation of effective models serving families struggling to meet the needs of their children. Central to the design of the model is a "whole family" approach thus providing services, either directly from model interventions, or partnering with appropriate community resources for children and/or parents. Assessment activities also include all family members to provide a comprehensive understanding of individual and family functioning. FCP's approach uses prevention services with a focus on enhancing protective factors and decreasing risk factors which resulted with no families becoming involved with Child Protective Services.

The FCP creates and maintains community development projects aimed at supporting school communities, connecting with service providers, and advancing Family Connections programming through marketing and communication. Projects include community outreach in response to the COVID-19 pandemic, partnering with community schools and stakeholders and offering support to provide therapeutic services for families, developing partnerships and relationships with referral sources through community outreach efforts, translation assistance for

Spanish-speaking families, and the training of staff and interns to administer and interpret post-termination information from families. The Blue Ribbon Project is a 100% volunteer 501(c)(3) nonprofit community organization based in Anne Arundel County, Maryland. They exist as a support network for survivors of child abuse, foster care, and child sexual assault and are committed to the prevention of child abuse and neglect. The Positive Schools Center, Social Work Community Outreach Service, UMSSW (PSC) works with Baltimore Public schools to reduce disparities in school discipline for children of color and children with disabilities to improve student outcomes.

Due to the needs of Baltimore City residents, FCP clinicians apply a lens of mental health equity and systemic disparities to the work. FCPs focus on social and racial justice greatly impacts family engagement practices; highlighting critiques about the inequitable distribution of resources and serves as a foundation for trust-building and rectifying fractures in family stability that may be attributable to the inequitable distribution of power. By placing responsibility for the lack of community power on systems and institutions, rather than personal failures, allows for a therapeutic non-judgmental stance in supporting caregivers and children at risk of child abuse and neglect. In response, the FCP partnered with the University of Maryland's Positive School Center (PSC) to create a program entitled Community Outreach and Resilience in Schools (CORS). CORS services are developed with families, teachers, school staff and community agencies to create a plan of action for educational health, behavioral health, and social support services.

The Family Connections Program achieved outcomes similar to previous years. Despite COVID-19 and the Omicron variant impacting communities during winter months, Family Connections was able to ensure a continuity of high-quality services by quickly enrolling and training its staff in telehealth practices, including weekly therapeutic interventions, following safety protocols including wearing KN95 masks, providing staff with additional protective equipment and conducting health screenings prior to individual and family sessions, partnering with private organizations to support home drop-offs of household, personal hygiene, food, and other items to families' doorstep. Preliminary analysis suggests significant declines in caregiver trauma and depressive symptomatology, while decreases in average child trauma symptomatology were also observed. Per Family Connections data, further outcomes in overall caregiver, child, and family well-being and safety significantly improved over time. FCB successfully integrated two new assessments: the Africultural Coping Systems Inventory and the Index of Family Protective Factors (IFPF) that were created with Black families in mind which better reflects the population served.

The second contract, the Child Maltreatment Prevention Services contract that is with The Family Tree offers a 24-hour parenting hotline, home visits, as well as complete pre and post services assessments with caregivers. The annual awarded contract amount is $101,770 to provide the necessary services to at-risk children and families for the purposes of prevention child abuse or neglect through parent education classes, parent support groups, parent and caregiver stress line, and lay therapy to families who reside in Baltimore City and Prince George's County. The CAPTA and Promoting Safe and Stable Families (PSSF) funded contract for an array of services including in-person services, a toll-free 24-hour statewide hotline (or stress line) for parents to call when having a parenting crisis, supporting appropriate discipline methods, positive parenting classes, home visiting and parents' anonymous support groups, referrals to public and private social service agencies, and supportive services to grandparent-caregivers.

In the spring of 2019, The Family Tree launched a new chat feature on the website (www.familytreemd.org) which allows visitors on the site to interact with the organization in real time by typing a question or concern on-line. The helpline responded to 1,898 phone calls and web chats, with a total of 466 (or 25%) of the interactions were web chats and requests. This is a 60% increase of web chat usage from the previous reporting year.

The following data reflects activities and families served October 1, 2021 through September 30, 2022 by The Family Tree. The parenting HelpLine was marketed at 34 outreach and community events reaching 4,848 people. In total, the help line responders provided 1,718 referrals to Maryland families. The Parent Support Groups had 35 participants, 4 from Baltimore City and 31 from Prince George's County. The Parenting Education program served 708 parents and caregivers exceeding its goal of serving 400 by 77%. A total of 682 individuals attended virtually and 26 individuals attended in person. Of the 708 parent or caregiver participants, 542 (77%) completed the program. On the pre and post assessment, 278 (51%) participants showed an increase on their Parent Child Relationship Inventory score in Limit Setting/Discipline and 276 (51%) increased their score in Parental Involvement. Four hundred (400) of the participants who completed the parenting classes also completed the satisfaction survey. Three hundred sixty (90%) of those participants agreed that the program met or exceeded their expectations.

There were 33 families and a total of 70 children that participated in the Family Connects Maryland Home Visiting program. In response to Covid-19 and the Governor's Executive Stay-At-Home Order, The Family Tree began offering virtual home visits which also allowed families to schedule appointments during times that were most convenient for them. As a result, visits were conducted using various platforms reaching a total of 147 families. The Family Tree switched to the Parents as Teachers home visiting evidence-based model. The model serves mothers prenatally through the child's 5th birthday to meet the needs of families who may not qualify for other home visiting programs offered in the state such as Health Families, Family Connects, and Nurse Family Partnership.

SSA does not utilize CAPTA funds, alone or in combination with other funds, to improve legal preparation and representation including provisions for the appointment of an individual appointed to represent a child in judicial proceedings.

A portion of CAPTA funding continues to be allocated to 24 LDSS annually to improve outcomes of child maltreatment services by providing funds for client needs through the allocation of Flex Funds. Funding supports activities such as assessments of a child's mental or psychological ability to function and activities of multidisciplinary teams. Funds can be used to offset costs to participants (mileage, childcare, etc.), bring specialists to the team meetings or provide for the team's infrastructure. CAPTA funding to the LDSS may also be utilized to support LDSS requests for training and assistance with secondary trauma interventions for staff.

A large portion of CAPTA funding supports the prevention of out of home placement by supporting parents affected by substance use disorder as well as addressing the safety needs of substance exposed newborns through peer support of the Sobriety Treatment and Recovery Team (START) model. START is being implemented in 10 LDSS. CAPTA funding is used to hire and retain the services of START Family Mentors. Key components and goals of the START model are child safety & well-being, helping parents achieve recovery, and preventing foster care entry

utilizing a family-centered services approach. START model staffing includes a Family Mentor housed at the LDSS that collaborates directly with LDSS staff as a dyad to support the START model and the development, implementation, and monitoring of the Plan of Safe Care (POSC). START targets families referred to Family Preservation Services with parental substance use as the primary child welfare risk factor and at least one child in the home is between 0-5 years of age with a priority focus on Substance Exposed Newborns.

There were 95 families with child(ren) 0-5 referred to START during 2022. At the time of referral, 55% of families were receiving ROH-SEN services, 31% were receiving IR-Neglect services, 9% were receiving ROH-Caregiver Impairment services, 1% were receiving IR-Abuse services, and another 4% were receiving other services within the LDSS. Of the 95 referred families, 50 (52.6%) consented and began START services. Of those who did not begin START services, 51% did not begin because they did meet other selection criteria, 29% did not begin because the jurisdiction caseload was full, while only 11% of referred families declined participation (9% had an "Other" unspecified reason for non-participation). Most of the enrolled family care heads were white (84%) and women (94%).

Including families who began services before 2022, there were 34 families whose START case closed in 2022. Of those 34 families, the child(ren) remained with at least one parent in 50% of cases, the child(ren) was in temporary care of relatives in 6% of the cases, the child(ren) was in the care of relatives who had attained or were seeking custody in 18% of cases, and 9% of cases had a mixed status of children at case closure. The child(ren) was placed in foster care in 18% of cases. When the family's case closure was within START team control (defined as case closure reason being "Closed START Case, end services", "Case transferred to the out of home placement unit", "Case transferred to another unit for adoption", or "Voluntary, care head discontinued participation in START") most care heads achieved indicators of early recovery by the end of their START services (55%).

In total, 56 unique START families (including those that began services prior to 2022) and 67 Non-START families were served by FMs in 2022. Across START and Non-START families, FMs had 1,356 and 1,784 child-focused interactions, respectively. Additionally, FMs had 1,267 START parent interactions and 1,282 non-START parent interactions. FMs also had 578 and 296 interactions, respectively, with relatives or resource parents. These interactions and other related activities translated into 4,093 hours of activities: 38% of which were spent on START families, 25% was spent on Non-START families, while 36% was spent on advocacy activities. Among the START served families the majority of the FMs' activities related to parent recovery supports (54%). The second most common activity related to promoting child safety (19%), followed by performing activities on-behalf of a family contact (10%), followed by providing support to others in the family (9%), and lastly coaching parents in navigating systems (8%).

For more information on the state's continued efforts to support and address the needs of Substance Exposed Newborns or Fetal Alcohol Spectrum Disorder, the development, implementation, and monitoring of the Plans of Safe Care (POSC), refer to Section 6: Populations at Greatest Risk of Maltreatment, SEN.

American Rescue Plan Act (ARPA) of 2021 CAPTA State Grant:

To date, SSA has not begun to utilize the funding awarded through the American Rescue Plan Act CAPTA State Grant. Barriers include transitions of several key staff overseeing ARPA funding and plan, competing priorities and emerging needs. While funds have not been expended, the agency fully intends to utilize theses resources in a timely an effective manner to support child abuse and neglect prevention and the child welfare workforce. The agency is currently in the process of reviewing the initial plan for funding and identifying areas in which amendments may be needed based on changing priorities and emerging needs. The agency is utilizing its implementation structure to engage partners and gather feedback around possible plan amendments. Initial feedback includes expanding services to community-based prevention focused programs through existing agency contracts with the Family Tree and Family Connections.

As identified in the 2023 APSR, the agency plans to utilize a portion of these resources to enhance the current training system for Child Protective Services caseworkers and supervisors by utilizing virtual reality training experiences designed to enhance skills in developing authentic partnerships with families and reducing the impact of implicit bias. This activity is currently in the procurement phase of the process in which the agency is identifying the best appropriate procurement method and provider to secure these services though an identified vendor. The agency also plans to utilize this funding to enhance existing prevention services within the community that support meeting some of the individualized needs identified for children and families and supporting enhanced training focused on parental substance. SSA identified several priorities to address the needs and services for Substance Exposed Newborns (SENs) and parental substance use, specifically Cannabis use. ARPA funding will support training to educate child welfare staff and key stakeholders providing services to parents with identified Cannabis use. Additionally, the agency will utilize ARPA funding to offer training to community providers and agencies on Mandated Reporting; how do we support families instead of reporting families? as well as researching more effective assessment and structured decision-making tools that can be tailored to Maryland's Child Welfare structure and the needs of children and Families we serve.

State's response to the annual citizen review panel report(s)
State Council on Child Abuse and Neglect (SCCAN) Annual Report

- Due to staffing changes, SCCAN has not produced an updated annual report for CY2022. A new Executive Director was hired in June 2023. Once this report is provided to DHS/SSA, a response will be developed and then included with the next APSR/CFSP submission. See Appendix C for 2020-2021 SCCAN Report.

Citizens Review Board for Children (CRBC) Annual Report

- See Appendix D for CRBC FY2022 Annual Report

- See Appendix E: (SCCAN) and Appendix F: (CRBC) for SSA's written response to the annual citizen review panel reports.

Supporting the needs of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder

- See Populations at Greatest Risk of Maltreatment Section.

Maryland's State Liaison Officer:
Keisha Peterson
Director, Protection, Preservation, and Prevention Services
311 W. Saratoga St.
Baltimore, MD 21201
keisha.peterson@maryland.gov

Section 9: Targeted Plans

Disaster Plan

There were no disasters that required DHS to activate the state disaster plan for mass care services. The state mass care plan was activated during the Gubernatorial Inauguration, which was a planned event. There were no necessary changes to the state plans based on that activation.

Within the past year, the Maryland Department of Emergency Management has staffed a position titled 'Chief Equity Officer.' This position is a primary subject matter expert and senior advisor on diversity, equity, and inclusion strategies for emergency response system programs, including a resource for State Agencies and local jurisdictions. The incumbent in this position has been invited and included to join all disaster mass care planning meetings and efforts.

Additionally, The Maryland Department of Disabilities (MDOD) is an integral support agency for all disaster mass care planning efforts. MDOD ensures that all mass care state operations account for the unique access and functional needs of individuals and that services provided align with the commitment the State has made to ensure inclusiveness. MDOD liaisons are present in all aspects of preparedness, planning and response, including: the provision and dissemination of assistive technology equipment, quality assurance visits at mass care sites to ensure inclusion, and the creation or editing of all mass care plans to ensure equality of state programs.

Also, during any specific disaster, The Maryland Department of Human Services works closely with the Maryland Department of Planning to create a general statistical analysis of the community impacted. The information provided by the Department of Planning usually includes (situationally dependent) information on the primary languages used in the communities impacted, the transportation capabilities of the community impacted and an economic analysis of the impacted communities. For example, during COVID-19 response, the Maryland Department of Human Services worked with the Maryland Department of Planning to create a statewide map layering statistical information on COVID positive infection rates, unemployment rates and similar data to help determine potential food distribution needs for impacted communities.

Health Plan

The agency has not made any significant updates or revisions to the Health Plan.

The agency updated the Health Care Oversight and Coordination Policy in September 2022 and disseminated the information via webinars to SSA staff, resource parents and providers and medical providers. In 2023 the agency plans to review and revise the psychotropic medication

oversight policy originally instituted in October 2014. The policy is critical to ensure that children involved in the child welfare system with mental health needs receive restorative, supportive, and holistic care that is monitored to ensure safety and optimal outcomes. Psychotropic medications can be an important part of a youth's treatment plan when used in a considerate and careful way under close medical/clinical supervision. This policy revision will update mandatory processes and procedures regarding informed consent and oversight and monitoring for psychotropic medication.

The agency continues to monitor psychotropic medication use among use in foster care from a population level perspective via a contract with the University of Maryland School of Pharmacy. A report will be produced in March 2023 based on data from calendar years 2015 through 2020. The report will describe annual trends in any psychotropic medication use and by therapeutic class for the state overall and by individual jurisdictions. Psychotropic medication use in relation to healthcare visits associated with a mental health diagnosis will also be included in the report.

Assessment of Performance:
During this reporting period, the agency with the leadership of the DHS/SSA State Child Welfare Medical Director, continued working with Improving Timely Health Care for Children and Youth in Foster Care Affinity Group. The group continues to meet routinely to work towards goals including updating foster care health assessment forms, improving characterization of behavioral/developmental assessments, streamlining processes for MCO/Provider designation and integrating use of the Maryland Electronic Health Information Exchange (CRISP) for relevant clinical information such as chronic medical and behavioral/developmental conditions, immunizations, medications, hospitalizations and Emergency Department visits and will be completing work December 31, 2023. Quality improvement activities initiated through the Foster Care Affinity Group included mapping the Maryland biannual dental exam flow process to determine barriers to care and opportunities for improvement, maximally using healthcare venues experienced in working with the foster care population to improve compliance and quality of the initial placement foster care exams, and using MCO special needs coordinators for assistance in comprehensive exam scheduling. The agency during this period also formally incorporated the Audit Compliance Quality Improvement (ACQI) Team.

With the ACQI Team regular meetings with each of the 24 LDSS have been ongoing to monitor Medical and dental exam requirements compliance and current data trends. Opportunities for performance improvement are discussed with local jurisdictions based on best practices and support from key partners such as MA, MCOS, mental and dental providers and local professional organizations such as the Maryland American Academy of Pediatrics and Maryland Dental Association. These strategies have identified barriers to compliance and strategies that have led to improved compliance in these health exam metrics. New monitoring of compliance with follow up exams has commenced during the reporting periods with efforts to improve this process and documentation in CJAMS.

As the agency and 24 LDSS get acclimated to usage of CJAMS, DHS/SSA actively evaluated CJAMS operability after a full year of state usage; however, improvements in data entry, case management performance and quality for health services are still needed. While there are challenges around data entry consistency and completeness in the new system, the medical

director was able to continue to examine performance related to race and ethnicity, types of out-of-home placement as well as disabilities and conditions. Reviewing data and performance informs administration policy and workforce efforts on equity. Further work will be done on the quality of health care by reviewing a sample of uploaded medical records.

Foster and Adoptive Parent Diligent Recruitment Plan

The agency has not made any significant updates or revisions to the Foster and Adoptive Parent Diligent Recruitment Plan.

DHA/SSA continues to partner with Maryland Resource Parent Association (MRPA), Child Welfare Academy (CWA), and Adopt-Us-Kids (AUK) for ongoing recruitment and retention efforts. AUK ran a banner ad for the month of August 2022 to assist with diligent recruitment for foster families.

Child Welfare Academy has increased resource parent training and retention due to the alteration of training from in-person to virtual. AUK has selected Maryland for targeted media outreach and continues to submit families for recruitment weekly. MRPA provides training and webinars for all resource parents. Foster Parent College (FPC) provided the following data.

- Training Activity Report Totals for Report Period: 1/1/22-12/31/22
  - Number of individuals who participated in FPC online training: 2,996
  - Number of courses started: 20,183
  - Number of courses complete: 19,473

The continuation of virtual training allowed for greater accessibility and reach across jurisdictions, enabling more resource parents to take advantage of training opportunities throughout the year.

SSA contracts with the Child Welfare League of America (CLWA) to provide training to the local jurisdictions on the New Generation PRIDE curriculum. The CWLA also provides access to all resource parents on the Foster Parent college webinars. DHA/SSA continues to contract with Center for Adoption Support and Education (CASE) and Adoptions Together for ongoing permanency and stability for Maryland youth. DHS/SSA continues to provide Adoption and Legal Guardianship Incentive payments to families that apply and are eligible. DHS/SSA continues to provide Post Adoption Permanency funds to families that apply and are eligible.

Training Plan

The 2022 Training Plan/Matrix (see Appendix G) highlights the newly developed child welfare professional development and resource parent training courses. The in-service training series continues to prioritize the required IPM, Family First Prevention Services, Human Trafficking and LGBTQ Competency Trainings. Additionally, there were 16 new in-service courses added in 2022 that covered such issues as Intimate Partner Violence (IPM), and various aspects of substance abuse intervention. There were also six new training sessions for Resource Parents including several courses on Grief, Loss and Resilience and several others on stress management and self-care. The training matrix provides the following required information: Title IV-E

Training Category, Course Description, Duration, Trainer, Training Audience, Title IV-E Cost Allocation, Estimated Cost to develop and implement training and Training Term Status; short term for limited trainings and long term for consistent training offered at various points throughout the year.

Section 10: Statistical Reports

CAPTA Annual State Data Report

The tables below outline the number of CPS staff, education level, gender, age range and race and ethnicity by calendar year. In CY2022, the total number of CPS staff decreased by 23 full time employee (FTE) positions due to vacancies. In terms of education, most caseworkers continue to hold a Master's degree or higher with the remainder holding a Bachelor's degree. Overall, in CY2022 there continued to be more females (90%) than males (10%) in CPS frontline positions. Finally, when looking at race and ethnicity, most frontline staff continued to be African American (41%) or White (52%). There is a racial disparity when looking at supervisors' positions with 65.3% of those positions being filled by White individuals. DHS/SSA did see a reduction in this disparity from 72.5% of supervisor positions filled by White individuals in 2021.

Table 64: Number of CPS Staff (Filled Pins)

Child Protective Services (CPS) Staff	CY2021	CY2022
Case worker Staff (FTE)	327.5 (82.6%)	298.5 (79.92%)
Supervisor Staff (FTE)	69 (17.4%)	75 (20.08%)
TOTAL	396.5	373.5

Table 65: CPS Staff Education Level, Gender, Race and Ethnicity by Calendar Year

Education Levels	CY2021	CY2022 Workers	CY2022 Supervisors
Bachelor's degree	94.5 (24%)	101.5 (34%)	0
Master's or above degree	299 (76%)	193 (66%)	75 (100%)
Gender	**CY2021**	**CY2022 Workers**	**CY2022 Supervisors**
Males	40 (10%)	29 (10%)	4 (5%)
Females	356.5 (90%)	269.5 (90%)	71 (95%)
Race/Ethnicity	**CY2021**	**CY2022 Workers**	**CY2022 Supervisors**
America Indian	0 (0%)	1 (0%)	0 (0%)
Asian	4 (1%)	0 (1%)	0 (0%)

Black/African American	173 (43.7)	121 (41%)	24 (32%)
Hispanic	14 (3.5%)	16 (5%)	1 (1.3%)
Native Hawaiian	0 (0%)	0 (0%)	0 (0%)
White	198 (50%)	154.5 (52%)	49 (65.3%)
2 or more Races	5 (1.2%)	4 (1%)	1 (1.3%)
Unknown	2 (0%)	2 (1%)	0 (0%)

Table 66: CPS Staff Age Range by calendar year

Age Groups	CY2022 Workers	CY2022 Supervisors
Less than 40 years old	167 (56%)	29 (39%)
40 to 59 years old	116 (39%)	38 (51%)
60 or more years old	15.5 (5%)	8 (11%)

Qualifications, and Training

The qualifications for Child Protective Services (CPS) caseworkers and supervisors remain the same as outlined in the CFSP. CPS caseworkers require a minimum of a Bachelor of Arts or a Bachelor of Science Degree in a human service-related field. No experience is required for entry-level case workers other than the possession of a degree in a related human services field. CPS Supervisors, as well as all Child Welfare Supervisors, must have a Master of Social Work degree and possess an advanced license to practice social work in the state of Maryland. Supervisors must have a minimum of three (3) years of experience in child welfare or a related field. CPS employees continue to be required to attend the pre-service training offered at the Child Welfare Academy and pass the competency exam administered to the pre-service training participants. Information related to DHS/SSA Pre-service, and Inservice Training is noted in Section 3, Items 26 and 27.

Maryland Caseload Standards

Maryland continues to strive to maintain an average worker caseload at the standards established by the Child Welfare League of America (CWLA). For CPS investigations the caseload standard is 1:12. According to how SSA currently gathers the data, as of December 2022, the average CPS caseload per caseworker was 6 which represents a decrease of 2.8 from last year. During that same period, the supervisor/worker ratio averaged 1 supervisor to 4 workers. The standard CWLA supervisor-to-worker ratio is 1:5 supervisors to workers. As a state expectation CPS supervisors should not carry a caseload however with the staff shortages and the increased responsibilities of CPS staff many CPS supervisors across the state are carrying a reduced caseload. More information can be found in the Safety Outcome 1 section regarding workload versus caseload.

Currently SSA collects data about CPS caseworker positions filled and divides that by the CPS cases assigned in the calendar year. This has been determined to not be an accurate reflection of

caseloads across the state. This data does not include positions that have been vacant for most of the year or where workers were on leave for various reasons. Nor does this data reflect positions that have had to be utilized for non-case carrying positions such as Family Team Decision Making (FTDM) facilitators and appeals coordinators.

Moving forward SSA is going to explore how to track the actual number of case-carrying positions and workers available to receive cases. This will be done in partnership with Human Resources Development and Training (HRDT) utilizing data from our time management system, Workday.

Juvenile Justice Transfers

The state of Maryland reviewed this reporting requirement. At this point no children under the care of the State child protection system have been transferred into the custody of the State juvenile services system. Juvenile Justice Transfers are captured in the CJAMS system under the Child Removal Tab and the field is Removal End Reason. A user would select Transfer to Another Agency and then select Juvenile Justice Agency. The Department defined these children as having a legal status of supervision of custody and still residing in their home. They are not committed to the State or in Foster Care.

ETV Vouchers

Please see Appendix H and information below for the number of youth who received Education and Training Voucher (ETV) awards July 1, 2021 - June 30, 2022 (the 2021-2022 school year) and July 1, 2022 - June 30, 2023 (the 2022-2023 school year). The 2022-2023 school year data is as of May 24, 2023.

Table 67: Number of ETV Vouchers

	Total ETVs Awarded	Number of New ETVs
Final Number 2021-2022 School Year (July 1, 2021-June 30,2022)	145	53
2022-2023 School Year* (July 1, 2022- June 30, 2023)	91*	34

Inter-Country Adoptions

The state of Maryland provides services for inter-country adoptions prior to the adoption through resource provision as well as the exploration of adoption subsidies. The state can also provide post adoption services if the youth is at risk of entering foster care in the way of family preservation services or post adoption services. After an inter-country adoption, the youth will receive the same services as other youth that enter care. In FY2022, there were no children who were adopted from other countries and entered DHS custody.

Monthly Caseworker Visit Data

Data for FY2023 will be submitted by December 15, 2023.

Section 11: Financial Information

Payment Limitations: Title IV-B, Subpart I: The amount Maryland expended for childcare, foster care maintenance and adoption assistance payments for FY2022 title IV-B, subpart I is $0.

Payment Limitation: Title IV-B, Subpart I: The amount of non-federal funds that were expended by the state for foster care maintenance payments used as part of the Title IV-B, subpart I state match for FY2022 is $0.

Payment Limitation: Title IV-B, Subpart I: The estimated expenditures for administrative costs on the CFS-101, Parts 1 and II and actual expenditures for the most recently completed year on the CFS-101, Part III is $0.

Payment Limitation: Title IV-B, Subpart II
Maryland approximates 25 percent of the grant with state funds.

Payment Limitations: Title IV-B, Subpart II:
The FY2022 state and local share expenditures amount for the purpose of Title IV-B, subpart II is $33.5 million. The 1992 base year is $31.7 million.

Refer to FY2024 CFS-101 Part I, Part II, Part III in Appendix A.

ACRONYMS

ACRONYM	***DEFINITION***
ACQI	Audit, Compliance, and Quality Improvement
AFCARS	Adoption and Foster Care Analysis Reporting System
AGO	Attorney General's Office
ANI	Area Needing Improvement
APHSA	American Public Health Services Administration
APPLA	Another Planned Permanent Living Arrangement
APSR	Annual Program Services Review
AUK	AdoptUSKids
B3	Building Better Beginnings Initiative
BSU	Bowie State University

ACRONYM	*DEFINITION*
BSW	Bachelor of Social Work
CA/N	Child Abuse/Neglect
CANS	Child and Adolescent Needs and Strengths
CANS-F	Child and Adolescent Needs and Strength-Family
CAP	Corrective Action Plan
CAPTA	Child Abuse Prevention and Treatment Act
CASA	Court Appointed Special Advocates
CASE	Center for Adoption Support and Education
CB	Children's Bureau
CBCAP	Community-Based Child Abuse and Prevention
CCWIS	Comprehensive Child Welfare Information System
CEU	Continuing Education Unit
CFE	Center for Excellence
CFSP	Child and Family Services Plan
CFSR	Child and Family Services Review
CHESSIE	Maryland Child Electronic System Information Exchange
CIP	Continuous Improvement Plan
CJAMS	Maryland Child, Juvenile and Adult Management System
CJIS	Criminal Justice Information Services
CMS	Centers for Medicare and Medicaid Services
COMAR	Code of Maryland Regulations
CPA	Child Placement Agency
CPE	Continuing Professional Education
CPS	Child Protective Services
CPSS	Community Partnership and Services Summary

ACRONYM	*DEFINITION*
CQI	Continuous Quality Improvement
CRBC	Citizens Review Board for Children
CRM	Constituent Referral Management System
CSEA	Child Support Enforcement Administration
CWA	Child Welfare Academy
CWLA	Child Welfare League of America
CY	Calendar Year
DDA	Developmental Disabilities Administration
DHS	The Maryland Department of Human Services
DJS	Maryland Department of Juvenile Services
DOJ	U.S. Department of Justice
E360	Entity 360
EA	Emerging Adults
EBP	Evidence-Based Practice
ECS	Early Childhood Specialist
EYBI	Eyberg Child Behavior Inventory
FAFSA	Free Application for Federal Student Aid
FASD	Fetal Alcohol Spectrum Disorder
FBI	Federal Bureau of Investigation
FC2S	Foster Care to Success
FCT	Family-Centered Treatment
FCCIP	Foster Care Court Improvement Project
FCP	Family Centered Practice
FFT	Functional Family Therapy
FFPSA	Families First Prevention Services Act

ACRONYM	*DEFINITION*
FIA	Family Investment Administration
FIM	Family Involvement Meetings
FPC	Foster Parent College
FPS	Family Preservation Services
FTDM	Family Team Decision Meetings
FUP	Family Unification Program
FYI	Fostering Youth to Independence
GAP	Guardianship Assistance Program
GED	General Educational Development
GOC	Governor's Office for Children
GOCI	Governor's Office of Community Initiatives
GROW Model	Goal, Reality, Options, Will Model
HFA	Healthy Families America
HRDT	Human Resources Development and Training
ICPC	Interstate Compact on the Placement of Children
IEP	Individualized Education Programs
IPM	Integrated Practice Model
IPV	Intimate Partner Violence
IR	Investigative Response
KN	Kinship Navigator
KNPA	Kinship Navigator Program Administrator
LAP	Lethality Assessment Program
LBHA	Local Behavioral Health Authority
LDSS	Local Department of Social Services
LEA	Lead Education Agency

ACRONYM	*DEFINITION*
LGBTQ	Lesbian, Gay, Bi-sexual, Transgender, Questioning
LMS	Learning Management System
MACS	Maryland Addiction Consultation Services
MARFY	Maryland Association of Resources for Families and Youth
MCF	Maryland Coalition of Families
MCIA	Maryland Commission on Indian Affairs
MCO	Managed Care Organizations
MD THINK	Maryland's Total Human Services Information Network
MD-CJIS	Maryland Criminal Justice Information System
MDH	Maryland Department of Health
MDH/DDA	Maryland Department of Health / Developmental Disabilities Administration
MDHC	Maryland Department of Housing and Community Services
MDM	Master Database Management
MDOD	Maryland Department of Disabilities
MFN	Maryland Family Network, Incorporated
MFIRA	Maryland Family Initial Risk Assessment
MFRA	Maryland Family Risk Assessment
MFRRA	Maryland Family Risk Re-Assessment
MNADV	Maryland Network Against Domestic Violence
MOU	Memorandum of Understanding
MRPA	Maryland Resource Parent Association
MSDE	Maryland State Department of Education
MST	Multi-Systemic Therapy
MSW	Master of Social Work
MTFC	Multidimensional Treatment Foster Care

ACRONYM	*DEFINITION*
NCANDS	National Child Abuse and Neglect Data System
NFP	Nurse Family Partnership
NOP	Non-Overlapping Period
NYTD	The National Youth in Transition Database
OAG	Office of the Attorney General
OISC	Outcomes and Improvement Steering Committee
OLM	Office of Licensing and Monitoring
OOH	Out-of-Home
OSRI	Onsite Review Instrument
OTHS	Office of Technology for Human Services
PAC	Providers Advisory Council
PARI	Prevention of Adolescent Risks Initiative
PCIT	Parent Child Interaction Therapy
PDR	Parent Daily Report
PDSA	Plan Do Study Act
PIP	Program Improvement Plan
PNG	Policy Network Group
POSC	Plan of Safe Care
PPI	Placement and Permanency Implementation
PPP	Protection, Preservation, Prevention
PSSF	Promoting Safe and Stable Families
QA	Quality Assurance
QI	Qualified Individual
QLIK	Quality-Learning-Interactions and Knowledge
QRTP	Qualified Residential Treatment Program

ACRONYM	*DEFINITION*
QSRI	Quality Service Reform Initiative
RCC	Residential Child Care
RCCPP	Residential Child Care Program Professionals
RCYCP	Residential Child & Youth Care Practitioner
RFP	Request for Proposal
RNPF	Regional Navigator Program
RTC	Residential Treatment Center
SABG	Federal Substance Abuse Prevention and Treatment Block Grant
SCCAN	State Council on Child Abuse and Neglect
SEN	Substance Exposed Newborn
SILA	Semi Independent Living Arrangements
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Services Administration
START	Sobriety Treatment and Recovery Team
STS	Secondary Traumatic Stress
SUD	Substance Use Disorder
SYAB	State Youth Advisory Board
TA	Technical Assistance
TANF	Temporary Assistance to Needy Families
TAY	Transition Age Youth
TCF	Temporary Cash Assistance
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
TOL	Transfer of Learning
TPR	Termination of Parental Rights
UMSSW	University of Maryland, School of Social Work

ACRONYM	*DEFINITION*
WDN	Workforce Development Network
WDU	Workforce Development Unit
WIC	Women Infants and Children

CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CHAFEE, and ETV and Reallotment for Current Federal Fiscal Year Funding

For Federal Fiscal Year 2024: October 1, 2023 through September 30, 2024

1. Name of State or Indian Tribal Organization AND Department/Division:	**3. EIN:**	1-526002033-A8
Maryland Department of Human Services (DHS)	**4. UEI:**	GM1WZ4NRTM51
2. Address: (insert mailing address for grant award notices in the two rows below)		
311 W. Saratoga St.	**5. Submission Type:** (mark X next to option)	
Baltimore, Maryland 21201	- New	X
a) **Contact Name and Phone** for Questions: Vivian Mbah: 410-767-7046	- Reallotment	
b) **Email address** for grant award notices: maria.matiella@maryland.gov		

REQUEST FOR FUNDING for FY 2024:

The annual budget request demonstrates a grantee's application for funding under each program and provides estimates on the planned use

Hardcode all numbers: no formulas or linked cells.

6. Requested title IV-B Subpart 1, Child Welfare Services (CWS) funds:		$4,095,464
a) Total administrative costs (not to exceed 10% of the CWS request)		$409,546
7. Requested title IV-B Subpart 2, Promoting Safe and Stable Families (PSSF) funds and estimated expenditures:	**% of Total**	$0
a) Family Preservation Services	20.0%	$888,954
b) Family Support Services	20.0%	$888,954
c) Family Reunification Services	20.0%	$888,954
d) Adoption Promotion and Support Services	20.0%	$888,954
e) Other Service Related Activities (e.g. planning)	10.0%	$444,477
f) Administrative Costs (*STATES: not to exceed 10% of the PSSF request; TRIBES: no maximum %)*	10.0%	$444,475
g) Total itemized request for title IV-B Subpart 2 funds: NO ENTRY: Displays the sum of lines 7a-f.	100.0%	*$4,444,768*
8. Requested Monthly Caseworker Visit (MCV) funds: *(For STATES ONLY)*		$280,958
a) Total administrative costs (not to exceed 10% of MCV request)		$0
9. Requested Child Abuse Prevention and Treatment Act (CAPTA) State Grant: (*STATES ONLY*)		$1,696,140
10. Requested John H. Chafee Foster Care Program for Successful Transition to Adulthood: (Chafee) funds:		$1,303,236
a) Indicate the amount to be spent on room and board for eligible youth (not to exceed 30% of Chafee request).		$390,970
11. Requested Education and Training Voucher (ETV) funds:		$397,254

REALLOTMENT REQUEST(S) for FY 2023:

Complete this section for adjustments to current year awarded funding levels. This section should be blank for any "NEW" submission.

12. Identification of Surplus for Reallotment:

a) Indicate the amount of the State's/Tribe's FY 2023 allotment that will not be utilized for the following programs:

CWS	PSSF	MCV *(States only)*	Chafee Program		ETV Program
$0	$0	$0	$0		$0

13. Request for additional funds in the current fiscal year (should they become available for re-allotment)**:**

CWS	PSSF	MCV *(States only)*	Chafee Program		ETV Program
$0	$0	$0	$0		$0

14. Certification by State Agency and/or Indian Tribal Organization:

The State agency or Indian Tribal Organization submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA State Grant, Chafee and ETV programs, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.

Signature of State/Tribal Agency Official Rafael López, Secretary		***Signature of Federal Children's Bureau Official*** Joseph Bock for Aysha E. Schomburg
Title August 22, 2023		***Title***
Date		***Date*** 10/6/2023

Name of State or Indian Tribal Organization: Maryland Department of Human Services (DHS) **For FY 2024: OCTOBER 1, 2023 TO SEPTEMBER 30, 2024**

No entry required in the black shaded cells

SERVICES/ACTIVITIES	(A) IV-B Subpart 1- CWS	(B) IV-B Subpart 2- PSSF	(C) IV-B Subpart 2- MCV	(D) CAPTA	(E) CHAFEE	(F) ETV	(G) TITLE IV-E	(H) STATE, LOCAL, TRIBAL, & DONATED FUNDS	(I) Number Individuals To Be Served	(J) Number Families To Be Served	(K) Population To Be Served (narrative)	(L) Geographic Area To Be Served
1.) PROTECTIVE SERVICES	$ 1,474,367			$ 644,533				$ 90,909,380	21,337	-	Children	Maryland State
2.) CRISIS INTERVENTION	$ -	$ 888,954		$ -				$ 29,319,713	-	8,224	Families	Maryland State
3.) PREVENTION & SUPPORT	$ -	$ 888,954		$ 627,572				$ 361,932	-	1,888	Families	Maryland State
4.) FAMILY REUNIFICATION	$ 2,211,551	$ 888,954		$ -				$ 1,230,213	-	6,336	Families	Maryland State
5.) ADOPTION PROMOTION AND	$ -	$ 888,954						$ 385,224		397	Families	Maryland State
6.) OTHER SERVICE RELATED	$ -	$ 444,477						$ 563,595	-		-	-
7.) FOSTER CARE MAINTENANCE:	$ -						$ 41,078,150	$ 21,559,927	4,539	-	Children	Maryland State
(b) GROUP/INST CARE	$ -						$ 17,527,873	$ 154,047,237	484	-	Children	Maryland State
8.) ADOPTION SUBSIDY PYMTS.	$ -						$ 24,732,421	$ 24,306,704	5,416	-	Children	Maryland State
9.) GUARDIANSHIP ASSISTANCE	$ -						$ 371,161	$ 29,296,808	3,307	-	Children	Maryland State
10.) INDEPENDENT LIVING	$ -				$ 1,303,236			$ 292,328	324	-	Children	Maryland State
11.) EDUCATION AND TRAINING	$ -					$ 397,254		$ 79,451	190	-	Youth	Maryland State
12.) ADMINISTRATIVE COSTS	$ 409,546	$ 444,475	$ -				$ 6,529,986	$ 86,714,594				
13.) FOSTER PARENT RECRUITMENT & TRAINING	$ -	$ -		$ 424,035			$ -	$ 755,245				
14.) ADOPTIVE PARENT RECRUITMENT & TRAINING	$ -	$ -		$ -			$ -	$ 755,245				
15.) CHILD CARE RELATED TO EMPLOYMENT/TRAINING	$ -						$ -	$ -	-	-	-	-
16.) STAFF & EXTERNAL PARTNERS TRAINING	$ -	$ -		$ -	$ -	$ -	$ 982,132	$ 4,636,834				
17.) CASEWORKER RETENTION,	$ -	$ -	$ 280,958				$ -	$ 62,699				
18.) TOTAL	$ 4,095,464	$ 4,444,768	$ 280,958	$ 1,696,140	$ 1,303,236	$ 397,254	$ 91,221,723	$ 445,277,129				
19.) TOTALS FROM PART I	$4,095,464	$4,444,768	$280,958	$1,696,140	$1,303,236	$397,254		21.) Population data required in columns I - L can be found: (mark X below the option)				
20.) Difference (Part I - Part II)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00			On this form	In the APSR Narrative		
(If there is an amount other than $0.00 in Row 20, adjust amounts on either Part I or Part II. A red value in parentheses ($) means									X			

CFS-101, PART III: Annual Expenditures for Title IV-B, Subparts 1 and 2, Chafee Program, and Education And Training Voucher

Reporting on Expenditure Period For Federal Fiscal Year 2021 Grants: October 1, 2020 through September 30, 2022

No entry required in the black shaded cells

1. Name of State or Indian Tribal Organization:	**2. Address:**				**3. EIN: 1-526002033-A8**
Maryland Department of Human Services (DHS)	311 W. Saratoga St.				**4. UEI: GM1WZ4NRTM51**
5. Submission Type: (type New or Revision) New	Baltimore, Maryland 21201				
Description of Funds	**(A) Actual Expenditures for FY 21 Grants** (whole numbers only)	**(B) Number Individuals served**	**(C) Number Families served**	**(D) Population served** (narrative)	**(E) Geographic area served**
6. Total title IV-B, subpart 1 (CWS) funds:	$ 3,983,406	6,052	-	Children	Maryland state
a) Administrative Costs (not to exceed 10% of CWS allotment)	$ -				
7. Total title IV-B, subpart 2 (PSSF) funds: Tribes enter amounts for	$ -	-	7,335	Families	Maryland state
a) Family Preservation Services	$ 1,415,973				
b) Family Support Services	$ 909,361				
c) Family Reunification Services	$ 909,361				
d) Adoption Promotion and Support Services	$ 909,361				
e) Other Service Related Activities (e.g. planning)	$ 182,159				
f) Administrative Costs *(FOR STATES: not to exceed 10% of PSSF spending)*	$ 220,591				
g) Total title IV-B, subpart 2 funds: NO ENTRY: This line displays the sum of lines a-f.	$ *4,546,806*				
8. Total Monthly Caseworker Visit funds: *(STATES ONLY)*	$ 287,408				
a) Administrative Costs *(not to exceed 10% of MCV allotment)*	$ -				
9. Total Chafee Program for Successful Transition to Adulthood Program (Chafee) funds: *(optional)*	$ 1,263,223	-	-	-	-
a) Indicate the amount of allotment spent on room and board for eligible youth *(not to exceed 30% of Chafee allotment)*	$ -				
10. Total Education and Training Voucher (ETV) funds: *(Optional)*	$ 383,233	129	-	Youth	Maryland State

11. Certification by State Agency or Indian Tribal Organization: The State agency or Indian Tribal Organization agrees that expenditures were made in accordance with the Child and Family Services Plan which was jointly developed with, and approved by, the Children's Bureau.

Signature of State/Tribal Agency Official		***Signature of Federal Children's Bureau Official***	
Title	***Date***	***Title***	***Date***
Secretary, Maryland Department of Human Services	August 22, 2023	Joseph Bock for Aysha E. Schomburg	10/6/2023

MARYLAND DEPARTMENT OF HUMAN SERVICES

Larry Hogan, Governor | Boyd K. Rutherford, Lt. Governor | Lourdes R. Padilla, Secretary

March 2022

Maryland's Child Maltreatment Fatality Review Plan

The following information outlines the initial plan for the Maryland Department of Human Services/Social Services Administration (DHS/SSA) in developing a centralized Child Maltreatment Fatality Review (CFMR) process, including tracking, and preventing child maltreatment deaths.

Maryland plans to implement a continuous quality improvement, trauma-informed, comprehensive, and centralized DHS/SSA-led review process for child fatalities that are due to maltreatment. The role and purpose of a centralized CMFR, the principles that will drive the reviews, the elements necessary to implement a statewide CMFR process, and outstanding considerations are detailed in this plan. Content is based on feedback and insight from SSA and Local Department of Social Services (LDSS) staff, stakeholders, and partners, including those represented in the Preventing Child Fatalities workgroup, all within the framework of a culture of safety.

A centralized CMFR process in Maryland will consist of a review of a representative sample of child fatalities. It will include efforts to understand the entire spectrum of factors that lead to a child's death due to maltreatment with the goal of preventing future deaths. The reviews will reinforce organizational values and shift the focus away from discussions of blame-worthy acts towards creating and supporting a culture of safety.

The comprehensive CMFR process will be two-fold in scope. First, it will be multidisciplinary in nature and lead to a broader understanding of the circumstances and risk factors that led to the child's death. The reviews will promote consistency in practice, workforce development, stakeholder, and community engagement, and will result in developing recommendations. Second, LDSS staff and supervisors will be engaged through a conversation process that will explore critical decisions and interactions throughout the department's history with the child or family and provide an opportunity to share, process, and learn in a safe, non-punitive environment. This effort will be framed in a close review and understanding of available data as it relates to child maltreatment fatalities and prevention.

Elements of Maryland's Centralized Child Maltreatment Fatality Review Process

1. The CMFR will be DHS/SSA led and situated within the Child Protective Services and Family Preservation Program in collaboration with Continuous Quality Improvement.
2. Ongoing state-led reviews will include fatality cases that are a minimum of 45 days from the report date and meet the following triage criteria:
    a. All youth in Out-of-Home placement;
    b. Children under 3 years old;
    c. Children with an open LDSS case or active within last 12 months;
    d. Any maltreatment related death - regardless of child welfare history; and
    e. Administrative requests.
3. A multidisciplinary team will contribute to the reviews. Core members of the team may be drawn from the following experts:
    a. LDSSs and SSA staff, including those with responsibilities for the investigation and/or prevention of child deaths;
    b. Continuous Quality Improvement representatives;

   c. DHS/SSA Medical Director;
   d. Workforce Development; and
   e. Additional representatives from agencies, providers, or professions involved in protecting children's health and safety will be considered on a case appropriate basis.
4. Available and relevant data (e.g., trend data, regional trends, ages for unexplained deaths and parental substance use, etc.) will be included in the review process to assure that there is a review and understanding of data as it relates to child maltreatment prevention.
5. Use of a standard case summary template for detailing the circumstances that led to the fatality that the CMFR team reviews as part of their triage activities. Case summaries compile relevant case information from Maryland's system of record (CJAMS) and the 1080 Form sections
6. Use the Safe Systems Improvement Tool (SSIT) as the standardized tool to guide reviews and record recommendations. This specific tool is a communication tool that is completed and scored at the culmination of the review, centered on all aspects of the review and the CMFR conversations when rating the items. The tool helps to synthesize and organize all information gleaned from CMFR conversations and any other components of the review.
7. The CMFR team will collaborate, coordinate, and share information with other child fatality reviews, teams, or councils (i.e. Department of Health State Child Fatality Review Team, Department of Health Local Child Fatality Review Teams, Citizen Review Board for Children, State Council on Child Abuse and Neglect, etc.).
8. Policy Directive #22-02, Child Fatality/Serious Physical Injury/Critical Incident, includes the centralized CMFR process and information on the revised DHS/SSA 1080 Form for Child Fatality/Serious Physical Injury/Critical Incident reports and the DHS/SSA 2037 form on Disclosure of Information.
9. The DHS/SSA 1080 Forms have been revised as a single form series with section A:: Initial Child Fatality/Serious Physical Injury/Critical Incident Report; section B:Interim Child Fatality/Serious Physical Injury/Critical Incident Report; and section C: Final Child Fatality/Serious Physical Injury/Critical Incident Report. Sections A and C of the 1080 Form for fatality cases inform the case summaries the CMFR team reviews to triage fatality cases for inclusion in the state-led review.
10. Inclusion of CMFR debriefing conversations with staff and supervisors as part of the CMFR process. A "conversation" is a voluntary opportunity for staff to join with a facilitator to process, share, and learn from child fatalities in an effort to best support quality case management practices and influence increasingly safe outcomes for children. It captures rich information and data for use in quality improvement and prioritizing improvement opportunities.
11. Supplemental guidance to Policy Directive #22-02 to address unsafe sleep-related fatal incidents.

Principles of Maryland's Centralized Child Maltreatment Fatality Review Process

1. The multidisciplinary review process will engage LDSS and state agency leadership, frontline staff, and other key child welfare stakeholders. Ownership for the process and the findings will be shared across agencies.
2. The CMFR process will implement a safety culture response system dedicated to learning and system change. It will support a focus on identifying underlying systemic issues to improve prevention efforts and response by child welfare.
3. The output of the review will consist of recommendations to improve outcomes for all children

and families within, and outside of, the child welfare system in an effort to prevent future child fatalities.

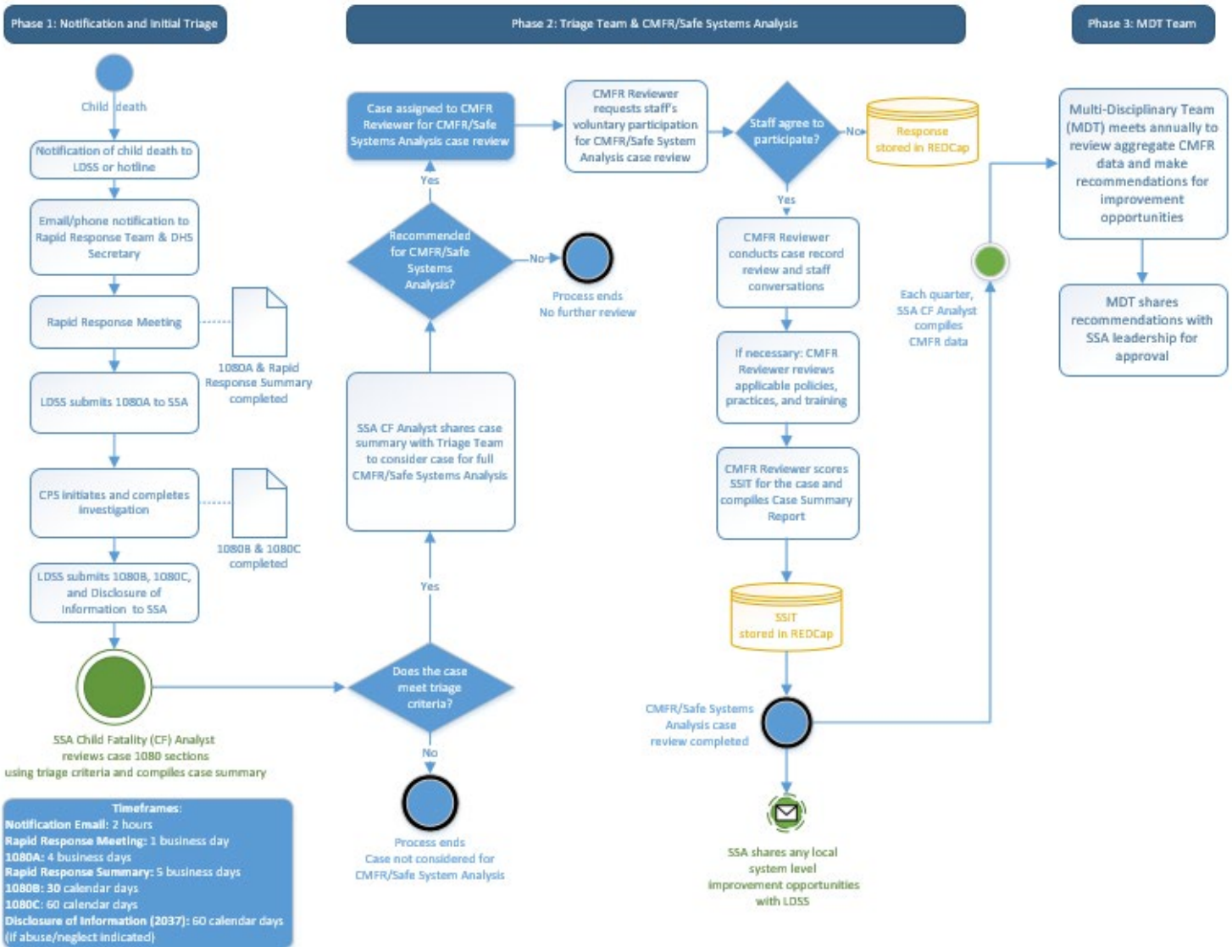
4. Intentional partnering with agencies around prevention efforts will occur through identifying proximal areas of needed improvement.
5. Training and support for staff, including needed tools and resources, will be central to supporting the advancement of a safety culture.

Additional Considerations for DHS/SSA's Centralized CMFR Process

As DHS/SSA begins the initial implementation of a centralized CMFR process the following are considerations to be explored as possible future enhancements to the process.

- The inclusion of families and feedback from families in the review process is important. Assuring these voices and perspectives are heard throughout the review process is an element that DHS/SSA plans to consider in implementation.
- Explore a regular process to review hotline data, specifically data for calls to the hotline for children under age three as research indicates this is an indicator for increased risk for a fatality for the victim child as well as other children in the home.

Flow Chart for Centralized CMFR Process



MARYLAND DEPARTMENT OF HUMAN SERVICES

MARYLAND STATE COUNCIL ON CHILD ABUSE & NEGLECT ANNUAL REPORT

JANUARY 1, 2020 – DECEMBER 31, 2021

MARYLAND

SCCAN
Maryland's
State Council on Child Abuse and Neglect

ACKNOWLEDGMENTS

With tremendous gratitude, we acknowledge the many individuals and organizations who share their time, experience, expertise and passion for promoting child well-being and preventing child maltreatment and other adverse childhood experiences (ACEs) *before they occur*. Special thanks this year go to:

- Council Members (Appendix B) for sharing their expertise and for the many volunteer hours they have contributed to the State Council on Child Abuse and Neglect (SCCAN).

- Council Chair, Wendy Lane and Maryland Essentials for Childhood (EFC) Committee Chair, Joan Stine, for their leadership.

- Council Member agencies for dedicating staff time and expertise to the important cross agency work of the Council and Maryland Essentials for Childhood. Interagency collaboration and coordination are critical to effectively addressing childhood trauma.

- Achieving Racial Equity in Child Welfare Workgroup Co-Chairs, Rachel White and Erica LeMon for their leadership. And, Workgroup Members (See Appendix C) for developing SCCAN's Anti-Racist Statement and working to pass the Child Welfare Data bill in 2021. Special thanks go to Dr. Michael Sinclair, PhD and his graduate students at Morgan State for drafting the historical preamble to the Anti-Racist Statement, including supportive literature.

- Childhood Resilience Action Team Chair, Frank Kros and Coordinating Committee Members Quinton Askew, Dave Brown, Kay Connors, Marianne Gibson, Jessica Lertora, Vanessa Milio, Amie Myrick, Claudia Remington, Joan Stine, and D'lisa Worthy for their leadership and the Action Team (See Appendix D) for their many contributions to the work.

- Pat Cronin, Executive Director of The Family Tree, her Board, and staff. Presidents, Charles Roebuck and Sally Bauer, and the Board for funding the ACE Interface Project, supporting ACEs Education & Advocacy Day 2020 in Annapolis for policy makers and the ACEs Roundtable for Members of the General Assembly to ensure that Maryland becomes a N.E.A.R. Science/ Trauma-Informed State. Pat Cronin and the staff of The Family Tree for their co-backbone support of Maryland Essentials for Childhood Initiative, particularly Matila Jones and Ruby Parker for their leadership and support of the ACE Interface Project.

- ACE Interface Project Master Trainers and Presenters (See Appendix E) for dedicating their valuable time and skills to the efforts to ensuring Maryland becomes a N.E.A.R. Science-Informed State.

- Maryland ACEs Connection Community Managers, Matila Jones, Claudia Remington, Jamie Shepard and Erik Weber.

- The Opioid Operational Command Center and the Governor's Office for Crime Prevention, Youth, and Victims Services for their advocacy of Maryland's application to the National Governors Association Center for Best Practices' (NGA Center) 2020-2021 *Addressing ACEs State Learning Collaborative* and Governor Hogan's Executive Order on ACEs.

- The NGA Center, Duke-Margolis Center for Health Policy (Duke-Margolis) and the National Academy for State Health Policy (NASHP), along with mentor and fellow collaborative states for sharing a wealth of knowledge on statewide approaches to addressing ACEs across the lifespan.

- Dr. Maria Rodowski-Stanco, Dr.James Yoe, and Sabriya Dennis at the Behavioral Health Administration for coordinating, taking the lead on, and including Maryland Essentials for Childhood in the submission of Maryland's application for the CDC's Preventing Adverse Childhood Experiences: Data to Action grant which developed into the establishment of a cross-agency ACEs Data Workgroup.

- Vanessa Milio, former Executive Director of No More Stolen Childhoods (NMSC), and the Board of NMSC for lending their expertise to efforts to pass HB 974 (2020) and SB 134/ HB 263 (Child Sexual Abuse Civil Statute of Limitations Reform) through testimony, and media, and social media advocacy.

- Delegate C.T. Wilson for sponsoring and tirelessly advocating for HB 974 (2020) and SB 134/ HB 263 ((2021) The Hidden Predator Act of 2020 and 2021 - Child Sexual Abuse Civil Statute of Limitations Reform) to prevent child sexual abuse *before it occurs*.

- Judiciary Committee Chair Luke Clippinger and Vice Chair Vanessa Atterbeary for their leadership in Committee to pass HB 974 (The Hidden Predator Act of 2020).

- The Members of the House of Delegates for passing HB974 (2020) legislation to prevent child sexual abuse in school settings *before it occurs*.

- Vanessa Milio and Maroon PR for the design of legislative talking points for SB 134/ HB 263, social media images, and S.E.S.A.M.E. Social Media Toolkit.

- The Legal Resource Center for Public Health Policy at the University of Maryland Francis King Carey School of Law, Professor and Director, Kathleen Hoke, and law students Felicia Langel and Brooke Kasoff for their legal expertise, testimony, and support of efforts to pass the Hidden Predator Act of 2020.

- The following organizations for their support and advocacy on behalf of passing the Hidden Predator Act of 2020 and 2021: Advocates for Children and Youth, Baltimore County Progressive Democrats Club, Beau Biden Foundation, Boys & Girls Clubs of Cecil & Harford Counties, Call to Action Maryland, Center for Hope at Lifebridge Health Group, Children's Justice, Child USA, Child USAdvocacy, Citi Ministries, Citizens Review Board for Children, Court Appointed Special Advocates (CASA), Enough Abuse Campaign, Enradius, the Episcopal Dioceses of Maryland, Federation of Christian Ministries, First Star Institute, GBMC Healthcare, Harrity, Heartly House, Inc., Housing Authority of the City of Frederick, International Brotherhood of Teamsters, Justice 4 MD Survivors, Key School Survivors, Kros Learning Group, Maroon PR, Maryland Catholics for Action, Maryland Chapter of the Academy of Pediatrics, Maryland's Children's Alliance, Maryland Coalition Against Pornography, Maryland Coalition Against Sexual Assault, Maryland Coalition of Families, Mid-Atlantic P.A.N.D.A., Montgomery Young Democrats, MOST Network, NAACP Maryland State Conference, No More Stolen Childhoods, Parents Anonymous of Maryland, Parents' Coalition of Montgomery County, Partnership for a Safer Maryland, Prevent Child Abuse Maryland, Progressive Neighbors, ProMD Health, ProMD Helps, Renew Your Core with Trauma Healing, Sisterhood of Salaam Shalom, Survivors Network of those Abused by Priests (SNAP), The Family Tree, The Living Water, The Maryland Family Network, The Moore Center for the Prevention of Child Sexual Abuse at Johns Hopkins Bloomberg School of Public Health, and Turn Around.

- Marci Hamilton, CEO and Academic Director of Child USA, and interdisciplinary think tank to prevent child abuse and neglect at the University of Pennsylvania for sharing her time and expertise and written testimony on statute of limitations reform, as well as the resources of Child USA.

- Alix Boren, JD, Executive Director of Child USA, for her legal research on Maryland's civil statute of limitations.

- Kathryn Robb, JD, Executive Director of Child USAdvocacy, for her outstanding and considerable legal research, written testimony, advocacy, and oral testimony on behalf of HB 687 and HB 974 The Hidden Predator Acts of 2020 and 2021.

- Delegate C.T. Wilson, Jena Cochrane, Sarah Conway, Lil Hughes Knipp, Theresa Lancaster, David Lorenz, Patti Mills, Kathryn Robb, Kurt Ruprecht, David Schappelle, Carolyn Surrick, Jean Wehner for their powerful, compelling, and courageous oral and written testimony, media advocacy, and legislative advocacy to pass HB 974 and SB 134/ HB263 The Hidden Predator Acts of 2020 and 2021. Allies for their powerful and compelling testimony: Kay Connors, LCSW-C Michael Fitzpatrick, Paul Griffin, JD, Jennifer Gross, Felicia Langel, Wendy Lane, MD, MPH, Claudia Remington, JD

- Sarah Conway for her development of Justice4MDSurvivors.org in support of Maryland child sexual abuse survivor efforts for child sexual abuse statute of limitations reform.

- Elizabeth Letourneau, PhD and Rebecca Fix, PhD of the Moore Center for the Prevention of Child Sexual Abuse at the Johns Hopkins School of Public Health and Wendy Lane, MD, MPH of the University of Maryland School of Medicine for their work on the ***Maryland Guidelines and Best Practices for the Design, Assessment, and Modification of Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse***.

- Les Nichols for dedicating countless *pro bono* hours to share his expertise as a CPTED architect and his experience as the former National Vice President, Child & Club Safety for Boys & Girls Clubs of America in assisting SCCAN in the development of the ***Maryland Guidelines and Best Practices for the Design, Assessment, and Modification of Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse***.

- Charol Shakeshaft for her review of the ***Maryland Guidelines and Best Practices for the Design, Assessment, and Modification of Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse*** and recommendations for collection of data points to evaluate the extent to which the design, assessment, and modification are successful in reducing child sexual abuse.

- Jillian Storms for sharing her architectural expertise; and, Jillian Storms, Joan Schaffer and Cassandra Viscarra for their collaboration in drafting the ***Maryland Guidelines and Best Practices for the Design, Assessment, and Modification of Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse***.

- The Maryland Association of School Business Officials, R. Leslie Nichols, President, at R.L. Nichols & Associates, LLC, Ron Pierce, School Prevention & Intervention Specialist, at the Maryland Center for School Safety, Claudia Remington, Executive Director for SCCAN, Jillian Storms, AIA, School Architect, at MSDE, Merril Plait, PE, Director, office of Facilities & Improvement, at Baltimore County Public Schools, Todd Vukmanic, CPD, Senior Project Manager and Lori Walls, Director, at Crabtree, Rohrbaugh Architects for their collaboration on two presentations at the MD ASBO Virtual Conference on effective implementation of the ***Maryland Guidelines and Best Practices for the Design, Assessment, and Modification of Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse***.

- The many partners, stakeholders, and citizens who contribute to moving SCCAN Recommendations and MD EFC efforts forward.

TABLE OF CONTENTS

State Council on Child Abuse and Neglect (SCCAN)
311 W. Saratoga Street, Room 405
Baltimore, Maryland 21201
Phone: (410) 767-7868 Mobile: (410) 336-3820
claudia.remington@maryland.gov

December 1, 2021

The Honorable Larry Hogan
Governor of Maryland
State House
100 State Circle
Annapolis, Maryland 21401-1925

The Honorable Bill Ferguson
President of the Senate
State House
100 State Circle, Room H-107
Annapolis, Maryland 21401-1991

The Honorable Adrienne A. Jones
Speaker of the House
State House
100 State Circle, Room H-107
Annapolis, Maryland 21401-1991

Re: Family – General Article, Annotated Code of Maryland, § 5-7A-09, State Council on Child Abuse and Neglect (SCCAN) Final Report for 2017

Dear Governor Hogan, President Ferguson and Speaker Jones:

I would like to begin with a heartfelt word of thanks for the actions you took to implement State Council on Child Abuse and Neglect (SCCAN) key recommendations. During 2020-2021, Governor Hogan issued and Executive Order on Adverse Childhood Experiences (ACEs), designating the Governor's Office of Crime Prevention Youth and Victims Services to coordinate efforts, including monitoring data on ACEs; and, the General Assembly passed legislation creating a Trauma-Informed Care Commission and mandating collection and analysis of ACEs and positive childhood experiences (PCEs) data for middle schoolers and high schoolers in the Youth Risk Behavior Survey/Youth Tobacco Survey; among key actions laid out in the Executive Summary of the report.

Pursuant to the requirements of Family Law Article, Annotated Code of Maryland, § 5-7A-09 and the federal Child Abuse Prevention and Treatment Act (CAPTA), I respectfully submit on behalf of the State Council on Child Abuse and Neglect (SCCAN) its unanimously adopted Annual Report. The Council makes

recommendations for systems changes and improvements through this report that address its legislative mandates:

1) *to "evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities;"*
2) *to "report and make recommendations annually to the Governor and the General Assembly on matters relating to the prevention, detection, prosecution, and treatment of child abuse and neglect, including policy and training needs;"*
3) *to "provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community and in order to meet its obligations;"*
4) *to "annually prepare and make available to the public a report containing a summary of its activities;" and,*
5) *to "coordinate its activities … with the State Citizens Review Board for Children, local citizens review panels, and the child fatality review teams in order to avoid unnecessary duplication of effort."*

As the SCCAN mandates are quite broad, the Council must choose priorities on which to focus each year. For 2020-2021, we have chosen to continue our focus on the primary prevention of child maltreatment, health care for children involved in the child welfare system, racial equity for children and families involved in the child welfare system, and efforts to build resilience in children and families during the pandemic. On pages 47-61, the Council[1] recommends several actionable steps to improve Maryland's child and family serving systems in order to protect children and to prevent child maltreatment and other Adverse Childhood Experiences (ACEs) *from occurring in the first place*. Specific recommendations are made to prioritize prevention of ACEs, create a Children's Trust & Prevention Fund, coordinate the work of child and family serving systems, pass additional child sexual abuse prevention legislation; get a clearer picture of the racial disparities within the child welfare system, and improve health care for children involved in child welfare. Each of these issues has become more urgent as a result of the coronavirus pandemic, with job losses, school closures, and isolation increasing the risk of abuse and neglect for Maryland children.

As you read through the Council's report and recommendations, I hope you will see our deep commitment to the healthy growth and development of every child within our state and the primary prevention of child maltreatment and other ACEs. That dedication extends to the relationships and environments of children − their parents, their families, their communities, and their state.

Sincerely,

Wendy Lane, MD, MPH, SCCAN Chair

cc: DHS Secretary Lourdes R. Padilla
MDH Secretary Dennis Schrader
DJS Secretary Sam Abed
MSDE State Superintendent of Schools, Mohammed Choudhury
MDD Secretary Carol A. Beatty
DBM Secretary David R. Brinkley
DPSCS Secretary Robert L. Green
DLLR Secretary Tiffany Robinson
Governor's Office of Crime Prevention, Youth, and Victim Services, V. Glenn Fueston, Jr., Executive Director
SCCAN Members

[1] While state agency designees sit on the Council to provide information and perspective to inform Council recommendations, state agencies take no position either for or against the recommendations.

EXECUTIVE SUMMARY

SCCAN's 2020-2021 Annual Report to the Governor and General Assembly continues to provide a framework for a seismic culture change in how we as a state address child abuse and neglect, along with related adverse childhood experiences (ACEs) and childhood trauma. Child physical, sexual, and emotional abuse and child neglect, along with parental mental illness, parental substance abuse, domestic violence, parental incarceration, divorce and separation, experiencing racism, witnessing violence, living in an unsafe neighborhood, living in foster care, peer violence, bullying, historical and intergenerational trauma, as well as other adverse experiences disrupt the healthy development of children. Individually and particularly when experienced in combination, these ACEs lead to poor child health, educational, and relational outcomes. These outcomes then impact communities by reducing public safety and economic productivity at an immense cost to taxpayers. In North America, total health system costs attributed to ACEs were estimated, in a study funded by the World Health Organization, to amount to $748 billion per year.[2] Tennessee's Sycamore Institute study estimated that ACEs led to $5.2 billion in medical costs and lost productivity among Tennessee adults in 2017.[3] And, a recent study published in *JAMA Pediatrics* by researchers at Columbia and Harvard University, found that "Childhood adversity accounted for approximately 439,072 deaths annually in the U.S. through associations with leading causes of death including heart disease, cancer, and suicide, or 15 percent of the 2,854,838 total number of U.S. mortalities in 2019."[4] The significant costs of ACEs emphasize that the future prosperity of any society depends on its ability to foster the health and well-being of the next generation. As Maryland policy makers invest early and wisely in children and families, the next generation will pay that back through a lifetime of productivity and responsible citizenship.

As a result of the COVID-19 pandemic, the ensuing stay-at-home orders, economic downturn, unemployment, food and housing insecurity, day care and school closings, and the deaths of family members, communities are seeing a significant increase in parental and child stress. Parental stress creates increased risk for ACEs such as child maltreatment, and parental mental health, substance misuse, intimate partner violence, and divorce and separation to name a few. Now more than ever, it is critical that we consider instituting trauma-informed and resilience-building public and private policies and practices to create the safe, stable, and nurturing relationships and environments for children and prevent and mitigate ACEs.

Building infrastructure to disseminate the science and support collective statewide and community efforts is essential. SCCAN facilitated Maryland's participation in the U.S. Centers for Disease Control and Prevention's (CDC) Essentials for Childhood (EFC) Framework Statewide Implementation technical assistance program. The Essentials for Childhood initiative is helping us find ways to promote relationships and environments that help children grow up to be healthy and productive citizens so that *they*, in turn, can build stronger and safer families and communities for *their* children (a multi-generation approach). Maryland Essentials for Childhood (MD EFC) includes public and private partners from across the state and receives technical assistance from the CDC. Participating in this program allows Maryland to learn from national experts and leading states. When people learn about the science of the developing brain, epigenetics, the

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[2] Mark A Bellis , Karen Hughes , Kat Ford , Gabriela Ramos Rodriguez , Dinesh Sethi , Jonathon Passmore Life **course health consequences and associated annual costs of adverse childhood experiences across Europe and North America: a systematic review and meta-analysis, September 3, 2019.**

[3] Courtnee Melton, The Economic Costs of ACEs in Tennessee, The Sycamore Institute, February 1, 2019.

[4] *Exposure to childhood adversity is linked to early mortality and associated with nearly half a million annual U.S. deaths,* October 2021.

ACE Study, and theories of resilience, they begin to understand the interconnection of many of the social problems that confront our state; and, begin learning and working together to innovatively solve these problems.

SCCAN and MD EFC's efforts over the last decade have been a catalyst for disseminating the N.E.A.R. science (neurobiology, epigenetics, ACEs, and resilience) across Maryland's child and family serving agencies, sectors, and communities. In December of 2019 MD EFC held an ACEs Roundtable for the Maryland General Assembly, increasing interest among Members in legislative action to address ACEs. SCCAN and MD EFC ACE Interface testimony was offered in support of legislation passed to create a Trauma-Informed Care Commission. MD EFC's ACE Interface Project also teamed up with MDH's Regrounding Our Response Initiative, strategically training ACE Interface Master Presenters within the state's opioid crisis response sector, to begin to address the trauma quite often underlying substance use disorder. In January of 2020, MD EFC representatives met with Lt. Governor Rutherford and MD EFC ACE Interface Master Trainers and the Executive Director of SCCAN were asked to present to members of the Opioid Operational Command Center. These combined efforts culminated in support by the Governor's Office for Maryland's participation in the National Governor's Association's ACEs Learning Collaborative with Delaware, Pennsylvania, Virginia, and Wyoming. MD EFC and SCCAN efforts within the executive and legislative branches have helped to ensure action on key SCCAN recommendations toward making Maryland a trauma informed and resilient state:

- Governor Hogan issued an Executive Order on ACEs
- Governor Hogan dedicated $25 million in COVID relief funding to create Project Bounce Back to build post-COVID resilience among Maryland youth, families and communities. The Project created a public-private partnership which includes the Maryland State Department of Education, the Governor's Office of Crime Prevention, Youth, and Victim Services, the Boys and Girls Clubs of America, Microsoft, LinkedIn Learning, KPMG, Discourse Analytics, and eCare Vault to provide critical services to young people.
- The Maryland General Assembly (MGA) passed legislation to create a Trauma Informed Care (TIC) Commission HB548/SB299
- The Governor's Office of Crime Prevention, Youth and Victims Services was established as the state coordinating body for both the Executive Order and HB548/SB299
- The Executive Order requires that state agencies provide data and other information with the GOCPYVS to study and monitor policies and programming to prevent and mitigate ACEs
- .HB548/SB299 requires each state agency lead to appoint two staff members to lead their agency's effort to become trauma-informed
- HB548/SB299 requires the development of a statewide strategy toward an organizational culture shift into a trauma-informed state government
- HB548/SB299 requires the TIC Commission to establish metrics to evaluate and assess the progress of the statewide trauma informed care initiative
- The MGA passed legislation HB771/SB548 requiring inclusion of ACEs questions in the Youth Risk Behavior Survey/Youth Tobacco Survey for both middle schoolers and high schoolers
- Several MD EFC partners and ACE Interface Master Trainers were appointed by the Governor to serve on the TIC Commission

In addition to these major accomplishments, members of MD EFC formed a COVID-19 Childhood Resilience Action Team to prevent and mitigate childhood trauma associated with and/or exacerbated by the pandemic.

The Action Team is focused on creating a website domain containing a childhood resilience resource library and informing the public of the availability of the resources. The Behavioral Health Administration will provide grant funding to develop the childhood resilience website, ACEs training and data to support the Governor's Executive Order and Trauma-Informed Care Commissions efforts to prevent and mitigate ACEs across the state.

Similarly, members of SCCAN and MD EFC formed an Achieving Racial Equity in Child Welfare Workgroup in response to the movement for racial justice brought about by the murder of George Floyd. The Achieving Racial Equity Workgroup developed and SCCAN adopted an Anti-Racist Statement to guide the Council's efforts on racial equity; and, successfully advocated for legislation to ensure DHS and MSDE collect and disseminate critical population level data on children in the child welfare system disaggregated by gender, race, and ethnicity. That data will be essential to informed decision-making that eliminates racial disparities, dismantles systemic racism within the child welfare system, and reduces childhood adversity associated with experiencing racism and the foster care system.

SCCAN's Annual Report for 2020-2021 includes the following:

- A discussion of Maryland data on the magnitude of the problem
- A description of the 2020 and 2021 SCCAN & MD EFC actions and accomplishments toward achieving our four strategic goals
- Recommendations to the Governor, the General Assembly, and child and family serving agencies.
- A brief background of SCCAN's, mandate, focus, and efforts is found in Appendix F
- An overview of the key concepts of neurodevelopmental science and the impact of adversity on the developing brain which are foundational to many of the SCCAN recommendations is included in Appendix G

Key Recommendations for the Governor, the General Assembly, and Agencies[5]:

To align public policy and practice with the science of childhood trauma and the developing brain:

1. Educate all Children's Cabinet and senior-level management staff in N.E.A.R. science and science-based communications strategies.
2. Develop and implement a Trauma and Resilience-Informed State Action Plan for Preventing and Mitigating Childhood Trauma/ACEs that:
    - Makes ***budgetary commitments*** to prevent and mitigate ACEs, ***including staffing an Office of Resilience*** similar to those in neighboring Pennsylvania and New Jersey to lead ACEs/trauma/resilience work
    - Establishes a ***public/private collaboration*** to serve as ***infrastructure*** to prevent and mitigate the impacts of ACEs on Marylanders and assures local solutions to address community issues. Recruit champions from all three branches of government, as well as private funders, business, faith-based, and local community leaders, and experts in trauma and resilience to participate.
    - Develops an ***ACE awareness and mobilization campaign, employing N.E.A.R. science and communication science strategies,*** to develop common unified language and messages when communicating about ACEs, trauma, and healthy social, emotional, and physical development by partnering with the Harvard Center on the Developing Child and FrameWorks Institute. (See Building Strong Brains Tennessee and Alberta Wellness Initiative)

[5] A comprehensive list of SCCAN Recommendations by Agent/Agency can be found on pages 59-69.

- Develops a ***framework or standard for state child and family serving agencies*** to become ***designated*** a ***trauma-informed agency***. (Footnote - Trauma-Informed State Agencies, MO, DE, PA, NJ)
- ***Surveys current ACEs, trauma-informed, and resilience efforts*** in state agencies, agencies contracted by the state and local communities and ***builds upon those efforts***
- Develops and/or adopts ***cross-agency, cross-sector ACEs training*** for agencies, providers, and communities; as well as, ***on-going technical assistance and training*** for state agencies to attain ***trauma-Informed agency designation***.
- ***Enhances the State's ACEs surveillance system, data collection and analysis*** building upon the work of the ACEs Cross-Agency Data Workgroup led by the Behavioral Health Administration.
- ***Promotes the creation of local community based cross sector coalitions***
- Includes a ***strong focus on early childhood,*** ensuring safe, stable, nurturing relationships and environments from the start
- ***Incorporates the six strategies and evidence-based programs and approaches*** listed in the CDC's *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence* resource tool.
- ***Aligns with the work of the Trauma-Informed Care and Health Equity Commissions*** and other trauma-informed, health equity, and racial equity efforts in the state. (See Appendix H)

4. Support legislation and funding of a Children's ACEs Prevention Trust Fund administered by a public-private board of directors to lead innovative interventions and financing across the state.[6]

5. Collect, review, analyze, publish, and effectively disseminate Maryland's state and local ACEs and positive childhood experiences (PCE) data using the Behavioral Risk Factor Surveillance System (BRFSS data) and the Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS).

6. Continue to collect BRFSS ACE data every three years

7. Expand Maryland's YRBS/YTS ACE module to include all CDC BRFSS ACE and PCE module questions and collect this data every two years. Legislation that passed in the 2021 legislative session will require ongoing inclusion of ACE questions in the YRBS but will require only 5 questions. Legislation should be amended to ensure that ACE questions are alternated so that all 10 ACE questions are included during each 4-year interval. Data on protective factors should be examined for each Maryland jurisdiction.

8. Children's Cabinet members should integrate the science of the developing brain, ACEs, and resilience across agencies and within individual agencies by:
    - Participating in developing and implementing a State Plan to Prevent and Mitigate ACEs
    - Identifying, designating, and empowering two staff from each agency with experience, expertise, and interest in brain, ACEs, and resilience science and multi-generational approaches to collaborate with sister agencies and serve as principal advisors to each agency Secretary/Director in trauma-responsive and trauma-informed care, including aligning agency training, policies, practices, and procedures with a trauma-informed approach, as required under Md. Code Ann., Human Services § 8-1301- 8-1308 (2021)

[6] https://ctfalliance.org/

- Ensuring that your agency's communications tools and messaging embed the ACE awareness and mobilization campaign, based on N.E.A.R. science and communication science strategies
- Considering the appropriateness of screening clients for ACEs and resilience factors[7]
- Providing the ***cross-agency, cross-sector ACEs training*** developed for agencies, providers, and communities through the work of the Trauma Informed Care Commission; as well as, ***on-going technical assistance and training*** for state agencies to attain ***trauma-Informed agency designation to your all state and local agency staff***
- Ensuring that your ***local agency staff participate in local community based cross sector coalitions***
- Ensuring that state contracts require providers meet performance measures to become trauma-informed based on the Maryland developmental framework or standards for a trauma-informed approach developed by the Trauma Informed Care Commission
- Embedding the science into agency mission, vision, strategic planning, and technical assistance to local agencies: and, create funding opportunities to local agencies for cross-sector planning and coordination of ACE prevention and mitigation efforts
- Ensuring agency policies and regulations reflect the science
- Ensuring agency practice models reflect the science
- Investing resources in evidence-based trauma prevention and treatment interventions and creating trauma-informed agencies[8]

9. Pass legislation to amend Md. Code Ann., Family Law § 5-1312 (2021) to include additional data to be collected by DHS and MSDE on youth in foster care

10. Pass legislation requiring all mandated reporters in Maryland to receive racial bias training focused on the role of bias and racism in child abuse and neglect reporting

11. Pass legislation requiring all DHS employees and local DSS supervisors and caseworkers in Maryland to receive racial bias training focused on the role of bias and racism in decision-making throughout the continuum of child welfare cases

12. Pass legislation providing for Paid Family Leave

13. Pass legislation eliminating the civil statute of limitations for child sexual abuse, including a two-year look-back window or "window of justice" to expose hidden predators

14. Pass legislation that requires all public and nonpublic schools and their contracting agencies to do CPS background checks on all applicants for positions involving direct contact with minors

15. Pass legislation requiring state and local child and youth serving agencies, and child and youth serving organizations receiving state funding to institute Comprehensive Child Sexual Abuse training, policies, and guidelines; similar to those required in public and nonpublic schools

[7] Bartlett, J.D., Adversity and Resilience Science, *Screening for Childhood Adversity: Contemporary Challenges and Recommendations*, 20, April 2020. Anda, R. Porter, L. Brown, D., American Journal of Preventive Medicine (2020) *Inside the Adverse Childhood Experience Score: Strengths, Limitations, and Misapplications*; and, Finkelhor, D., Child Abuse & Neglect (2017) *Screening for adverse childhood experiences (ACEs): Cautions and suggestions*.

[8] See the National Child Traumatic Stress Network for resources on creating trauma-informed systems.

16. Hold a legislative hearing regarding implementation and possible reforms to strengthen Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), including the issue of informed consent for psychotropic medications

MAGNITUDE OF THE PROBLEM IN MARYLAND

Important to addressing any problem is understanding of its scope. There is considerable need for improvement in providing comprehensive data and analysis of childhood adversity for both individual case determinations and systems improvement decision-making. In 2016, the Council and its' partners supported the Governor's supplemental budget request to create a shared services platform into which all the human service agencies could integrate their data systems. The proposal also provided for replacing the three legacy data systems within DHS – CARES (for public assistance); CSES (for child support enforcement); and MD CHESSIE (for child welfare). DHS assured the Council and partners that this ground-breaking project, MD THINK, would bring needed accuracy, efficiency, data analysis capabilities, and tracking of critical outcomes for children across child and family serving agencies. Disappointingly five years later, key data points are either not regularly and systematically collected or are not readily accessible and therefore not analyzed [e.g., health care data required under Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), service provision data, disaggregated referral and pathway data for children and families involved in child welfare, and ACEs of children involved in child welfare]. In addition, despite the requirement under Md. Code Ann., Human Services § 8-1101- 8-1103 (2018) to integrate child welfare data with data from CRISP (Chesapeake Regional Information Systems for our Patients), Immunet, and Medicaid to create a centralized data portal and electronic health passport, much of this important health information remains inaccessible to DHS leadership and staff, as well as to foster youth, foster parents, biologic parents, and foster care workers. CJAMS child welfare data must be linked to other electronic health data at the patient level to accurately assess children's health care needs and treatment and services received. Many other states and jurisdictions have successfully linked Medicaid and Child Welfare data; Maryland needs to expeditiously create these linkages. Doing so *will provide critical data and a clearer picture of not only how well children are doing within the child welfare system, but how those same children and families are faring in sister child and adult serving systems (health, education, courts, juvenile services, corrections, housing, etc.) and across Maryland.*

CPS reports are known to underestimate the true occurrence of maltreatment. Non-CPS studies estimate that 1 in 4 U.S. children experience some form of child maltreatment in their lifetimes.[9] It is important to look at multiple sources of data to understand the true scope of the problem. To give the reader some perspective on the problem in Maryland, the Council considers data from three Maryland sources below: Maryland CPS Data (incidence), Behavioral Risk Factor Surveillance System ACE Module data (childhood prevalence among Maryland adults of all ages), and Youth Risk Behavior Survey data (prevalence to date among adolescents).

[9] Finkelhor D, Turner HA, Ormond R, Hamby SL. Violence, crime, and abuse exposure in a national sample of children and youth: an update. JAMA Pediatrics 2013; 167(7):614-621. doi:10.1001/ jamapediatrics.2013.42.

CHILD WELFARE DATA, CHILD ABUSE AND NEGLECT REPORTS, PATHWAYS & SERVICES PROVISION

Figure A illustrates the number of referrals (alleging suspected maltreatment), reports (screened-in referrals), their pathways (investigation or alternative response, risk of harm), dispositions, and service provision.

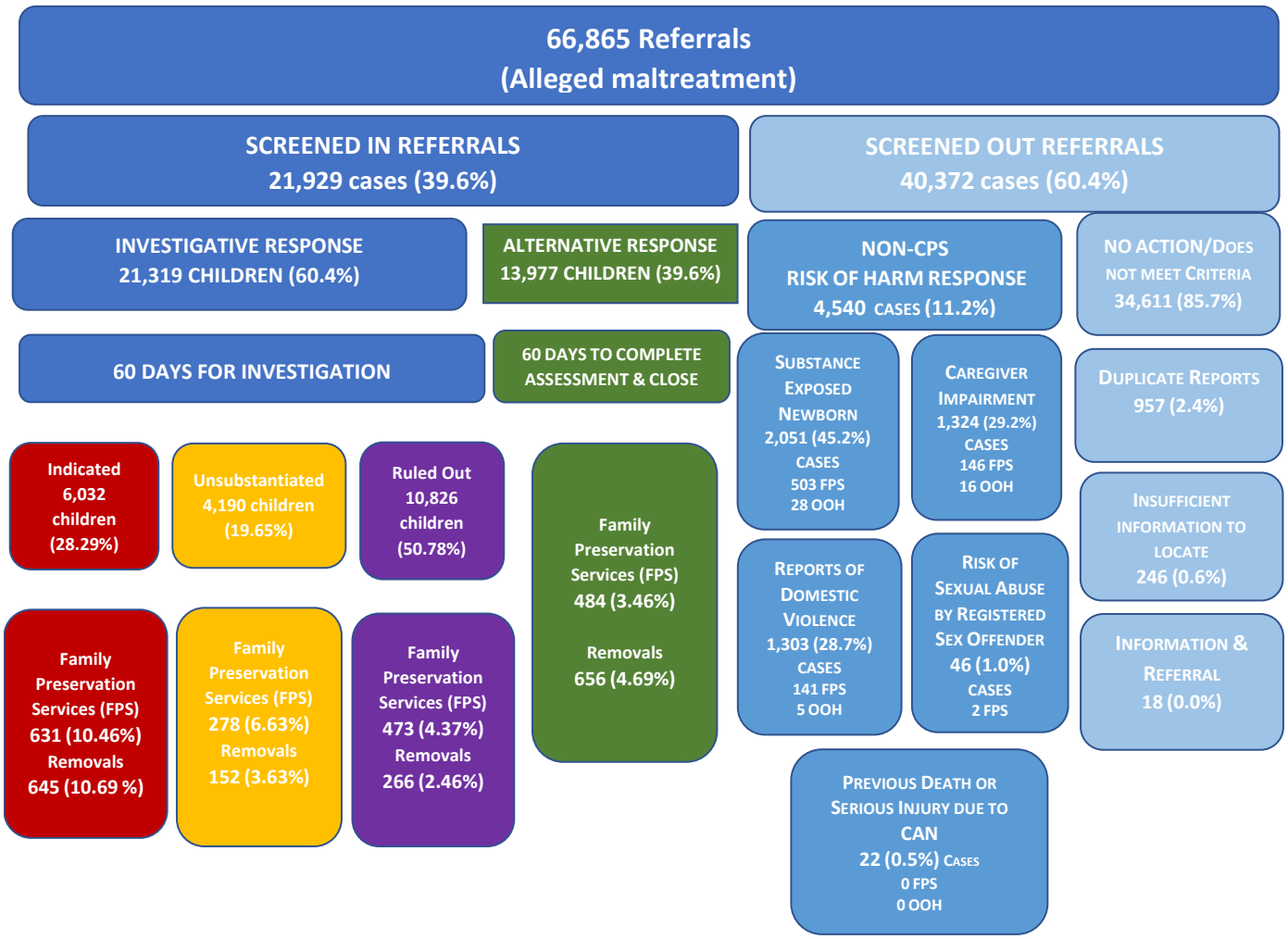
- During FFY 2019, DHS SSA reports that it received 66,865 referrals of suspected child abuse or neglect, up from 6 64,200 referrals in 2018. Of those, 21,929 reports or 39.6% were screened in for a CPS response (either investigative or alternative response).
- During FFY 2019, 21,319 investigations were completed. Of this total, 6,032 or 28,3% were indicated for abuse or neglect. The 6,032 indicated cases represent 9% of the total abuse and neglect reports. Once there is an indicated referral, children are considered victims of child abuse/neglect.[10]
- During FFY 2019, 13,977 screened-in reports (20.9% of total reports) received an alternative response (AR). Of those 13,977 cases, 484 (or 3.46% of AR cases) received services and 656 cases (or 4.69% of AR cases) ended up with a removal; and, the majority of AR cases (91.85%) received neither services nor ended up in a removal.
- Data was not readily available to indicate what, if any, services were offered to and accepted by children and their families. This is unfortunate as many of the children referred to child welfare experience significant risk factors (multiple types of maltreatment, parental mental illness, substance abuse, incarceration, domestic violence) that result in poor short and long-term outcomes. ***It is unclear from available data the extent to which children and families are not only referred for services but linked and provided those services.***
- Of particular concern to both SCCAN and the Citizens Review Board for Children is the absence of data to verify the extent to which children are receiving necessary health and mental health services and care coordination. Almost 60% of cases reported to child protective services (CPS) by mandated reporters and concerned citizens go unaddressed according to the data provided by DHS, SSA (Figure A). Even cases that receive a child welfare response lack accurate tracking and reporting of services and outcomes. This is particularly troubling as children involved with child welfare face complex challenges of chronic and extreme stress that threaten their long-term health and well-being; and, being known to CPS is a risk factor for child maltreatment fatalities[11].

Data from SCCAN's 2013-2018 Annual Reports emphasized the importance of tracking health services and outcomes for children involved with child welfare. Gathering and analyzing this data should be a high priority for ensuring our state's appropriate care of these our *most* vulnerable children. Because children and families involved in child welfare are often involved in multiple public systems − public health, behavioral health, primary care, Medicaid, child welfare, criminal and juvenile justice, education, public assistance, and child support enforcement—**it is essential that these systems work in unison and share data effectively to meet these children's health care needs.** Brain science and the ACE Study indicate that leaving these needs unmet leads to poor behavioral, health, educational, employment, and relational outcomes in the future. **A comprehensive state plan to prevent and mitigate ACEs should include gathering, sharing and analyzing data to help understand the magnitude of the problem and ensure data-driven solutions.**

[10] In one report of child abuse and neglect, there may be multiple case types (physical abuse, neglect, sexual abuse, mental injury), as well as multiple victims and maltreators. As a result, one report may have multiple findings for multiple victims. For instance, one report may indicate physical abuse but rule out neglect on one child and indicate physical abuse and neglect on another child. This results in multiple findings per report.

[11] Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities, p. 14.

Figure A: FFY2019 Child Maltreatment Referral, Pathways, and Services



RACE AND ETHNICITY DATA for Reports, Pathways, and Services

	Screened-In Cases		
	All CPS	AR	IR
Hispanic	2,509	903	1,606
Black (NH)	12,288	4,426	8,862
White (NH)	9,657	3,567	6,090
All Others (NH)	480	204	276
Unknown/Declined	5,706	2,456	3,250
Missing	569	203	366
Total	32,209	11,759	20,450

CPS Screened-In Cases by Race and Ethnicity Compared to the Maryland Child Population by Race and Ethnicity[12]

	Percentage of 2020 MD Child Population	Percentage of Screened-In Cases
Hispanic	16.6%	7.8%
White (NH)	40.6%	30.0%
Black (NH)	30.6%	38.2%
All others (NH)	12.2%	1.5%

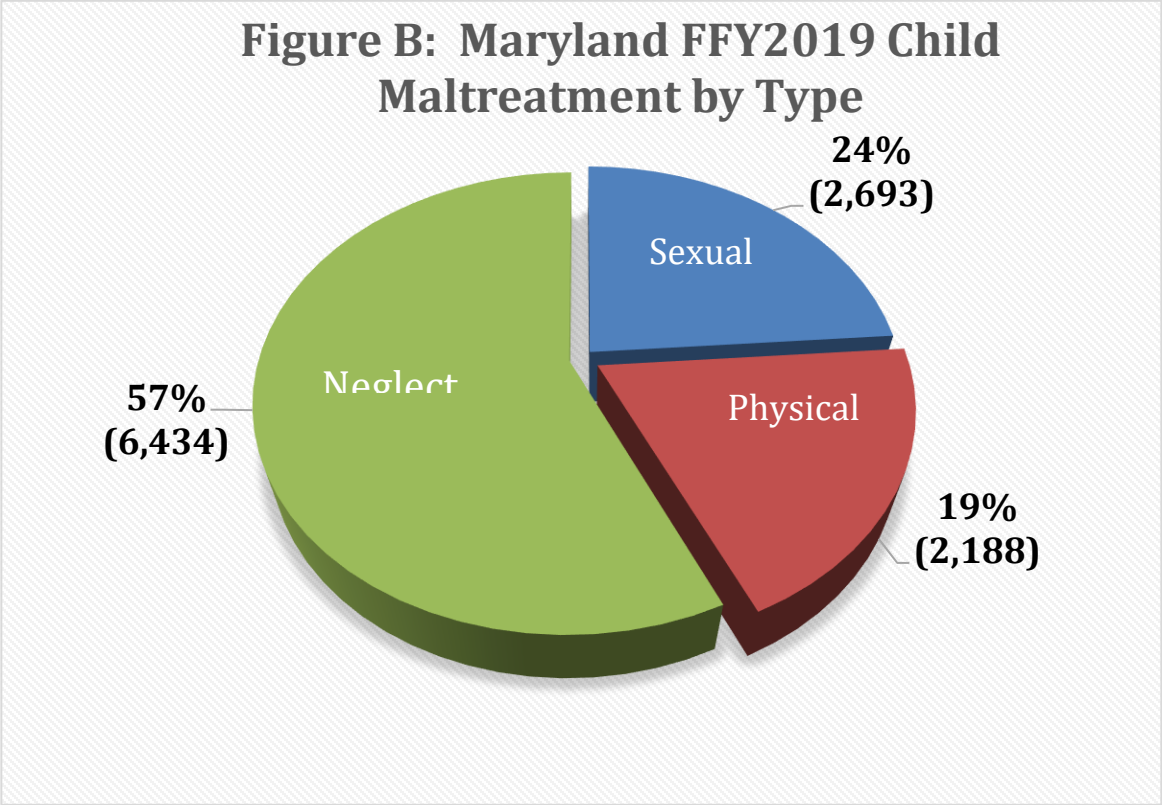
SCCAN requested that each data point in Figure A, referrals, pathways, and services be disaggregated by race, gender, age, and ethnicity. It appears that the new CJAMS system is unable to disaggregate this data at this time. A comparison of the racial and ethnic make-up of children/families investigated for maltreatment (i.e. screened-in) to the racial and ethnic make-up of all children in Maryland shows several disparities. While Black families are over-represented in child maltreatment investigations, White and Hispanic families are under-represented.

Child Maltreatment by Type

- Neglect is the largest category of child abuse/neglect at 57% (down from 63% in 2017), followed by sexual abuse at 23% (up from 11% in 2017), physical abuse at 18% (down from 26% in 2017), sex trafficking at 1% (1st reported period) and mental injury at 0%. See Figure B below.
- Chronic neglect is given less attention in policy and practice, however can be associated with a wider range of damage than physical or sexual abuse. Science tells us that young children are especially vulnerable to poor physical and mental health outcomes of neglect. A broad range of developmental impairments can occur, including cognitive delays, stunting of physical growth, impairments in executive function and self-regulation skills, and disruptions of the body's stress response.[13]
- Sexual abuse was up from 11% of indicated cases in 2017 to 23% of indicated cases in 2018. SCCAN asked for a deeper dive into this data to begin to understand the significance of this

[12] Maryland census data from: https://planning.maryland.gov/MSDC/Pages/pop_estimate/CensPopEst.aspx
[13] *In Brief, The Science of Neglect*, Harvard Center on the Developing Child.

increase. Due to demands for data analysis concerning COVID-19 issues, the data and analysis could not be provided by SSA. Further analysis of this data would be helpful, especially if this trend continues.



Caregiver Risk Factors for Child Maltreatment:

Caregiver risk factors are characteristics of a caregiver that may increase the likelihood that their children will be victims of abuse and neglect. Parental drug and alcohol abuse are documented risk factors. However, the extent of the problem in Maryland is challenging to ascertain because different data sources provide very different statistics. The U.S. Department of Health and Human Services, Administration for Children and Families *Child Maltreatment 2019* report on National Child Abuse and Neglect *Data* (NCANDS) analyzed data for two caregiver risk factors, alcohol abuse and drug abuse, defining those risk factors as:

- Alcohol abuse: The compulsive use of alcohol that is not of a temporary nature.
- Domestic Violence: Any abusive, violent, coercive, forceful, or threatening act or word inflicted by one member of a family or household on another. In NCANDS, the caregiver may be the perpetrator or the victim of the domestic violence.
- Drug abuse: The compulsive use of drugs that is not of a temporary nature.
- Financial Problem: A risk factor related to the family's inability to provide sufficient financial resources to meet minimum needs.
- Inadequate Housing: A risk factor related to substandard, overcrowded, or unsafe housing conditions, including homelessness.
- Public Assistance: A risk factor related to the family's participation in social services programs, including Temporary Assistance for Needy Families; General Assistance; Medicaid; Social

Security Income; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); etc.

- Any Caregiver Disability: This category counts a victim with any of the six disability caregiver risk factors—Intellectual Disability, Emotional Disturbance, Visual or Hearing Impairment, Learning Disability, Physical Disability, and Other Medical Condition.

Data submitted to NCANDS by the Maryland Department of Human Services showed that 2.3% of child maltreatment victims (i.e. cases with an indicated finding) in Maryland had a caregiver risk factor of alcohol abuse and 5.8% had a caregiver risk factor of drug abuse.[14] Maryland's caregiver alcohol abuse and drug abuse risk factor numbers are significantly smaller than numbers in most other states (victims with alcohol abuse caregiver factor varies from 46% in Massachusetts to Maryland's 2.3%; victims with drug abuse caregiver factor varies from 57.8% in West Virginia to Maryland's 5.8%, Florida's 2.0% and Arkansas's 2.1%).

In contrast, DHS reported significantly higher parental substance abuse (both alcohol and other substances) to SCCAN (see Figure C below) than they did to NCANDS. The data reported to SCCAN indicates that parental substance abuse was a factor in the removal decision for 35.5% of all children removed from their homes in FY 2019. These numbers are more in line with data collected by the National Surveys on Drug Use and Health 2009-2014 that indicates that at least 1 in 8 children nationally (not limited to child welfare involved children) lived in a household with at least 1 parent with a substance abuse disorder.[15] SCCAN is concerned about the accuracy of the data for this and other key child maltreatment risk factors. For example, domestic violence over the last three years has fluctuated from 16.7% in 2016 to 38.1% in 2017 to 25.6% in 2018 to 38.6% as reported to NCANDS and 24.3% reported to SCCAN in 2019. As addressing caregiver risk factors is key to preventing and responding to child maltreatment, it is critical to have accurate data upon which to base policy and practice decisions.

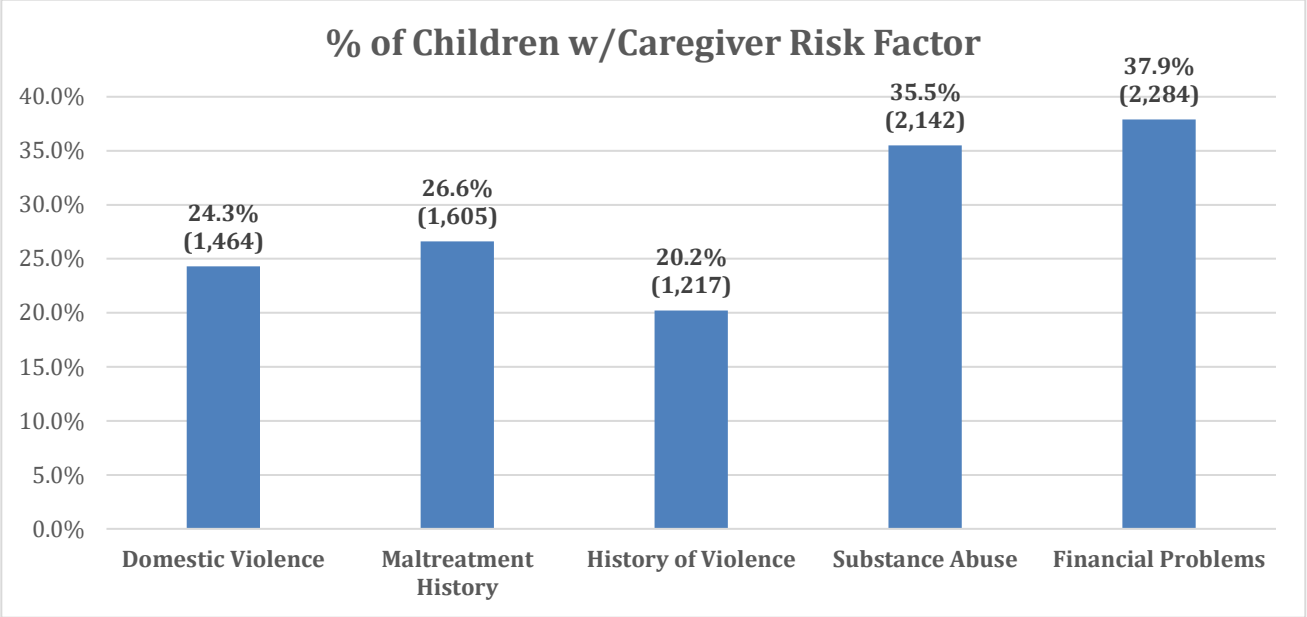
Parental **Risk Factors Among Maryland Children Who Receive an Investigative Response from DSS no matter the finding (as reported to SCCAN by DHS) See Figure C below**:

- 24.3% of child victims had a caregiver risk factor of domestic violence (down from a reported 38.1% in 2017 and 25.6% in 2018).
- 35.5% of child victims had a caregiver risk factor of substance abuse (down from a reported 37.9% in 2018; and, different from 2.3% and 5.8% with a caregiver risk factors for alcohol - and drug abuse, respectively, as reported to NCANDS).
- 37.9% of child victims had a caregiver risk factor for financial problems (down from 40.2% in 2018).
- 26.6% of child victims had a caregiver risk factor of maltreatment history (down from 28.2% in 2018).
- 20.2% of child victims had a caregiver risk factor of a history of exposure to violence (down from 22.7% in 2018).

[14] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2020), *Child Maltreatment 2019*

[15] https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.html

Figure C: Maryland FFY2019
Risk Factors among MD Children with an Indicated Maltreatment Finding



CAREGIVER RISK FACTOR	# of children with risk factor as reported by MD SSA to SCCAN	% of children with risk factor as reported by MD SSA to SCCAN	# of children with risk factor reported by MD SSA to NCANDS	% of children with risk factor reported by MD SSA to NCANDS
Alcohol abuse	Not reported	Not reported	173	2.3%
Drug abuse[16]	Not reported	Not reported	447	5.8%
Domestic Violence	1464	24.3%	2955	38.6%
Maltreatment History	1605	26.6%	NCANDs did not analyze this factor	NCANDs did not analyze this factor
History of Violence	1217	20.2%	NCANDs did not analyze this factor	NCANDs did not analyze this factor
Financial Problems	2284	37.9%	2637	34.4%
Inadequate Housing	Not reported	Not reported	248	3.2%
Public Assistance	Not reported	Not reported	432	5.6%
Any Reported Disability	Not reported	Not reported	401	5.2%
Substance Abuse[17]	2142	35.5%	NCANDs did not analyze this factor	NCANDs did not analyze this factor

Given the strong likelihood that NCANDS data – obtained from DHS child welfare data – grossly underestimates the risk of parental substance abuse, SCCAN is concerned that parental risk factors may or may not be accurately identified or documented by trained child welfare workers, go undocumented in the

[16] NCANDS collects separate data on alcohol abuse and drug abuse.
[17] DHS SSA collects data on substance abuse, combining both alcohol and drug abuse.

child welfare data systems, and thus are inaccurately reported to NCANDS. As this is data upon which child welfare policy is formulated, it is critical to ensure that risk factors are accurately identified and documented in the child welfare data systems; and, accurately reported to policy makers.

Child Abuse & Neglect Fatalities as Reported by DHS:

- In FFY 2019, DHS reported to NCANDs that 55 Maryland children had died with child maltreatment as a contributing factor. Child maltreatment fatalities have increased each year over the last 5 years 2015, 28 deaths; 2016, 32 deaths; 2017, 41 deaths; 2018, 40 deaths; 2019, 55 deaths. It was reported that of those 55 children who died in 2019, none of their families had received Family Preservation Services within the previous 5 years and only one child was removed from and reunited from his/her family within the previous 5 years.
- SSA reported 64 child fatalities in FFY 2019 to SCCAN. Thirty-seven (57.8%) of child deaths were < 1 years old; 20 (31.3%) were 1-3 years old; and 7 (11%) were between 6-17 years old.
- According to SSA, in FFY 2019, 34 (53.1%) of child fatalities were African American; 26 (40.6%) were White; 7 (10.9%) were Hispanic; 2 (3.1%) were Asian; and 2 (3.1%) were designated “other” race or ethnicity.
- SCCAN requested data on serious physical injuries, disaggregated by age and race, but did not receive this information from DHS, SSA. This is of great concern to the Council. This data should be publicly available on a regular basis.

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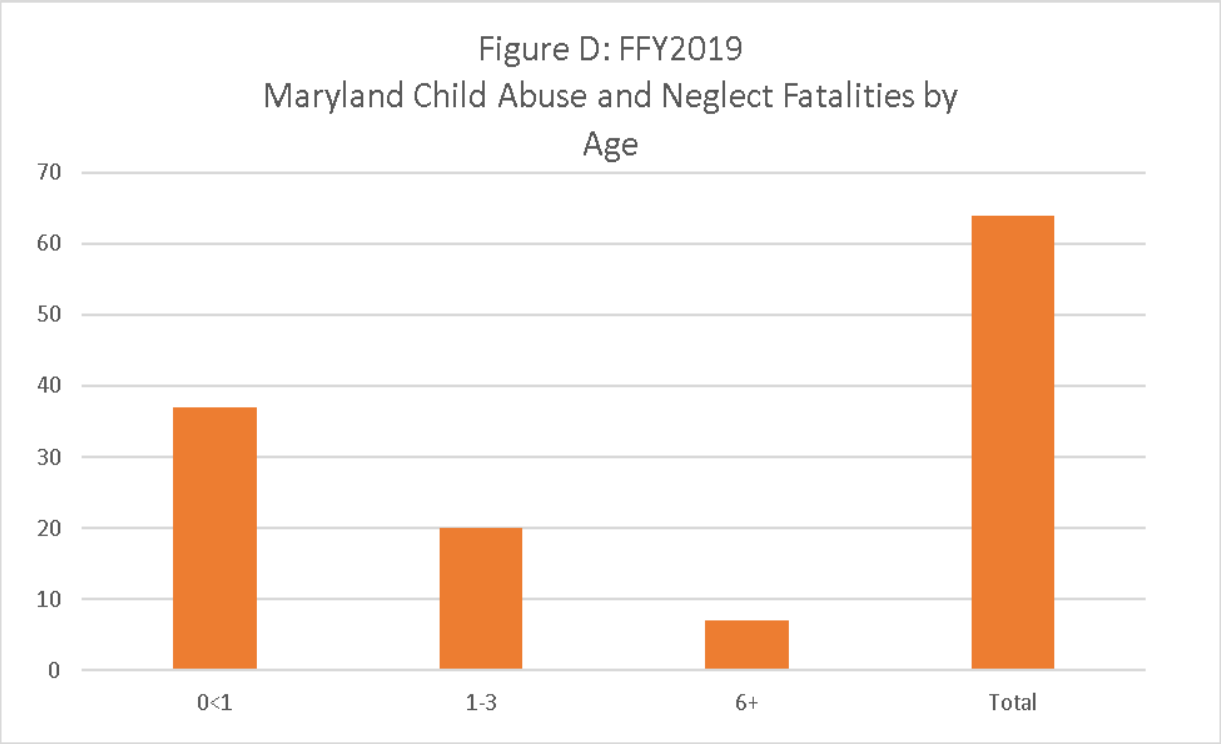


Age Group	Fatality Count	Hispanic Ethnicity	Asian	Black/African American	Other	White
0<1	37	3	1	20	1	15
1-3	20	3	1	9	0	10
6+	7	1	0	5	1	1
Total	64	7	2	34	2	26

As with maltreatment investigations, there is an over-representation of Black children in child maltreatment fatalities, and an under-representation of Hispanic children. The percentage of white child maltreatment fatalities closely reflects their percentage of Maryland children.

COLLECTING ACE DATA in MARYLAND:

Background: <u>The Adverse Childhood Experiences Study</u>

The ACE Study examines the social, behavioral and health consequences of adverse childhood experiences throughout the lifespan. ACE Study participants (17,337) were members of Kaiser Permanente Medical Care Program in San Diego, California and reflected a cross-section of middle-class American adults. The study is an ongoing collaboration between Kaiser Permanente and the Centers for Disease Control and Prevention (CDC) that began with two-waves of participants beginning in 1995 and 1997. Participants were asked questions regarding ten adverse childhood experiences which included all forms of child maltreatment and five indicators of family dysfunction: substance abuse, parental separation/divorce, mental illness, domestic violence, and/or criminal behavior within the household. Key findings of the ACEs Study can be found in prior SCCAN annual reports and at the CDC ACEs website.

Collecting ACE Data through the Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance System (YRBSS)

BRFSS and the ACEs Module

The Behavioral Risk Factor Surveillance System (BRFSS) is a CDC supported, state-administered random-digit-dial (landline and cell phone) survey conducted in all 50 states, the District of Columbia, and three U.S. territories, that collects data from non-institutionalized adults regarding health conditions and risk factors. The purpose of the BRFSS is to assess the population prevalence of chronic health conditions, risk factors, and the use of preventative services.

Since 2009, states have been collecting ACEs data through their BRFSS. In 2013, SCCAN and MD EFC recommended adding the ACEs module to Maryland's BRFSS and successfully advocated in 2014 for inclusion of the module in the 2015 BRFSS. SCCAN and MD EFC recommended inclusion of the ACE module in the BRFSS every three years and the module was repeated in 2018 and 2020 (See 2019 SCCAN Annual Report for 2018 BRFSS ACE data). The BRFSS ACE module collects data on eight of the original ten ACEs, excluding physical and emotional neglect from the questionnaire.

PREVALENCE OF ACEs IN MARYLAND YOUTH:

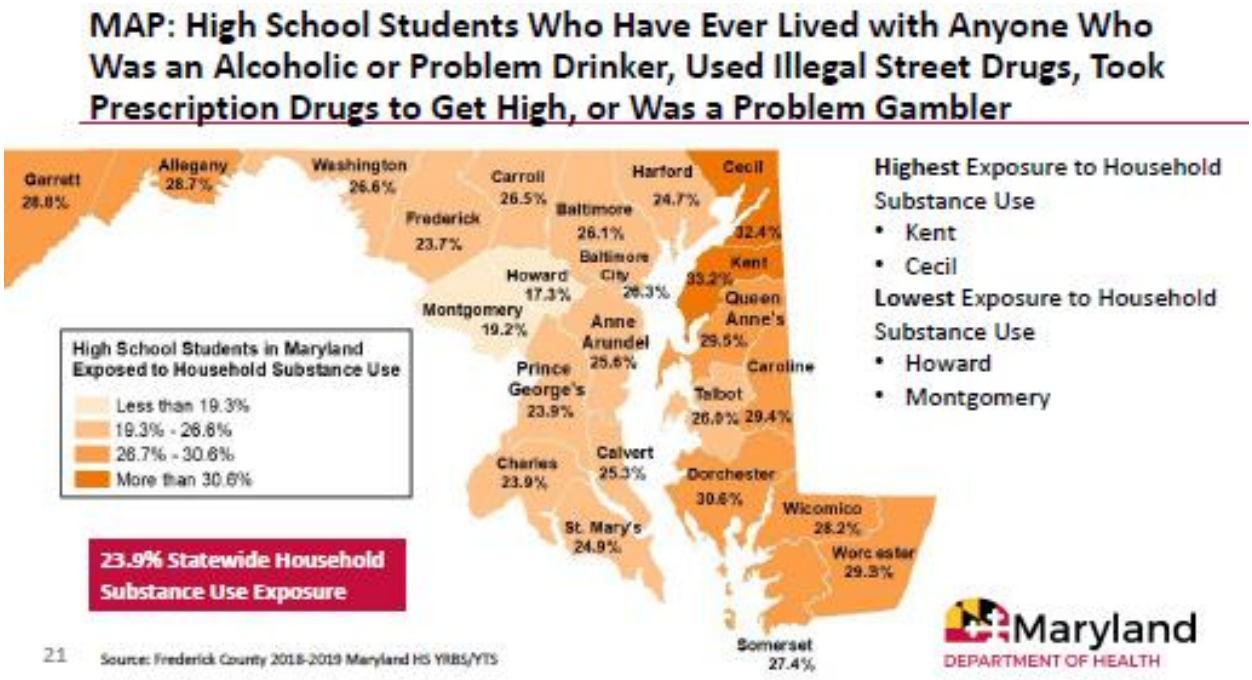
41,891 Maryland high school students from 184 high schools participated in the 2018 Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS). There was an 80% overall high school response rate. Four ACE questions were asked in the survey: emotional abuse, household substance abuse, household mental illness, and household incarceration. Children who have experienced any of the four ACEs measured by the Maryland YRBS/YTS are more likely to have other ACEs, as well.[18] To get a clear

[18] Bethell, C., et.al., *Methods to Assess Adverse Childhood Experiences of Children and Families: Toward Approaches to Promote Child Well-being in Policy and Practice,* Academic Pediatrics Journal, (2017).

picture of the adversity experienced by Maryland youth, it is important that the full panoply of the CDCs ACE module questionnaire be included in Maryland's YRBSS. The CDC ACE module includes 8 of the original ACE questions, 2 incidence ACE questions, 3 community ACEs, and 3 positive childhood experiences (PCE) questions. (See Appendix I)

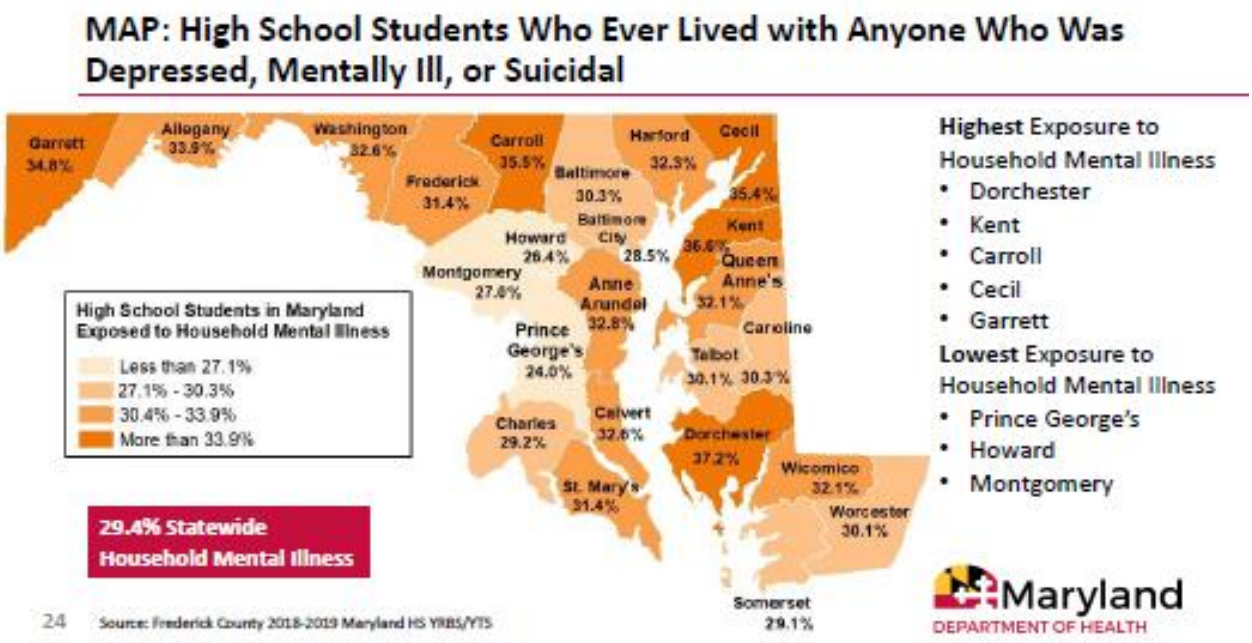
The YRBS/YTS is administered only during even years and there is no new data available at this time. However, analysis of the 2018 YRBS data has continued over the past year. In particular, jurisdiction-level data has been analyzed by Nikardi Jallah, MPH from the MDH Center for Tobacco Prevention and Control and released to stakeholders.

Household Member with Substance Use or Gambling Disorder by Jurisdiction:



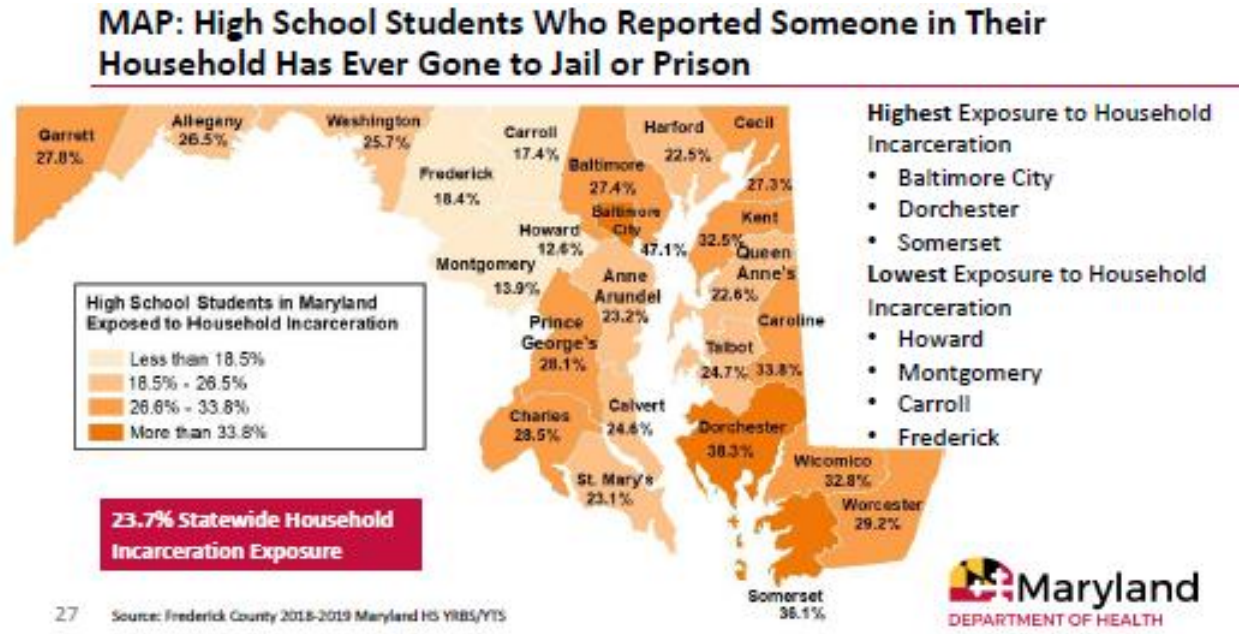
Substance use is common among caregivers in all Maryland jurisdictions, with about 24% of teens exposed to household substance use. Rates are highest in Kent and Cecil Counties, and lowest in Howard and Montgomery Counties.

Household Members with Depression, Mental Illness, or Suicidality



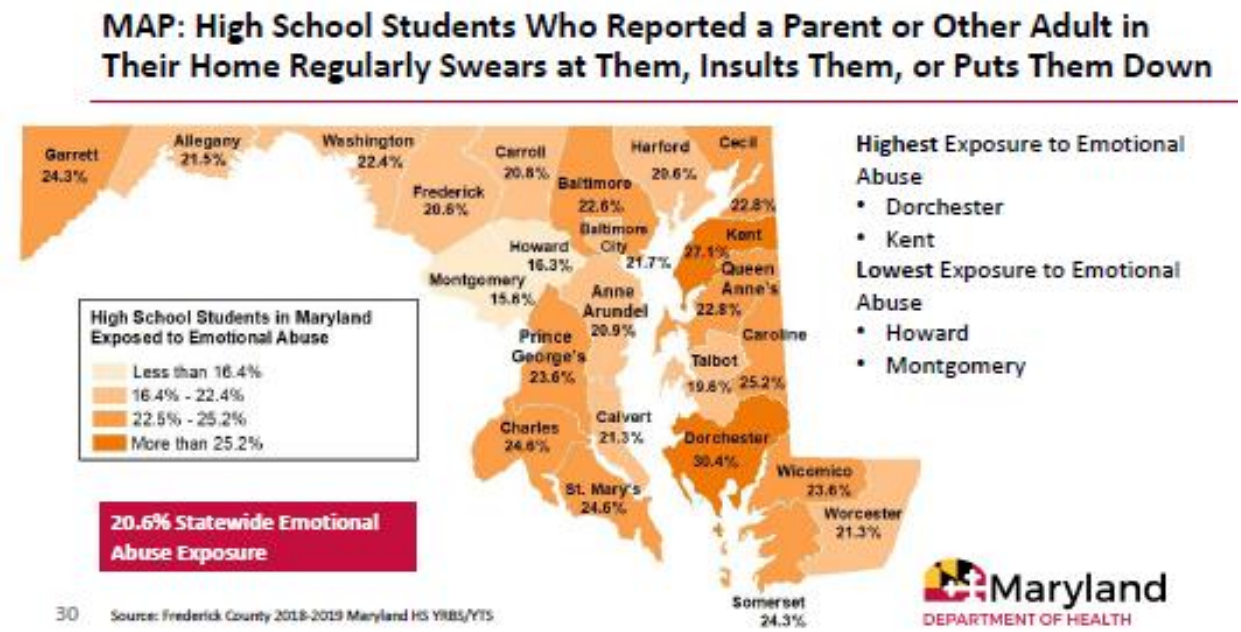
Mental illness is common among caregivers and household members in all Maryland Jurisdictions, with 29% of Maryland teens living with someone diagnosed with a mental illness. The highest rates of household mental illness were seen in Dorchester, Kent, Carroll, Cecil, and Garrett Counties. The lowest rates of household mental illness were seen in Prince George's, Howard, and Montgomery Counties.

Household Members Who Have Gone to Jail or Prison



Nearly 25% of Maryland teens have a caregiver or household member who has gone to jail or prison. Rates of household incarceration are highest in Baltimore City, Dorchester County, and Somerset County. Rates of household incarceration are lowest in Howard, Montgomery, Carroll, and Frederick counties.

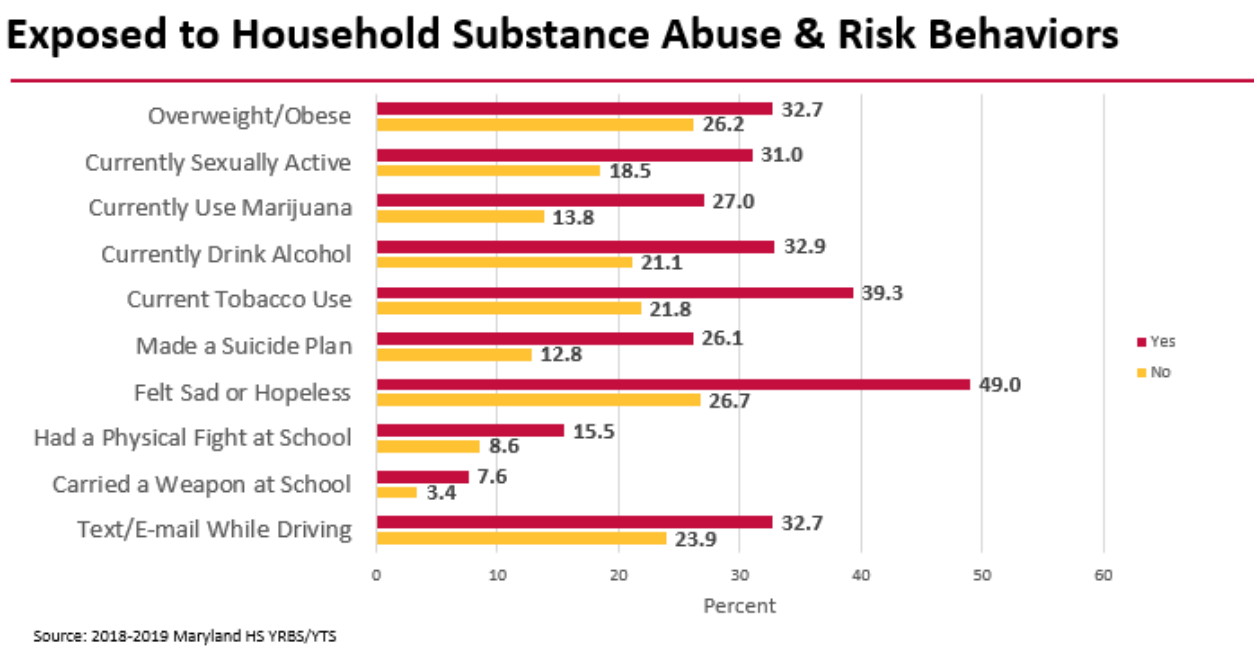
Emotional Abuse in the Home



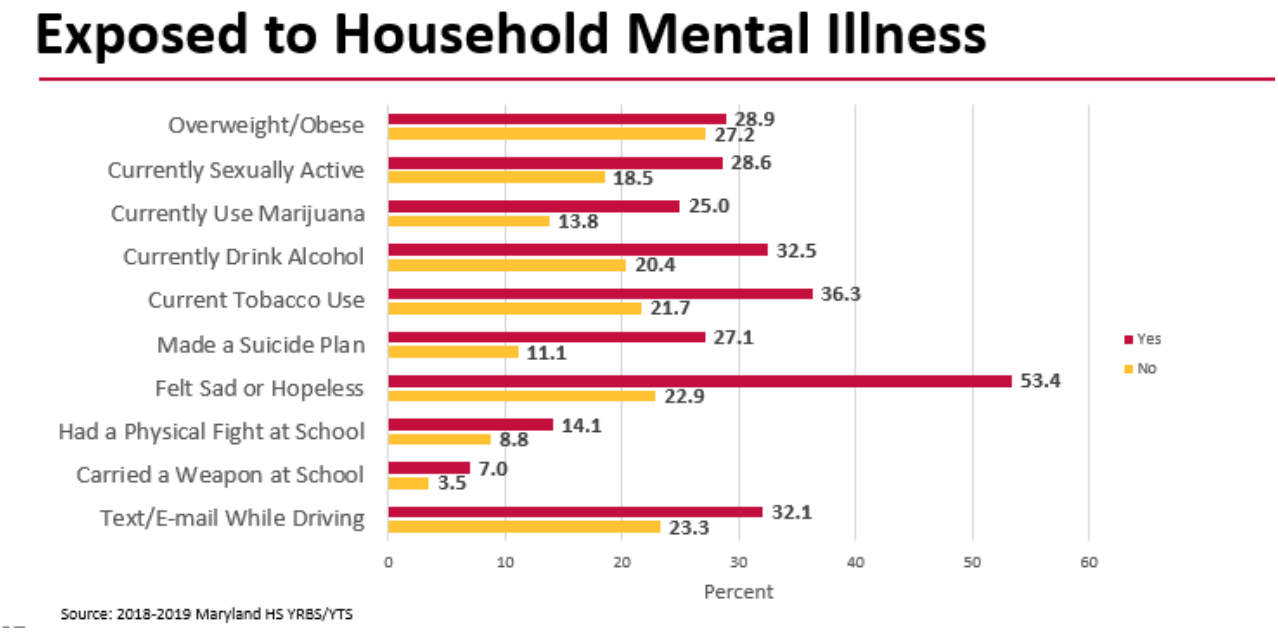
Approximately one in five Maryland teens reports regular emotional abuse by adults in their household. This is important because emotional abuse can have more deleterious effects on teen's mental health than even physical abuse.[19] The highest rates of exposure to emotional abuse were seen in Dorchester and Kent Counties. The lowest rates were seen in Howard and Montgomery Counties.

[19] Miller-Perrin, et al. Child Abuse & Neglect, 2009

ACEs and Adolescent Risk Behaviors:

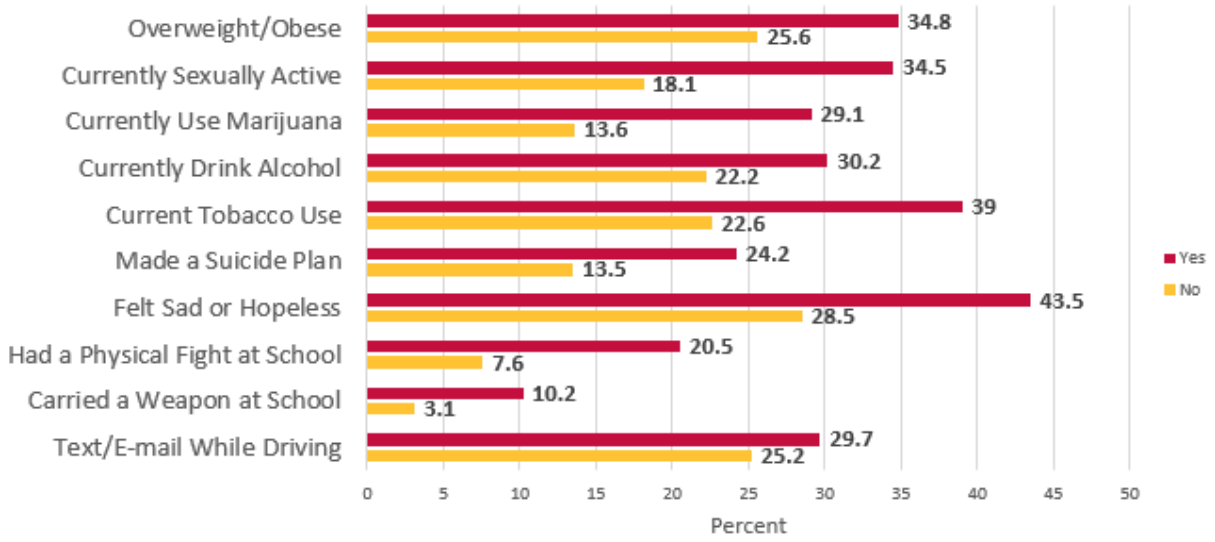


Teens exposed to household substance abuse have higher rates of obesity, risky behavior, and mental health issues compared to those not exposed to household substance abuse.



Teens exposed to household mental illness have higher rates of risky behavior than those not exposed. More than half of teens living with someone with mental illness reported symptoms of depression, and more than one quarter had made a suicide plan.

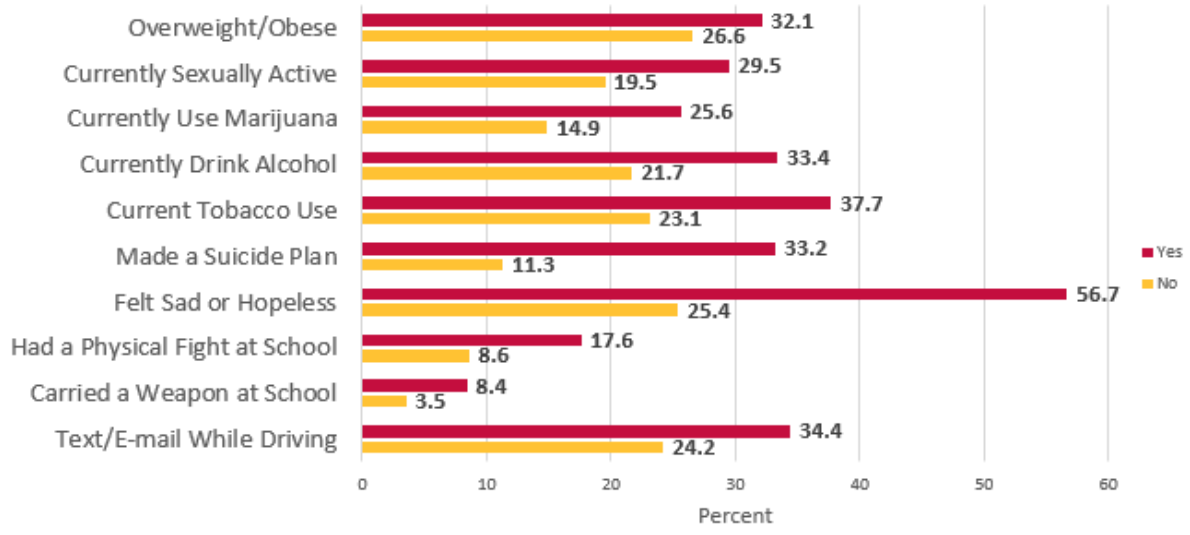
Exposed to Household Incarceration



Source: 2018-2019 Maryland HS YRBS/YTS

When compared to unexposed teens, those exposed to household incarceration had higher rates of overweight/obesity, risky behavior, and depressive symptoms. Almost half of teens exposed to household incarceration reported symptoms of depression and nearly one quarter had made a suicide plan. Nearly 40% reported smoking cigarettes, and approximately 30% reported current marijuana or alcohol use.

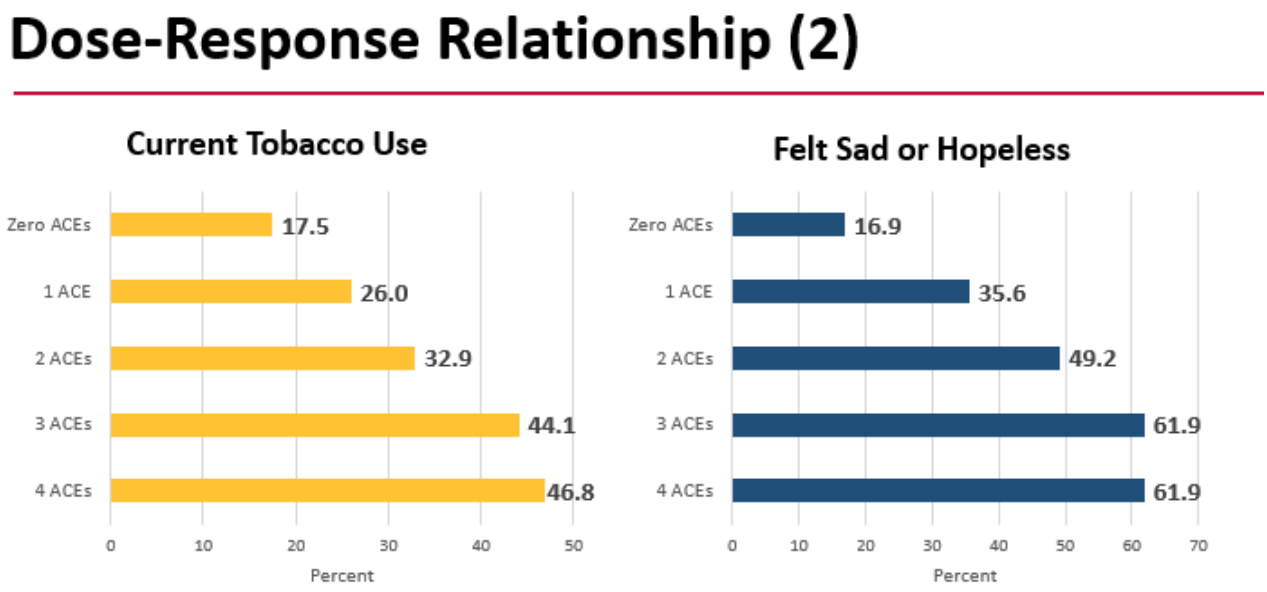
Exposed to Emotional Abuse

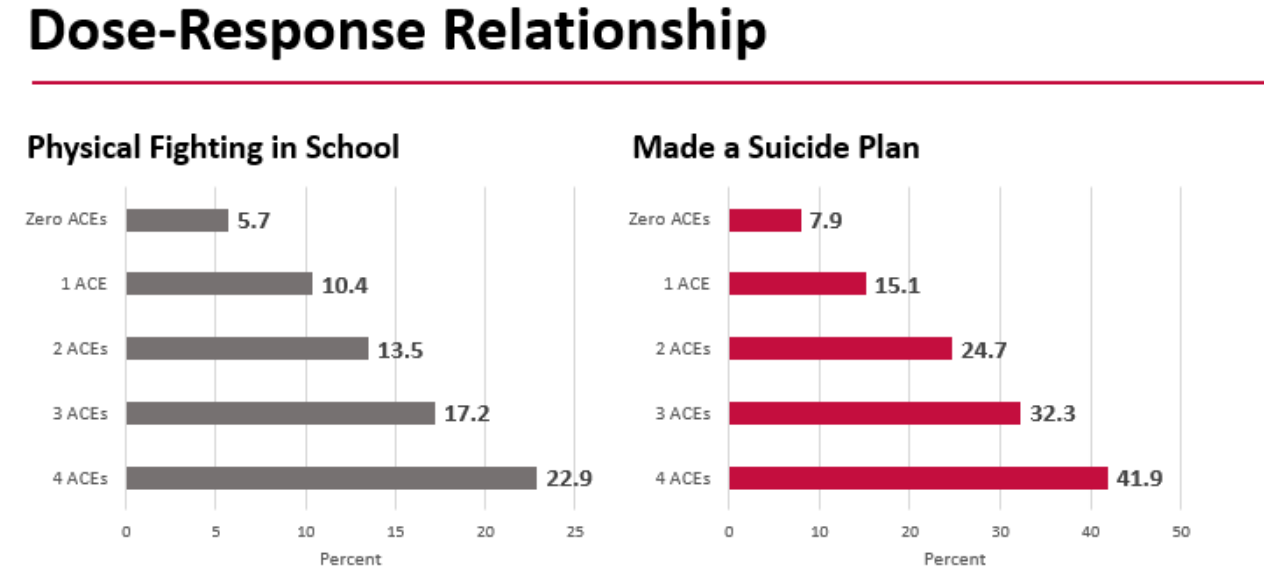


Source: 2018-2019 Maryland HS YRBS/YTS

Findings for emotional abuse are similar to those for other ACEs. However, rates of depressive symptoms (57%) and suicidal ideation (33%) among teens exposed to emotional abuse were higher than those of teens exposed to any of the other ACEs included in the YRBS.

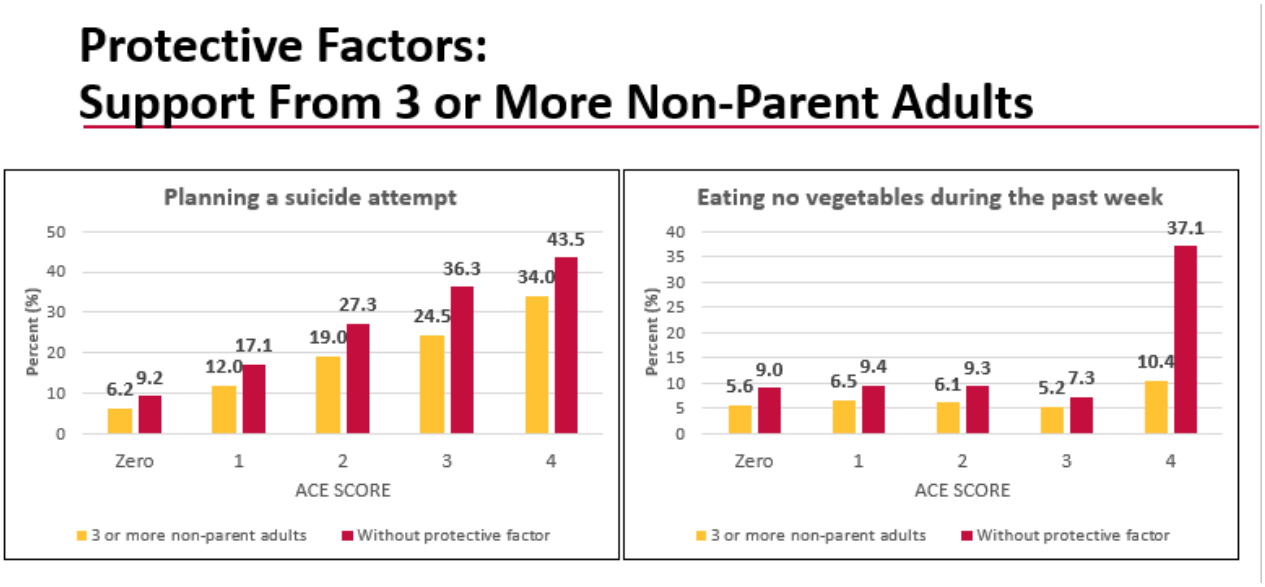
Dose Response Relationship ACEs and Risk Behaviors:





YRBS data show a dose response relationship between the number of ACEs Maryland teens experience and their likelihood of tobacco use. Likewise, as ACEs increase, the likelihood of symptoms of depression and suicidal ideation also increase. Dose response relationships can also be seen between ACE exposure and fighting at school.

Protective Factors: Support from 3 or More Non-Parent Adults



Having the support of multiple non-parental adults appears to have a buffering effect. While there is a dose response relationship between ACE score and suicidal ideation, adult support reduces that risk across every ACE level. Similarly, the presence of supportive adults appears to have a positive effect on healthy eating, most substantially among teens exposed to four or more ACEs. These findings suggest that providing additional social support to at-risk teens could reduce risky behavior and improve both their mental and physical health.

Conclusions:

What we know so far is that ACEs are common in Maryland, no jurisdiction is spared, and ACEs may have pervasive effects on health behaviors and outcomes. Dissemination of this data and implementation of prevention and intervention strategies based on brain science, ACEs, trauma-informed care, and resilience are critical not only to current child well-being, but health and well-being throughout the lifespan. Unfortunately, childhood trauma is something that we have been reticent to discuss until now. As Jack Shonkoff, Director of the Harvard Center on the Developing Child, so aptly put it: "A defeatist attitude is completely disconnected from what 21st Century science is telling us, and we should be going after that like a bear." Poor health outcomes/behaviors can be prevented – understanding the relationships between ACEs and health outcomes is one of the first steps in understanding points of intervention/prevention.

Maryland Department of Health (MDH), Division of Health Promotion Administration should conduct a more in-depth analysis of Maryland's ACE data. At a minimum, a complete examination of the association between ACEs and health outcomes should be undertaken. Ideally, expanded analysis of ACE data should be completed. This should include:

- Adjustment for age, race/ethnicity, income status
- Analysis of chronic disease prevalence by type of ACE (e.g. Household mental illness, Physical abuse)

- Summary of regional or county-level prevalence rates, to the extent possible given the small sample sizes for some counties.
- Production of a large report or series of data briefs/fact sheets
- The IBIS data portal for BRFSS data should be modified so that users can examine associations between ACEs and health outcomes themselves. The current configuration of the data only allows for examination of the likelihood of having a specific number of ACEs given the presence of a health outcome, rather than the likelihood of having a health outcome given the presence of ACEs.
- The YRBS ACE questions should be expanded to include all 10 ACEs. Legislation that passed in the 2021 legislative session will require ongoing inclusion of ACE questions in the YRBS but will require only 5 questions. We recommend that ACE questions be alternated by YRBS year so that all 10 ACE questions are included during each 4-year interval. Data on protective factors should be examined for each Maryland jurisdiction.

SCCAN'S ACTIONS & ACCOMPLISHMENTS 2020-20211

Maryland Essentials for Childhood Initiative:

Since 2006, SCCAN has focused its efforts and recommendations on preventing child abuse and neglect *before it occurs* and promoting public and systems awareness of Adverse Childhood Experiences (ACEs) science to inform policy and practice changes in Maryland systems in order to improve the lives of our children. In 2012 SCCAN adopted the goals of *the Center for Disease Control and Prevention's state level implementation of Essentials for Childhood* as a framework for its efforts and recommendations, working side-by-side with its partners, to create a statewide collective impact initiative—Maryland Essentials for Childhood (MD EFC) —with the mission of preventing and mitigating child maltreatment and other ACEs. SCCAN and MD EFC continue to choose specific priorities and develop recommendations that advance the following overarching strategic goals:

1. Educate key state leaders, stakeholders, and grassroots on brain science, ACEs, and resilience; in order to build a commitment to put science into action to reduce ACEs and create safe, stable, and nurturing relationships and environments for all Maryland children.
2. Identify and use Data to inform actions and recommendations for systems improvement
3. Integrate the Science into and across Systems, Services & Programs
4. Integrate the Science into Policy and Financing Solutions

Maryland Essentials for Childhood Initiative works statewide toward achieving the four strategic goals above with the purpose of creating the safe, stable, and nurturing relationships and environments that support the healthy development of all Maryland children, i.e., becoming a trauma-informed and resilient state. Additionally, in response to pressing global events of 2020 and 2021, SCCAN and MD EFC began to examine the impact of the COVID-19 pandemic and systemic racism on Maryland's children. As the pandemic and racial inequity are significant adversities in the lives of Maryland's children, SCCAN and MD EFC members formed two working groups to develop potential solutions to mitigate short and long-term harms of the pandemic and systemic racism within the child welfare system. Below is a brief description of key actions by SCCAN and MD EFC Partners to achieve our collective goals.

Key Successes of SCCAN & MD EFC Partners2020-2021:

COVID-19 Childhood Resilience Action Team:

When the harsh realities of the global pandemic emerged in the spring of 2020, members of SCCAN and Maryland Essentials for Childhood recognized that the needs of children and families were about to change—and keep changing—in dramatic ways. Recruiting interested child and family serving professionals from across the state, SCCAN and Maryland Essentials for Childhood organized an effort, known as the COVID-19 Childhood Resilience Action Team, to research, identify, collect, and distribute emerging resources that could inform and support the resilience of children so significantly impacted by COVID-19 and beyond.

The Team's effort to locate and organize resources to benefit Maryland's children and their caregivers developed in two phases. In the first phase, more than 70 volunteers from scores of organizations (See Appendix D) formed groups that worked collaboratively to identify relevant issues, research and vet viable

solutions and supports and plan for sharing of the collected materials. These dedicated volunteers have now assembled a resource library encompassing 17 categories and hundreds of individual items to help children and families navigate both the seen and unforeseen effects of the pandemic. Resources for children, caregivers, and service providers are included and encompass health, mental health, behavioral health, education, childcare and economic supports.

The Childhood Resilience Action Team is now in Phase 2 and focused on creating a website domain containing the resource library and informing the public of the availability of the resources. The Behavioral Health Administration will provide grant funding to develop the childhood resilience website, ACEs training and data to support the Governor's Executive Order and Trauma-Informed Care Commissions efforts to prevent and mitigate ACEs across the state.

The work of these committed volunteers to contribute hundreds of hours toward creating this new statewide resource library is truly salutary. While challenged by the demands and changes in their own professional work and organizations, these forward-looking volunteers responded to the emerging needs of children and families resulting from the pandemic and created a rich and diverse collection of resources that will provide benefits for years to come.

Achieving Racial Equity within Maryland's Child Welfare System Workgroup:

The Achieving Racial Equity Workgroup began meeting in October 2020. Initially the group educated itself and fellow SCCAN and MD EFC members through expert presentations by Dr. Adrianne M. Fletcher, PhD of Case Western Reserve University and Alexandra Citrin, MSW, MPP and Maya Pendleton, MPP of the Center for the Study of Social Policy; and, creating an extensive resource list for members continued learning. They developed an Anti-Racist Statement, adopted by the Council in May 2020, and supported legislation requiring the Maryland Department of Human Services and Maryland Department of Education to provide disaggregated data by race, gender, age, and geographic region on outcomes for children and youth in Maryland's Child Welfare System.

Since the beginning of the child welfare system, disparity in treatment and services offered to African American children has existed. In fact, prior to 1865, slavery was the primary welfare institution for African Americans.[20] African Americans were not alone in tracing the history of the U.S child welfare system and the racist, discriminatory and disparate practices that have been used with children of color from the creation of the system, to current times. Native American and Indigenous people have also been victims of biased practices and discriminatory procedures within the child welfare system.[21]

After slavery was abolished, many White children were sent to orphanages, almshouses or sent west on "Orphan Trains" to live with foster families through indentured servitude. African Americans were largely excluded from that type of assistance with the exception being the Society of Friends (an abolishment group

[20] Dettlaff, A. J., Weber, K., Pendleton, M., Boyd, R., Bettencourt, B., & Burton, L. (2020). It is not a broken system, it is a system that needs to be broken: The upEND movement to abolish the child welfare system. *Journal of Public Child Welfare*, *14*(5), 500-517. Barth, R. P., Jonson-Reid, M., Greeson, J. K., Drake, B., Berrick, J. D., Garcia, A. R., ... & Gyourko, J. R. (2020). Outcomes following child welfare services: what are they and do they differ for black children?. *Journal of Public Child Welfare*, *14*(5), 477-499.

[21] Bird, S. E. (2018). Introduction: Constructing the Indian, 1830s–1990s. In *Dressing in feathers* (pp. 1-12). Routledge. Berkhofer, R. F. (1979). *The white man's Indian: Images of the American Indian, from Columbus to the present* (Vol. 794). Vintage.

in Philadelphia, PA).[22] The under-funded and short-lived Freedman Bureau provided direct relief for many African American children and their respective families. More often than not, most of the support services provided (i.e. day care, orphanages) to African American children were through self-help efforts offered through schools, churches, and other social organizations[23]. It was not until 1910, with the founding of the National Urban League, that large-scale efforts began to advocate for equitable distribution of child welfare services.

By 1935, mothers' pension laws had been adopted in 46 states. Similarly, the Social Security Act established Title IV-A, which was Aid to Dependent Children (ADC). However, many states instituted "home suitability clauses"[24], "illegitimate child clauses" and "substitute father in the house clauses". These clauses were established to weed out "immoral" homes and often excluded African American from receiving any public welfare benefits. Consequently, states like Mississippi, Florida and Louisiana were notorious for removing African American children from their families because their families were, in their opinion, too poor to take care of children.[25]

During the 1960's there was a major shift in America's conceptualization of the poor. The growing use of contraception and liberalized abortion laws increased social acceptability of many unwed, single parent households. The reduction of White children eligible for adoption led many private agencies to focus on African American children. African American children began to be over-represented in the child welfare system.[26]

Maryland only began disaggregating child welfare data by race beginning in 2015. The data shows black children and families continue to be disproportionately overrepresented year after year in Maryland. In addition to overrepresentation, Black children also experience disparate outcomes. In Maryland, Black Youth are overrepresented in out of home foster care placements and are also more likely to exit care without achieving permanency compared to their white counterparts. Of all youth emancipated (not being adopted, reunified, or placed in guardianship) Black youth comprise the overwhelming majority.

With this information, in the Fall of 2020, SCCAN dedicated time, attention and resources to address racial inequities and disparate outcomes within Maryland's child welfare system. Below are SCCAN's accomplishments and recommendations to date.

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[22] Dettlaff, A. J., & Boyd, R. (2020). Racial disproportionality and disparities in the child welfare system: Why do they exist, and what can be done to address them?. *The ANNALS of the American Academy of Political and Social Science*, *692*(1), 253-274. Cénat, J. M., Noorishad, P. G., Czechowski, K., Mukunzi, J. N., Hajizadeh, S., McIntee, S. E., & Dalexis, R. D. (2021). The Seven Reasons Why Black Children Are Overrepresented in the Child Welfare System in Ontario (Canada): A Qualitative Study from the Perspectives of Caseworkers and Community Facilitators. *Child and Adolescent Social Work Journal*, 1-16.

[23] Burslem, R. R. (2021). TRANSFORMING OUTCOMES TO INCREASE PARTICIPATION IN THE INDEPENDENT LIVING PROGRAM SPONSORED BY SUNRISE CHILDREN'S SERVICES. Bremner, R. H. (1983). Other people's children. *Journal of Social History*, *16*(3), 83-103.

[24] Fong, K. (2020). Getting eyes in the home: Child protective services investigations and state surveillance of family life. *American Sociological Review*, *85*(4), 610-638. Piven, F. F., & Cloward, R. (2012). *Regulating the poor: The functions of public welfare*. Vintage.

[25] Lawrence-Webb, C. (2018). African American children in the modern child welfare system: A legacy of the Flemming Rule. *Serving African American Children*, 9-30. Simon, R. J. (1984). Adoption of black children by white parents in the USA. *Adoption: Essays in Social Policy, Law, and Sociology. New York/London, Tavistock Publications*.

[26] Hamilton, E., Samek, D. R., Keyes, M., McGue, M. K., & Iacono, W. G. (2015). Identity development in a transracial environment: Racial/ethnic minority adoptees in Minnesota. *Adoption quarterly*, *18*(3), 217-233.

Accomplishments

To address racial disparities and disparate outcomes for youth and families involved in Maryland's Child Welfare System, SCCAN created an "Achieving Racial Equity in Child Welfare" Workgroup within SCCAN to develop recommendations to address current racial inequities and disparate outcomes for youth and families of color within the child welfare system. The Workgroup:

- Developed an Anti-Racism statement which was adopted by SCCAN. (See Appendix J)
- Prioritized 2021 Child Welfare Data Bill, HB258/SB592 which requires the Maryland Department of Human Services and Maryland Department of Education to provide disaggregated data by race, gender, age, and geographic region on outcomes for children and youth in in Maryland's Child Welfare System. The bill passed both the House and Senate unanimously.
- Began educating SCCAN and MD EFC members on historical systemic racism within the child welfare system and other child and family serving systems through presentations by expert speakers, including Dr. Adrianne M. Fletcher, PhD of Case Western Reserve University and Alexandra Citrin, MSW, MPP and Maya Pendleton, MPP of the Center for the Study of Social Policy.
- Built a list of resources to achieve racial equity, address white privilege, and reduce disparate outcomes within child and family serving systems. Resources will be added continually to the list and shared with SCCAN and MD EFC members and partners. (See Appendix K)

Recommendations

- Maryland Department of Human Services
    - Require caseworkers to input race demographic data on all cases brought to the attention of the Department of Human Services. Recent data received from the Department of Human Services indicates that of all new child abuse and neglect cases in fiscal year 2020, nearly a quarter did not include the race of the child.
    - Collect and make publicly available disaggregated data (race, gender, age, and geographic region) on the following indicators:
        - The number of referrals and the number of screened-in and screened out referrals
        - The stability of early care and education as measured by number of child care provider placements
        - The number and percentage of children 0-5 in a quality childcare program as defined by Maryland Excels
        - The number and percentage of children 0-5 in informal childcare
        - The number and percentage of children with CPS involvement referred to Infants and Toddlers
        - The number and percentage of children and youth receiving all Early Periodic Screening Diagnosis and Treatment visits recommended by Maryland Healthy Kids.
        - Data collected by child welfare medical director as defined in MD Human Services Code Section 8-1101 (2018)
    - The 2020 Department of Human Services, Child Welfare Indicators Report, indicates that 38% of children reported for suspected child abuse and neglect were Black Youth although Black Youth only make up 33% of the child population in MD. We recommend that:
        - DHS disaggregate referral (both screened in and screened out) data further by abuse type; specifically, when a youth is referred to the Department as a result of

neglect this information should be disaggregated by risk factor (food insecurity, housing status, poverty, etc.).

        - DHS collect referral source data and disaggregate referral data by the source type. (i.e. School, medical professionals, neighbors, family/friends, etc.)
    - According to DHS, 60% of referrals received are screened out. We recommend that:
        - DHS disaggregate all referrals data, screened in and screened out, by race, age, gender, and geographic region.
    - Require all DHS employees, and DSS supervisors and caseworkers receive annual racial equity training.
- Maryland Department of Education
    - Collect and make publicly available disaggregated data (race, gender, age, and geographic region) on the following indicators:
        - The number and percentage of all Maryland children with a current individualized education plan
        - The number and percentage of children in out-of-home placement with a history of individualized education plans.
        - The number and percentage of children in out-of-home placement with a current individualized education plan.
        - The number and percentage of children in out-of-home placement with an individualized family services plan.
        - Rate of college and postsecondary application, acceptance, and attendance amongst youth in out-of-home placement.
- Maryland General Assembly
    - Amend current statute to expand data currently collected by Maryland's Department of Human Services within their Child Welfare Indicators Report. Additional indicators include:
        - The number of referrals and the number of screened-in and screened out referrals
        - The number of referrals (both screened in and screened out) by referral source (i.e., school, medical professionals, neighbors, family/friends, etc.)
        - The number of referrals (both screened in and screened out) by abuse type; and, more specifically, when a child or youth is referred to the Department as a result of neglect this information should be disaggregated by risk factor (food insecurity, housing status, poverty, etc.).
        - The stability of early care and education as measured by number of child care provider placements
        - The number and percentage of children 0-5 in a quality childcare program as defined by Maryland Excels
        - The number and percentage of children 0-5 in informal childcare
        - The number and percentage of children with CPS involvement referred to Infants and Toddlers
        - The number and percentage of children and youth receiving all Early Periodic Screening Diagnosis and Treatment visits recommended by Maryland Healthy Kids.
        - Data collected by child welfare medical director as defined in MD Human Services Code Section 8-1101 (2018)
        - Disaggregate all indicators by race, age, gender, and geographic region.
    - Amend current statute to expand the data collected by the Maryland State Department of Education. Additional indicators include:

        - The number and percentage of all Maryland children with a current individualized education plan
        - The number and percentage of children in out-of-home placement with a history of individualized education plans.
        - The number and percentage of children in out-of-home placement with a current individualized education plan.
        - The number and percentage of children in out-of-home placement with an individualized family services plan.
        - Rate of college and postsecondary application, acceptance, and attendance amongst youth in out-of-home placement.
        - Disaggregate all indicators by race, age, gender, and geographic region.
    - Pass legislation to require all mandated reporters in the state of Maryland to receive racial bias training focused on the role of bias and racism in child abuse and neglect reporting.
    - Pass legislation to require all DHS employees and local DSS supervisors and caseworkers in the state of Maryland to receive racial bias training focused on the role of bias and racism in decision-making throughout the continuum of child welfare cases.

Maryland Essentials for Childhood Initiative:

GOAL 1: Raising awareness of N.E.A.R. Science and building a commitment to put the science into action to create the safe, stable, nurturing relationships and environments that reduce and mitigate ACEs and build resilience:

- With the tremendous leadership, staffing, and financial support of The Family Tree and the generous dedication of thousands of hours by our ACE Interface Master Trainers and Presenters, we have increased the breadth and reach of the ACE Interface Project[27]. Knowledge of the N.E.A.R. Science was strategically disseminated throughout Maryland public and private agencies and communities:
    - The Family Tree, supported by ACE Interface Master Trainers, trained an additional 42 Master Presenters through a specialized training to MSDE and local education agencies.
    - Through the generous support of The Family Tree, Dr. Robert Anda and Laura Porter trained an additional 30 Master Trainers in November 2021. The Project has added Master Trainers to the following sectors, agencies, and communities:
        - Psychiatric Rehabilitation
        - Supported Employment
        - Media Arts Education
        - Home Visiting
        - Frederick County Office of Children & Families
        - Springboard Community Services
        - Citizens Review Board for Children
        - St. Mary's Health Department
        - Maryland Community Action Partnership
        - University of Maryland Extension
        - Maryland CASA Association
        - Maryland Department of Human Services

*[27] For more on the ACE Interface Project, see the 2018 and 2019 SCCAN Annual Reports.

- Thriving Communities Collaborative
- Mental Health Association of Frederick County
- Adoptions Together
- University of Maryland, Baltimore County, Choice Program
- Howard County Government
- Morgan State University
- Howard County Office of Children & Families
- Maryland Child Care Providers and Technical Assistance Communities
- Human Services Consultation
- Community Youth Organization, Racial and Social Justice
- Roberta's House
- Worcester County Board of Education
- Boys & Girls Clubs of Metro Baltimore
- Judy Centers
- Frederick County Safe Babies Court
- Zero to Three

▪ As of December 2020, the ACE Interface Project has more than 200 Master Trainers and Presenters representing all 24 Maryland jurisdictions; and include two specialized cohorts:
  - Opioid Epidemic – MDH's Regrounding Our Response[28] to the Opioid Crisis- a multi-disciplinary approach to understanding the overdose epidemic. (32 Master Presenters statewide)
  - Education- MSDE and local education agency personnel. (57 Master Presenters statewide)

▪ From January 2020 to November 2021, volunteer ACE Interface Master Trainers and Presenters gave a total of 145 ACE Interface presentations (See Appendix F for list of key presentations) to over 17,609 attendees across all 24 jurisdictions (See Appendix L for presentations by jurisdiction).

▪ Since its inception in December 2017 through November 2021, volunteer ACE Interface Master Trainers and Presenters have given 390 ACE Interface presentations (See Appendix M for list of key presentations) to over 24,883 attendees across all 24 jurisdictions.

- Continued to develop and expand Maryland ACEs Action blog page on PACEs Connection[29]:
  - Increased membership five-fold to 1104 members, making Maryland ACEs Connection Community the 9th largest of 362 Communities on ACEs Connection and the 3rd largest statewide community after California, and North Carolina.
  - Provided a statewide mapping of ACE Interface trainings on the Maryland ACEs Action Community Tracker and a link to Maryland BRFSS ACE data by county on PACEs Connection.

[28] For more on the Regrounding Our Response Initiative, see the 2019 SCCAN Annual Report.
[29] Developed Maryland ACEs Action blog page on PACEs Connection. ACEs Connection is "the most active, influential ACEs community in the world." Its goal is to help community members and professionals stay current with news, research, and events regarding ACEs and trauma-informed/resilience-building practices. Maryland ACEs Action blog page is for anyone who wishes to share information about and promote ACEs research awareness, trauma-informed/resilience-building practices, and to influence positive social change in Maryland. Both ACEs Connection and Maryland ACEs Action are free and open to anyone who wishes to join this virtual community.

- GOAL 2: Identify and use data to inform actions and recommendations for systems improvement.
    - Successfully advocated for unanimous passage of the 2021 Child Welfare Data Bill, HB258/SB592 which requires the Maryland Department of Human Services and Maryland Department of Education to provide disaggregated data by race, gender, age, and geographic region on outcomes for children and youth in in Maryland's Child Welfare System
    - Worked closely with the Behavioral Health Administration (BHA) at MDH on Maryland's application to the CDC's ACEs Prevention and Data to Action Grant (PACE-D2A). Unfortunately, Maryland was not awarded one of the six grants nationwide (CT, GA, MA, MI, MN & NJ). However, the work and partnerships created in developing the grant have served as the foundation for the cross-agency ACEs Data Workgroup being led by BHA. SCCAN and MD EFC have shared key resources from the technical assistance they received from the CDC's Essentials for Childhood Initiative which have been incorporated into work of Maryland's ACEs Data Workgroup.
    - Supported HB771/SB548 Public Schools - Centers for Disease Control and Prevention Surveys – Revisions requiring that all sixteen of the CDC's Adverse Childhood Experiences and Positive Childhood Experiences questions be included in the YRBS/YTS for high school and middle school students. Legislation was passed to require "at least five questions" from the CDC's YRBS on ACEs or positive childhood experiences (PCEs).
    - Successfully advocated for the inclusion of 4 ACE questions that were included in the Fall 2018 and 2020 (deferred until 2021 due to pandemic) Youth Risk Behavior Study (YRBS) for Maryland high schoolers. Following upon the example of Monroe County, New York, Maryland and New Hampshire became the first two states to collect statewide ACE data through their YRBS.
    - Successfully advocated for BRFSS ACE data to be collected in 2015, 2018, and 2020.

- GOAL 3: **Integrate the N.E.A.R. Science into and across Systems, Services, and Programs.**
    - Successfully advocated for Maryland to join Delaware, Pennsylvania, Virginia, and Wyoming to participate in the National Governor's Association Center for Best Practices (NGA Center), Duke-Margolis Center for Health Policy, and the National Academy of State Health Policy's 2020-2021 *Addressing ACEs State Learning Collaborative*, an intensive, multi-state technical assistance project on statewide approaches to address ACEs across the lifespan. States with more advanced ACEs work (AL, CA, NJ, TN) served as models for participating states. The Behavioral Health Administration, the Governor's Office of Crime Prevention Youth and Victims Services (GOCPYVS), the Child Welfare Medical Director at DHS, SSA, the Opioid Operational Command Center at the Maryland Department of Emergency Management (MEMA), the Department of Juvenile Services (DJS) and SCCAN participated in the learning collaborative for Maryland. The work culminated in Governor Hogan's ***Executive Order on Adverse Childhood Experiences*** directing state agencies to coordinate efforts to reduce ACEs and consider how each agency's policies and programs could reduce ACEs and implement care models informed by ACEs. ***May 6th was declared ACEs Awareness Day*** to coincide with Mental Health Awareness Month.
    - Successfully advocated for the unanimous passage of HB548/SB299 – Trauma Informed Care- Commission and Training (Healing Maryland's Trauma Act) mirrored after the Elijah Cummings' Healing City Baltimore Act. The legislation creates an independent Commission that functions at DHS, is staffed by GOCPYVS, and to which MDH provides technical

advisory support. The Commission's purpose is to coordinate a statewide initiative to prioritize the trauma-responsive and trauma-informed delivery of state services that impact children, youth, families, and older adults. SCCAN's Executive Director and several MD EFC members, including multiple ACE Interface Project Master Trainers and Presenters, will serve as members of the Trauma-Informed Care Commission. The Commission is tasked to develop a statewide strategy toward an organizational culture shift into a trauma-responsive state; identify state programs and services that impact children, youth, families, and older adults; establish metrics (with MDH) to evaluate and assess progress of the initiative, develop and coordinate trauma-informed training (with MDH); disseminate information among agencies regarding best practices for preventing & mitigating the impact of trauma; study, develop, and implement a process and framework for an ACEs Aware Program in Maryland; make recommendations on improving existing laws related to children, youth, families, and older adults; and report to the Governor and General Assembly on metrics and agency progress on becoming trauma-responsive. Additionally, the legislation requires each agency head to designate two staff members to lead their trauma-responsive culture shift through training, and changes to policies, and practices.

- Recruited ACE Interface Master Presenters across professions, sectors, and communities to ensure a common language for the integration of N.E.A.R. science into the systems and networks that serve Maryland children and families. (See Appendix E)
- Multiple MD EFC Members and ACE Interface Trainers helped to found and now serve on the Board of Directors of the Infant Mental Health Association of Maryland and D.C., in order to promote infant mental health. The Association promotes healthy social, emotional, cognitive and physical development of infants from pre-conception through early childhood by creating safe, supportive, stable and nurturing relationships and environments.
    - Eighty-five percent of a person's brain development happens in the first three years of life. During this time if babies or young children experience traumatic stress, it can disrupt that brain development. However, one of the best buffers to the negative impact trauma can have is a strong attachment to at least one caretaker. If a young child has this strong attachment, despite experiencing traumatic stress, that strong healthy attachment can help ensure the child's brain development is not disrupted. For this reason, among others, support for parents with young children and for young children's behavioral health is especially important.

      One especially effective way to ensure that families with young children receive the services they need is to embed a social worker in the doctor's office where families go for their well visits. There are twelve (12) well baby visits in a baby's first two years. So, there are multiple opportunities to get to know these families and build a great deal of trust. That trust makes families more comfortable accepting and following through with referrals to other services.

      Maryland's Department of Health is working on the sustainability of programs with social workers embedded in pediatricians' offices, and we applaud those efforts. One way to make this affordable for a doctor's office is to allow that doctor to bill Medicaid for certain codes that aren't currently reimbursable. Effective prevention programs would benefit from allowing reimbursement for "Z codes" (which Oregon, Ohio, Philadelphia, and San Francisco Health Plan do). (See Appendix N)

      As set forth in the Maternal and Child Health priorities of the Health Services Costs

Review Commission, we urge MDH to:

- Open the code for preventive medicine counseling (99401);
- Attach reimbursement for z-code diagnoses; and
- Allow a Per Member Per Month[30] reimbursement for children being seen by medical practices that also have social workers meeting with families.

There are several Medicaid billing barriers that make it difficult for families with young children to receive the behavioral health services they need. First, in Maryland, a behavioral health provider needs to have a diagnosis for a patient on the first visit with that patient. It can be especially difficult with young children to have that diagnosis so early. In many other states, a clinician can have up to five visits with a patient before having a diagnosis. In Colorado, for example, reimbursement is permitted via H0002- Behavioral health screening.

- MDH should allow behavioral health providers to receive reimbursement for R69, R45, and R46 for up to five visits before requiring a specific behavioral health diagnosis.

For young children, a lot of the work the counselor needs to do to support the young child's behavioral health is with that child's caregiver. However, in Maryland, clinicians cannot bill for providing individual therapy and family therapy on the same day. Another barrier in Maryland is the inability to bill for evidence-based parenting support programs, like Chicago Parent Program, Mom Power, Circle of Security and others. Maryland rules should allow "multifamily group without patient present, billing groups via tele & reimbursement for H2027".[31]

- MDH should eliminate the exclusion that prevents behavioral health providers from billing for individual therapy with a child and family therapy for that child's family on the same day.
- Optumm should allow reimbursement for H2027 even when a child is not present.

Finally, the DC:0-5 diagnostic tool is much more well suited for diagnosing behavioral health issues in young children than the DSM V. However, Maryland Medicaid only allows diagnoses via the DSM V. Other states are integrating the DC:0-5 into their state behavioral health systems.[32]

- MDH should allow usage of the DC:0-5 in addition to the DSM V because it

[30] A Per Member Per Month reimburses allows a Managed Care Organization to receive a set monthly amount from Medicaid for the services they provide to that patient.

[31] Optumm (the behavioral health carve out Administrative Service Organization) denies these claims and says the patient (child) must be present. This is not an issue in other states. In Minnesota, they allow licensed mental health professionals or clinical trainees to receive reimbursement via H2027 HQHS – psychoeducation—the patient may or may not be there ($24.12 - $24.97 per 15 minutes with a single family or ($5.96 - $8.26 per 15 minutes for multiple families). Minnesota also allows reimbursement for Clinical Care Consultation via 90899 when a mental health professional or clinical trainee speaks to a patient's other professionals (child welfare, childcare provider, school staff, etc.). This can be in person or on the phone (rates vary by time (5 minutes to 30 plus minutes) and if on the phone or in person ($14.80-$79.82). Colorado allows reimbursement for care management with collaterals via T1017. Colorado also allows reimbursement via H0023- outreach attempts to keep family engaged or to re-engage family that is disengaged.

[32] **THERESE AHLERS, JULIE COHEN, CINDY OSER, AND AMANDA SZEKELY, *Advancing Infant and Early Childhood Mental Health: The Integration of DC:0-5™ Into State Policy and Systems*, July 31, 2018.**

is better suited for diagnosing behavioral health issues in young children.

- Partnered with the Maryland State Department of Education to increase the capacity of local education agencies (LEAs) to provide N.E.A.R. Science informed professional development for educators. Fifty-seven educators from LEAs have been trained as ACE Interface Master Presenters.
- Multiple SCCAN and MD EFC partners participate in the Frederick County Safe Babies Court Team (SBCT) Active Community Team monthly meetings, Maryland's first and only SBCT at this time. The SBCT approach improves outcomes for infants and toddlers involved in the child welfare system. The approach focuses on minimizing trauma and its impact on early development by improving how the courts, child welfare agencies, and related child-serving organizations work together to support young children and their families. There are SBCTs in local communities in 27 states. SCCAN recommends that DHS, MDH/BHA, and the Administrative Office of the Courts work together to expand SBCT across the state, as evaluations have identified improved outcomes in the following areas[33]:
  - ***Improved safety*** – children served by SBCT show a child maltreatment recurrence rate of .07% compared to national average recurrence rate of 9.1%
  - ***Faster time to permanency***- children served by SBCT exit foster care faster, 92.7% achieved permanency within 12 months, compared to 40.5% national permanency rate.
  - ***Preserved family relationships*** – 87.8% of children served by SBCT were reunified with either their parents or family members, compared to the national average of 66% of children who exited foster care to their parents, guardianship, or to live with relatives.
  - ***Placement stability*** - 94.2% of children served by SBCTs were in care for less than 12 months had no more than two placements, compared to the national median of 86%
  - ***Racial equity*** – One study indicated that children of all races and ethnicities were served equally well by SBCTs with regard to both placement stability and length of stay in foster care.
  - ***Increased service delivery*** – 93.9% of children served by SBCTs received needed Child-Parent Psychotherapy, compared to the national average of 66% of all children in the child welfare system receiving needed mental health services.
  - ***Cost savings*** – One cost analysis showed that up to two-thirds of the program's average cost per child could be directly generated from savings to jurisdictions due to children's shortened stays in foster care.

- GOAL 4: **Integrate the N.E.A.R. Science into Policy and Financing Solutions.**
  - Hosted SCCAN-MD EFC Education, Advocacy, and Awards Day at the General Assembly in February 2020: Approximately 50 SCCAN and MD EFC Members participated on February 6, 2020. Participants shared the contents of ACE legislative packets with Members of the General Assembly and/or their staff, including information on multiple ACE-informed bills before the General Assembly: The Hidden Predator Act, Trauma-Informed Schools Bill, Time to Care Act, Equitable Graduation Requirements for Foster Youth, and TANF Cash Assistance Eligibility Requirements. Frank Kros presented on the ACE Science and Policy to General Assembly Members and staff in attendance. SCCAN-MD

[33] *How does the Safe Babies Court Team™ approach improve outcomes for infants and toddlers?* Casey Family Programs Strategy Brief, November 2019.

Essentials for 2020 Childhood Leadership Awards were presented , to Joan L. Stine, MHS, MS, Advocate of the Year; The Board & Staff of No More Stolen Childhoods, Community Partner of the Year; and, posthumously to Congressman Elijah Cummings, Legislator of the Year; Framed graphic recordings of the ACEs Roundtable were awarded to Members of the General Assembly who participated in the ACEs Roundtable for Members of the General Assembly in December 2019.

- Created a legislative brief for Members of the Maryland General Assembly, ***Toward a More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient Communities*** (See 2019 SCCAN Report and the updated Appendix O), which outlines the N.E.A.R. science and catalogues ACE-informed policy and state legislation throughout the country.
- Developed and/or advocated for the following key legislation to promote safe, stable, and nurturing relationships and environments for children and prevent child maltreatment and other ACEs:

1. **Hidden Predator Act -Child Sexual Abuse Civil Statute of Limitations Reform- SB134/HB263 (2021). SB134 had a hearing but was not brought to a vote by the Judicial Proceedings Committee. HB263 was withdrawn. HB 974 (2020) passed the House 127-0 however because of the abbreviated session in response to the COVID-19 pandemic, no hearing was held In the Senate Judicial Proceedings Committee.** The Hidden Predator Act will eliminate the civil statute of limitations for child sexual abuse. More than 50 organizations participated in survivor and ally led efforts to pass the Hidden Predator Act, including efforts to galvanize survivor support and connection through the creation and promotion of the Justice4MDSurvivors.org website. Look-back windows in other states have been proven to provide justice to survivors, as well as identify and prosecute hidden predators. The national trend toward lookback windows has helped states expose hidden predators who were still harming children.

2. **Education- Guidelines on Trauma-Informed Approach HB 277 (2020) passed both Houses unanimously.** The law requires MSDE, in consultation with MDH and DHS, to develop guidelines for schools on a trauma-informed approach. MSDE must distribute the guidelines to local school systems and publish the guidelines on its website. School-based programs that address trauma symptoms improve educational outcomes for children.

3. **Time to Care Act- HB375/SB211 (2021) and HB839/SB539 (2020):** The bills did not get a vote in their respective Committees**.** Would have provided up to 12-weeks of paid family leave. Paid Family Leave is associated with decreased infant mortality, improved child health, improved parent-child bonding, and reduced child maltreatment.

4. **Equitable Graduation Requirements for Foster Youth- SB564 (2020) passed both houses unanimously.** The legislation standardizes graduation requirements for foster youth throughout Maryland and increases the opportunity for youth to graduate.

5. **Child Welfare Data Bill- HB258/SB592 passed both houses unanimously.** The legislation requires the Maryland State Department of Education to provide DHS with disaggregated data by county, gender, race, and ethnicity on the educational outcomes for young people in foster care to allow for a collaborative inter-agency response.

6. HB771/SB548 **Public Schools - Centers for Disease Control and Prevention Surveys – passed both houses** requiring that at least five questions from the CDC's Adverse Childhood Experiences and Positive Childhood Experiences questions be included in Maryland's YRBS/YTS for high school and middle school students.

7. **SCCAN and MD EFC Members participated in the 2019-2020 Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations created by SB 567 (2019).** The final report was submitted to the Governor and General Assembly in September of 2020 and included recommendations on how State courts could incorporate the latest science regarding the safety and well-being of children and other victims of domestic violence into court proceedings. Three pieces of legislation were introduced by Workgroup Members Senators Susan Lee and Mary Beth Carozza and Delegate Vanessa Atterbeary in the 2021 legislative session HB748/SB57, Family Law- Child Custody and Visitation passed each house in different forms by significant margins, but not in enough time to be reconciled and passed by both houses. Neither HB1036 nor SB675, Child Custody – Cases Involving Child Abuse or Domestic Violence – Training for Judges and Child's Counsel received a vote in their respective Committees. SB355, Family Law – Custody Evaluators – Qualifications and Training did not receive a vote in the Senate Judicial Proceedings Committee.

8. **Family Investment Program - Temporary Cash Assistance – Eligibility- HB1313 (2020)- passed the Senate unanimously and the House 111-23** This law prohibits DHS from reducing or terminating the assistance provided to Family Investment Program (FIP) recipients for noncompliance with work activity requirements if individuals have "good cause." Individuals who are noncompliant with FIP work requirements for good cause must receive a lesser sanction, particularly individuals who have children in the assistance unit. The bill modifies the conciliation processes for individuals found to be noncompliant and requires local departments of social services to assist individuals to return to compliance. Increases in family income improve family stability, reduce family stress, and prevent adverse childhood experiences

- Follow Up on Implementation of 2018 Bills Passed:

    1. HB 1582-Human Services Children Receiving Child Welfare Services-Centralized Comprehensive Health Care Monitoring Program to Meet the Health Needs of Children involved in the Child Welfare System passed unanimously out of both houses of the General Assembly and was signed into law by Governor Hogan on May 8, 2018. Md. Code Ann., Human Services § 8-1101- 8-1103 (2018) mandates:
        i. the creation of a Child Welfare Medical Director at DHS to:
            1. Ensure best practice medical review and evaluation of cases of suspected abuse or neglect, and
            2. Collect data on timeliness and effectiveness of health services provision and procurement; track health outcomes; analyze the data to assess the competency of health providers and the supply and diversity of services; and identify and propose systemic solutions to problems affecting health care for children in foster care.

ii. the creation of a centralized data portal with health information integrated from CRISP (Chesapeake Regional Information System for Our Patients), Immunet, and Medicaid, and
iii. the creation of an electronic health passport for foster youth.

- DHS hired Dr. David Rose as Child Welfare Medical Director in April 2019 and he left the department in August 2021. Under Dr. Rose efforts toward improving the health care of children in foster care have included the following:
    - Drafted DHS policies regarding health care service oversight and monitoring to align with the American Academy of Pediatrics' 2015 policy statement on health care issues in foster care and kinship care. The modified policies will clarify the timing and content of care entry assessments and periodic preventive care. Requests for changes to the Code of Maryland Regulations (COMAR) to implement these changes have been made to MDH. A draft policy has been drafted by DHS SSA, and feedback has been requested.
    - Required quarterly and annual internal reporting on existing foster care entry and periodic preventive care exams began in September 2019.
    - Worked with MD THINK-CJAMS on the health-related measures for case management. This health-related measures section, like MD CHESSIE, still requires hand input by DSS foster care workers. In addition, there have been some challenges with inputting information in the correct fields, which may require additional worker training and/or improved explanation of specific data fields.
    - At the recommendation of the Maryland Chapter of the American Academy of Pediatrics, Dr. Rose reached out to Dr. Lisa Burgess at Maryland Medicaid requesting collaboration in a 1-year Centers for Medicare and Medicaid (CMS) quality improvement learning collaborative. Dr. Rose and Dr. Burgess were co-chairs until Dr. Rose left DHS. While the primary focus of CMS is on improving the quality of Comprehensive Health Assessments, Maryland's collaborative will also examine subsequent health care management. The first meeting of the Learning Collaborative was held on August 10th, 2021. However, with the resignation of Dr. Rose, there have been weekly meetings between Medicaid and DHS staff, but the full learning collaborative membership has not met again.
    - Worked with CRISP for more than a year to access CRISP for patient information. The medical director (Dr. Rose) alone was given approval to access CRISP. DHS has not yet completed the necessary steps to enable this access. Because access was granted to the medical director, since his departure, no one at DHS currently has permission to access CRISP data. Consequently, DHS has not made significant progress towards data sharing with CRISP.
- The following issues are still of major concern to the Council:
    - There has been little or no progress toward integrating information from Medicaid, Immunet, and/or CRISP with CJAMS, nor in developing an electronic health passport. Many other states and jurisdictions, including

Texas, Washington, Oregon, Illinois, Washington, D.C., Milwaukee, WI, Allegheny County, PA, San Diego County, CA, and Dade and Monroe Counties, FL have found ways to electronically link Medicaid records with child welfare records, enabling child welfare professionals to have more accurate information about health visits and medications.[34] In addition, Hamilton County, OH has implemented a program to link child welfare records with those of Cincinnati Children's Hospital. Such linkages reduce data entry errors, reduce duplication of services, and improve care coordination. Without this data, it is difficult, if not impossible to assess whether children are receiving quality care by HEDIS or other valid measures. In DHS' 2019 report to the Legislature on health care services for children in out of home placement, DHS noted that "planning is underway for memoranda of understanding with MCOs around data sharing and care coordination." While SSA has been holding monthly Health Workgroup meetings that include MCOs, representatives from county DSS agencies, and other stakeholders, there is no mention of this effort, nor their accomplishments in the 2020 report.

- There has been little or no progress toward ensuring best practice medical review and evaluation of cases of suspected abuse or neglect.
- Data from the 2020 Citizen's Review Board for Children Annual Report indicate that health care data and services remain incomplete. Of the 871 children in foster care reviewed by CRBC, only 370 (42%) had health care needs met, and 360 (41%) had completed medical records. In addition, 323 (37%) were prescribed psychotropic medications.
- The DSS foster care workers continue to have primary responsibility for health care oversight of the children in their caseload. A survey of Local DSS Assistant Directors indicated that only 4 of 20 responding counties (20%) had a formal medical director or consultant. Local agencies most often relied on primary care and mental health providers for input regarding individual cases. Some also used their Medicaid MCO or behavioral health case manager for input. Most respondents indicated that they would like additional assistance, particularly for mental and behavioral health issues, health and developmental issues, informed consent for psychotropic medication use, case management, and completion of required health visits.
- In the annual reports (MSAR #11703 – Report on the Current Status of Health Care Services for Children in Out-of-Home Placement 2019 and 2020) required by Md. Code Ann., Human Services § 8-1102(C), DHS has not responded to most issues enumerated in the legislation in SECTION 3. In particular, DHS has not provided information on MCOs provision of additional case management for children in foster care, they have not addressed benefits and challenges of implementing regional health care monitoring programs, and they have not examined linkages between DHS data and electronic health records.

[34] Beth Morrow, *Electronic Information Exchange: Elements that Matter for Children in Foster Care*, The Children's Partnership, State Policy Advocacy and Reform Center, 2013.

- Recommendations:
  - DHS, MDH: Direct Maryland Medicaid, CRISP, and the Child Welfare Medical Director to link Medicaid and CRISP data to CJAMS to meet the requirements of Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), including the tracking of health care outcomes using HEDIS or other quality measures.
  - DHS: Create an electronic health passport to replace the current paper passport, as is required by Md. Code Ann., Human Services § 8-1101- 8-1103 (2018). This electronic passport is vital to ensure that foster youth, foster care workers, foster parents, biological parents, and health care providers have access to critical health information.
  - General Assembly: Hold a hearing regarding implementation and possible reforms to strengthen Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), including the issue of informed consent for psychotropic medications.
  - DHS, MDH: Direct the Child Welfare Medical Director, Medicaid, Medicaid Managed Care Organizations, and their special needs case managers to identify ways in which case managers can assist with ensuring health care needs of foster youth are met beyond the initial and comprehensive health screenings, including analyzing health care quality measures for children in care to meet the requirements of the statute.
  - DHS: Direct the Child Welfare Medical Director to work with Maryland CHAMP (Child Abuse Medical Professionals) to ensure best practice medical review and evaluation of cases of suspected abuse or neglect to meet the requirements of the statute.
  - DHS: Create at least 2 additional positions at DHS for physicians or nurse practitioners to assist the Medical Director in reviewing health care data, assessing quality of care, and providing input to local DSS agencies. One of these positions should be filled by a child psychiatrist to address the issue of psychotropic medication prescriptions for foster youth, including informed consent.

2. HB 1072- Child Sexual Abuse Prevention- Instruction & Training:

- SCCAN brought together the state and national expertise necessary to jointly develop the ***Maryland Guidelines and Best Practices for the Design, Assessment, and Modification of [School] Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse*** with the Interagency Commission on School Construction (See Appendix P). These guidelines were approved by SCCAN on May 7, 2020 and the Interagency Commission on School Construction on May 14, 2020.
- SCCAN worked with the Maryland Association of School Business Organizations (MD ASBO), MSDE, the Maryland Center for School Safety, Baltimore County Public Schools, R.L. Nichols & Associates, LLC - R. Leslie Nichols, CPP, and

Crabtree, Rohrbaugh Architects, to present two sessions, May 18th (***Legislative Mandates, Guidelines & Best Practices for Plan Development***, *PowerPoint pdf, recording*) and 19th (***Best Practices in Facility Design & Modification for Implementation***, *PowerPoint pdf, recording*) 2021, at the ASBO virtual conference in an effort to educate school business professionals on the implementation of the ***Maryland Guidelines and Best Practices for the Design, Assessment, and Modification of [School] Physical Facilities and Spaces to Reduce Opportunities for Child Sexual Abuse with the Interagency Commission on School Construction***. The audiences consisted of architects, facilities planners, facilities inspectors, planning and design specialists, construction specialists, CADD technicians, safety, security, and risk managers, project managers, auditors, buyers, purchasing analysts, energy and sustainability managers, workmen's compensation analysts, human resources, staff relations managers, business services managers, information and technology specialists, monitoring, accountability, and compliance specialists, principal's and attendance secretaries, pupil transportation specialists, and government affairs for Maryland Association of Boards of Education.

SCCAN RECOMMENDATIONS BY AGENT/AGENCY:

"No epidemic has ever been resolved by paying attention to the treatment of the affected individual."

Dr. George Albee,

The future prosperity of any society depends on its ability to foster the health and well-being of the next generation. When Maryland invests wisely in children and families, the next generation will pay that back through a lifetime of productivity and responsible citizenship. The Council and Maryland Essentials for Childhood are grateful to the Governor and General Assembly for their progress in developing infrastructure to move strategies to prevent and mitigate ACEs and build resilient children, youth, families, and communities in our state.

GOVERNOR

Through his Executive Order on ACEs and funding of Project Bounce Back, Governor Hogan demonstrated the strong leadership necessary to raise awareness of Adverse Childhood Experiences (ACEs) and encourage state agencies and local communities to invent wise responses in support of our children and Maryland's future prosperity. As next steps in aligning public policy and practice with the science of the developing brain, we recommend that the Governor:

1. Educate all Children's Cabinet and senior-level management staff in N.E.A.R. science and science-based communications strategies.
2. Develop and implement a Trauma and Resilience-Informed State Action Plan[35] for Preventing and Mitigating Childhood Trauma/ACEs that:
    - Makes ***budgetary commitments*** to prevent and mitigate ACEs, ***including staffing an Office of Resilience*** similar to those in neighboring Pennsylvania and New Jersey to lead ACEs/trauma/resilience work
    - Establishes a ***public/private collaboration*** to serve as ***infrastructure*** to prevent and mitigate the impacts of ACEs on Marylanders and assures local solutions to address community issues. Recruit champions from all three branches of government, as well as private funders, business, faith-based, and local community leaders, and experts in trauma and resilience to participate.[36]
    - Develops an ***ACE awareness and mobilization campaign, employing N.E.A.R. science and communication science strategies,*** to develop common unified language and messages when communicating about ACEs, trauma, and healthy social, emotional, and physical development.[37] Partner with the FrameWorks Institute, an interdisciplinary team of social scientists, linguists, and communications practitioners who work with policy makers, funders, and others to frame complicated social and scientific issues in understandable, actionable terms.
        - Partner with FrameWorks Institute (FWI) to develop an in-depth communications plan that can be implemented by state agencies and local communities across the state to use research-based values and metaphors to communicate about trauma and its effects on

[35] Trauma-Informed PA: A Plan to Make PA a Trauma-Informed, Healing-Centered State, July 2020.; NJ ACEs Statewide Action Plan, February 2021

[36] See, EPIC-Executives Partnering to Invest in Kids , Ready Nation, Washington County, OR, Faith-Based Organizations, and Faith Leader's Guide to Paper Tigers: Adverse Childhood Experiences)

[37] See *Building Strong Brains Tennessee*.

brain development. A similar plan in Tennessee included:

a. Three scientific symposia: Neurobiology, the Science of Programmatic Innovations, and the Science of Policy Innovations
b. Four three-day "Frame Labs" in which individuals from all sectors and professional disciplines learned values and metaphors that help even people who have no familiarity with child development.
c. A three-day "Train the Trainer" workshop for curriculum designers and agency training leaders
d. Ongoing technical assistance and a review of materials
e. Advisory services for the initiative steering group
f. In-depth editing and framing advice for communications projects (e.g. PSA scripts, social media content, press releases, agency websites, annual reports, public marketing materials, brochures, one-pagers, etc.).

- Develops a ***framework or standard for state child and family serving agencies*** to become ***designated*** a ***trauma-informed agency***[38]
- ***Surveys current ACEs, trauma-informed, and resilience efforts*** in state agencies, agencies contracted by the state and local communities and ***builds upon those efforts***
- Develops and/or adopts ***cross-agency, cross-sector ACEs training*** for agencies, providers, and communities; as well as, ***on-going technical assistance and training*** for state agencies to attain ***trauma-Informed agency designation***.
- ***Enhances the State's ACEs surveillance system, data collection and analysis*** building upon the work of the ACEs Cross-Agency Data Workgroup led by the Behavioral Health Administration.
- ***Promotes the creation of local community based cross sector coalitions***
- Includes a ***strong focus on early childhood,*** ensuring safe, stable, nurturing relationships and environments from the start
- ***Incorporates the six strategies and evidence-based programs and approaches*** listed in the CDC's *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence* resource tool
- ***Aligns with the work of the Trauma-Informed Care and Health Equity Commissions*** and other trauma-informed, health equity, and racial equity efforts in the state (See Appendix H)

3. Support legislation and funding of a Children's ACEs Prevention Trust Fund administered by a public-private board of directors to lead innovative interventions and financing across the state[39]

CHILDREN'S CABINET AGENCIES
GOC, GOCCP, DHS, MDH, DJS, MSDE, DOD, DPSCS, DBM, DLLR

1. Ensure that the Children's Cabinet standing agenda includes ACE-related agenda items.
2. Educate all Children's Cabinet and senior-level management staff in N.E.A.R. science and science-based communications strategies.
3. Develop and implement a Trauma and Resilience-Informed State Action Plan for Preventing and Mitigating Childhood Trauma/ACEs that:
    - Makes ***budgetary commitments*** to prevent and mitigate ACEs, ***including staffing an Office of***

[38] The Missouri Model: A Developmental Framework for Trauma-Informed Approaches; Delaware Developmental Framework for Trauma Informed Care
[39] https://ctfalliance.org/

Resilience similar to those in neighboring Pennsylvania and New Jersey to lead ACEs/trauma/resilience work

- Establishes a ***public/private collaboration*** to serve as ***infrastructure*** to prevent and mitigate the impacts of ACEs on Marylanders and assures local solutions to address community issues. Recruit champions from all three branches of government, as well as private funders, business, faith-based, and local community leaders, and experts in trauma and resilience to participate.
- Develops an ***ACE awareness and mobilization campaign, employing N.E.A.R. science and communication science strategies,*** to develop common unified messages about the importance of early childhood development, safe, stable and nurturing environments and how to build coping skills and community resilience. (Add link/footnote to BSBT) Partner with the FrameWorks Institute, an interdisciplinary team of social scientists, linguists, and communications practitioners who work with advocates, policy makers, funders, and others to frame complicated social and scientific issues in understandable, actionable terms. (See Governor's recommendation #2 for further details)
- Develops a ***framework or standard for state child and family serving agencies*** to become ***designated*** a ***trauma-informed agency***.
- ***Surveys current ACEs, trauma-informed, and resilience efforts*** in state agencies, agencies contracted by the state and local communities and ***builds upon those efforts***
- Develops and/or adopts ***cross-agency, cross-sector ACEs training*** for agencies, providers, and communities; as well as, ***on-going technical assistance and training*** for state agencies to attain ***trauma-Informed agency designation***.
- ***Enhances the State's ACEs surveillance system, data collection and analysis*** building upon the work of the ACEs Cross-Agency Data Workgroup led by the Behavioral Health Administration
- ***Promotes local community based cross sector coalitions***
- Includes a ***strong focus on early childhood,*** ensuring safe, stable, nurturing relationships and environments from the start
- ***Incorporates the six strategies and evidence-based programs and approaches*** listed in the CDC's *Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence* resource tool.
- ***Aligns with the work of the Trauma Informed Care and Health Equity Commissions*** and other trauma-informed and health equity efforts in the state. (See Appendix H)

4. Collect, review, analyze, and publish state and county-level ACE and positive childhood experiences (PCEs) module data from prior and ongoing Maryland Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey/Youth Tobacco Survey.

5. Integrate the science of the developing brain, ACEs, and resilience across agencies and within individual agencies by:

    - Participating in the development and implementation of a State Plan to Prevent and Mitigate ACEs
    - Identifying, designating, and empowering two staff from each agency with experience, expertise, and interest in brain, ACEs, and resilience science and multi-generational approaches to collaborate with sister agencies and serve as principal advisors to each agency Secretary/Director in trauma-responsive and trauma-informed care, including aligning agency training, policies, practices, and procedures with a trauma-informed approach, as required under Md. Code Ann., Human Services § 8-1301- 8-1308 (2021)

- ***Ensuring that your agency's communications tools and messaging embed the ACE awareness and mobilization campaign, based on N.E.A.R. science and communication science strategies***
- Considering the appropriateness of screening clients for ACEs and resilience factors[40]
- Providing the ***cross-agency, cross-sector ACEs training*** developed for agencies, providers, and communities through the work of the Trauma Informed Care Commission; as well as ***on-going technical assistance and training*** for state agencies to attain ***trauma-Informed agency designation to your all state and local agency staff***
- Ensuring that your ***local agency staff participate in local community based cross sector coalitions***
- Ensuring that state contracts require providers meet performance measures to become trauma-informed based on the above referenced Maryland developmental framework or standards for a trauma-informed approach
- Embedding the science into agency mission, vision, strategic planning, and technical assistance to local agencies: and, creating funding opportunities to local agencies for cross-sector planning and coordination of ACE prevention and mitigation efforts
- Ensuring agency policies and regulations reflect the science
- Ensuring agency practice models reflect the science
- Investing resources in evidence-based trauma prevention and treatment interventions and creating trauma-informed agencies[41]

6. Require that child serving agencies and youth serving organizations receiving state funding institute the Comprehensive Child Sexual Abuse training, policies and guidelines below (under the recommendation to the General Assembly).

7. Ensure your agency has a Report Child Abuse hotlink on its homepage and a link to DHS page for reporting suspected abuse.

GENERAL ASSEMBLY

1. Review Maryland Essentials for Childhood's ***Toward A More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient Communities.***[42]

2. Establish a Maryland Legislative Caucus to Prevent and Heal Childhood Trauma and develop a nonpartisan platform of legislation to prevent and mitigate ACEs.

3. Pass a joint resolution that policy decisions enacted by the MGA will acknowledge and take into account the principles of early childhood brain development, consider the concepts of toxic stress, adverse childhood experiences, and buffering relationships, and, note the role of promotion of healthy development, prevention, early intervention and investment in early childhood years as important strategies to achieve a lasting foundation for a more prosperous and sustainable state through investing

[40] Bartlett, J.D., Adversity and Resilience Science, *Screening for Childhood Adversity: Contemporary Challenges and Recommendations*, 20, April 2020. Anda, R. Porter, L. Brown, D., American Journal of Preventive Medicine (2020) *Inside the Adverse Childhood Experience Score: Strengths, Limitations, and Misapplications*; and, Finkelhor, D., Child Abuse & Neglect (2017) *Screening for adverse childhood experiences (ACEs): Cautions and suggestions*.
[41] See the National Child Traumatic Stress Network for resources on creating trauma-informed systems.
[42] See 2019 SCCAN Report and the updated Appendix O

in human capital.[43]

4. Pass legislation establishing a robust Children's/ACEs Prevention Trust Fund.[44]

   Maryland's current Children's Trust Fund was established by Sec. 13-2207 of the Maryland Health General Article. While funds initially supported small prevention grants, an ongoing source of income for the Trust Fund was never established. At the same time, many states across the country have developed robust prevention trust funds with combined annual revenues in excess of $100 million dedicated to prevention. Children's Trust Fund Boards actively raise funds to support statewide prevention efforts. This is a gap in Maryland's infrastructure to support prevention. The National Alliance for Children's Trust & Prevention Funds is available to consult with state leadership on the most successful models across the country.

5. Amend HB771/SB548 (2021) which requires ongoing inclusion of ACE questions in the YRBS but will require only 5 questions. Amend the bill to mandate that the 5 ACE questions be alternated by YRBS every two years so that all 10 ACE questions are included during each 4-year interval. Data on ACEs and protective factors should be analyzed for each Maryland jurisdiction.

6. Pass legislation to amend Md. Code Ann., Family Law § 5-1312 (2021) to:
   - Expand data currently collected by Maryland's Department of Human Services within their Child Welfare Indicators Report. Additional indicators include:
     i. The number of referrals and the number of screened-in and screened out referrals
     ii. The number of referrals (both screened in and screened out) by referral source (i.e., school, medical professionals, neighbors, family/friends, etc.)
     iii. The number of referrals (both screened in and screened out) by abuse type; and, more specifically, when a youth is referred to the Department as a result of neglect this information should be disaggregated by risk factor (food insecurity, housing status, poverty, etc.).
     iv. The stability of early care and education as measured by number of child care provider placements
     v. The number and percentage of children 0-5 in a quality childcare program as defined by Maryland Excels
     vi. The number and percentage of children 0-5 in informal childcare
     vii. The number and percentage of children with CPS involvement referred to Infants and Toddlers

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[43] Examples of State Legislation:

- 2013 Wisconsin passed Senate Joint Resolution 59. https://docs.legis.wisconsin.gov/2013/related/proposals/sjr59
- 2014 California Legislature, Assembly Concurrent Resolution No. 155, relative to childhood brain development passed.
- 2011 Washington House Bill 1965, passed creating the Washington State ACEs Public Private Initiative.
- 2014 Massachusetts passed a Safe and Supportive Schools Act within their gun violence reduction law:
- 2017 Vermont passed legislation to establish an Adverse Childhood Experiences Working Group of key legislators to consider future legislation. Four bills were introduced as a result of the report and Act 204 passed in 2018 based on the report.
- 2015 Minnesota HF 892/ SF 1204 Resolution on childhood brain development and ACEs.
- 2016 Alaska House Resolution 21
- 2017 Utah House Concurrent Resolution 10

[44] The National Alliance for Children's Trust & Prevention Funds.

viii. The number and percentage of children and youth receiving all Early Periodic Screening Diagnosis and Treatment visits recommended by Maryland Healthy Kids.
ix. Data collected by child welfare medical director as defined in MD Human Services Code Section 8-1101 (2018)
x. All indicators disaggregated by race, age, gender, and geographic region.

- Expand data collected by the Maryland State Department of Education. Additional indicators include:
    - The number and percentage of all Maryland children with a current individualized education plan
    - The number and percentage of children in out-of-home placement with a history of individualized education plans.
    - The number and percentage of children in out-of-home placement with a current individualized education plan.
    - The number and percentage of children in out-of-home placement with an individualized family services plan.
    - Rate of college and postsecondary application, acceptance, and attendance amongst youth in out-of-home placement.
    - All indicators disaggregated by race, age, gender, and geographic region.

7. Pass legislation requiring all mandated reporters in the state of Maryland to receive racial bias training focused on the role of bias and racism in child abuse and neglect reporting.

8. Pass legislation requiring all DHS employees and local DSS supervisors and caseworkers in the state of Maryland to receive racial bias training focused on the role of bias and racism in decision-making throughout the continuum of child welfare cases.

9. Pass legislation providing for Paid Family Leave. Paid Family Leave is associated with decreased infant mortality, improved child health, improved parent-child bonding, and reduced child maltreatment.

10. Pass legislation eliminating the civil statute of limitations for child sexual abuse, including a two-year look-back window or "window of justice". (See Appendix Q) Nine states have no civil statute of limitations for child sexual abuse.[45] Eleven states and the District of Columbia have created look back windows.[46] The average age of disclosure for child sexual abuse in 52. Maryland's current statute allows certain cases up to age 38. Goals of look back windows, opening prior barred claims for a short period of time include:

    - Identifying hidden child predators (during California's look back window, more than 300 hidden predators were identified). Civil litigation and discovery provide a critical tool to states to expose predators who remain a risk to children.
    - Disclosing the facts of the epidemic of child sexual abuse to public
    - Arming parents with facts to protect children

[45] Child USA, 2019 Alaska, Connecticut, Delaware, Florida, Illinois, Maine, Minnesota, Nebraska, and Utah.

[46] Ibid. California, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Massachusetts, Michigan, Minnesota, New Jersey, New York, and Utah.

- Shifting the costs for treatment and recovery after sexual abuse from the victim to those who caused the harm
- Providing justice for victims ready to come forward

11. Pass legislation that requires all public and nonpublic schools and their contracting agencies to do CPS background checks on all applicants for positions involving direct contact with minors.

12. Build upon legislation passed unanimously by both Chambers (HB 1072, Education Law Article, Sec. 6-113.1) by passing similar legislation to include the following:

    - Expand child sexual abuse prevention in public and non-public schools, by requiring child sexual abuse training, policies, and codes of conduct for volunteers.
    - Mandating that all state agencies, nonprofits, community-based organizations and businesses serving children and youth provide child sexual abuse prevention training, policies and codes of conduct for adults in direct contact with children and youth

    Child sexual abuse is a complex problem requiring a comprehensive approach. All adults in child and youth serving organizations play a role in preventing child sexual abuse *before it occurs.* Failing to provide adult-focused training to volunteers, as well as employees, of all child and youth-serving organizations leaves kids vulnerable both before and after abuse occurs. Comprehensive Child Sexual Abuse Prevention in youth serving agencies should include the components enumerated in HB 1072 as passed in 2018.

13. Hold a hearing regarding implementation and possible reforms to strengthen Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), including the issue of informed consent for psychotropic medications.

14. Pass legislation requiring an ongoing training program for judges who preside over child custody cases that involve domestic violence or child abuse as laid out in Workgroup to Study Child Custody Proceedings Involving Child Abuse or Domestic Violence Allegations Final Report.

JOINT DHS & MDH

In order to meet the requirements of Md. Code Ann., Human Services § 8-1101- 8-1103 (2018):

1. Direct Maryland Medicaid, CRISP, and the Child Welfare Medical Director to link Medicaid and CRISP data to CJAMS to meet the requirements of Md. Code Ann., Human Services § 8-1101- 8-1103 (2018), including the tracking of health care outcomes using HEDIS or other quality measures.

2. Direct the Child Welfare Medical Director, Medicaid, Medicaid Managed Care Organizations, and their special needs case managers to identify ways in which case managers can assist with ensuring health care needs of foster youth are met beyond the initial and comprehensive health screenings, including analyzing health care quality measures for children in care to meet the requirements of the statute.

3. Establish an ongoing Child Welfare Health Coordination Expert Panel led by the Child Welfare Medical Director to ensure communication and coordination between the multiple agencies that provide health care services to children within the child welfare system. Suggested members of this panel are included

in the footnote[47]. The Panel's responsibilities should include:

- Develop regulations and guidelines to ensure that children with suspected maltreatment receive timely, high quality, evidence-based medical assessments.
- Develop regulations and guidelines for effective management and oversight of health care services for children in foster care.
- Program evaluation and oversight to monitor the percentage of children who receive timely, appropriate, and accurate medical evaluations.
- Create a mechanism for adequate reimbursement of providers that is tied to provider performance
- Report annually to the Governor and legislature regarding the progress of implementation.

DHS

1. See Children's Cabinet agency recommendations above.

2. Create an electronic health passport to replace the current paper passport, as is required by Md. Code Ann., Human Services § 8-1101- 8-1103 (2018). This electronic passport is vital to ensure that foster youth, foster care workers, foster parents, biological parents, and health care providers have access to critical health information.

3. Direct the Child Welfare Medical Director to work with Maryland CHAMP (Child Abuse Medical Professionals) to ensure best practice medical review and evaluation of cases of suspected abuse or neglect to meet the requirements of the statute.

4. Create at least 2 additional positions at DHS for physicians or nurse practitioners to assist the Medical Director in reviewing health care data, assessing quality of care, and providing input to local DSS agencies. One of these positions should be filled by a child psychiatrist to address the issue of psychotropic medication prescriptions for foster youth, including informed consent.

[47] Suggested Members: Interagency Child Welfare Health Coordination Expert Panel

The Panel should include representatives from the following agencies and organizations:

- Maryland Children's Cabinet;
- Maryland Children's Alliance;
- Maryland Chapter of the American Academy of Pediatrics;
- Maryland CHAMP program (CHAMP physician and nurse affiliates);
- Maryland Forensic Nurses;
- DHS Out of Home Services;
- DHS Child Protective Services and Family Preservations Services;
- DHS Resource Development, Placement, and Support Services;
- MDH, Maternal and Child Health Bureau;
- MDH, Environmental Health Bureau, Center for Injury & Sexual Assault Prevention
- MDH, Medicaid;
- MDH, Behavioral Health;
- DHS and MDH representatives with expertise in their agency's child fatality review processes;
- Maryland State's Attorney's Association;
- County health department representatives;
- County DSS agency representatives;
- Maryland Legal Aid Bureau;
- Maryland CASA;
- GOCPYVS/VOCA
- Programs that currently contribute to medical and forensic services funding for children in the child welfare system

5. .As plans for the new hotline for reporting child abuse are implemented:
   - Ensure that de-identified aggregate data is collected and analyzed to inform decision-making to improve the reporting and screening system.
   - Ensure that local DSS have updated phone technology, sufficient staff and standardized training to implement the statewide hotline.

6. Identify, designate, and empower two staff from DHS with experience, expertise, and interest in brain, ACEs, and resilience science and multi-generational approaches to collaborate with sister agencies and serve as principal advisors to the Secretary in trauma-responsive and trauma-informed care, including aligning agency training, policies, practices, and procedures with a trauma-informed approach, as required under Md. Code Ann., Human Services § 8-1301- 8-1308 (2021).[48]

7. Require caseworkers to input race demographic data on all cases brought to the attention of DHS/SSA/local DSS. Recent data received from DHS/SSA indicates that of all new child abuse and neglect cases in fiscal year 2020, nearly a quarter did not include the race of the child.

8. Collect and make publicly available disaggregated data (race, gender, age, and geographic region) on the following indicators:
   i. The number of referrals and the number of screened-in and screened out referrals
   ii. The stability of early care and education as measured by number of child care provider placements
   iii. The number and percentage of children 0-5 in a quality childcare program as defined by Maryland Excels
   iv. The number and percentage of children 0-5 in informal childcare
   v. The number and percentage of children with CPS involvement referred to Infants and Toddlers
   vi. The number and percentage of children and youth receiving all Early Periodic Screening Diagnosis and Treatment visits recommended by Maryland Healthy Kids.
   vii. Data collected by child welfare medical director as defined in MD Human Services Code Section 8-1101 (2018)

9. The 2020 Department of Human Services, Child Welfare Indicators Report, indicates that 38% of children reported for suspected child abuse and neglect were Black Youth although Black Youth only make up 33% of the child population in MD. We recommend that:
   - DHS disaggregate referral (both screened in and screened out) data further by abuse type; specifically, when a youth is referred to the Department as a result of neglect this information should be disaggregated by risk factor (food insecurity, housing status, poverty, etc.).
   - DHS collect referral source data and disaggregate referral data by the source type. (i.e. School, medical professionals, neighbors, family/friends, etc.)

10. According to DHS, 60% of reports received are screened out. We recommend that:
    - DHS disaggregate all referrals data, screened in and screened out, by race, age, gender, and geographic region.

[48] "Applying the science of Child Development in Child Welfare Systems", Center on the Developing Child, Harvard University.

11. Ensure that leaders and participants in the development of MD THINK and CJAMS include experts in child welfare policy, database design and data management, and child health and health policy (the State Medical Director for Children Receiving Child Welfare Services) so that the system can effectively:

    - Integrate child-welfare, birth, and death data in order to analyze fatal maltreatment risks.
    - Collect longitudinal data on foster youth and their families so that well-being and long-term outcomes can be tracked. These outcomes should include frequency of placement changes, frequency of school changes, and medical and mental health services needed and received. This was a repeated recommendation included in DHS's Quality Assurance Processes in Maryland Child Welfare.[49]
    - Determine how often children involved with child welfare end up involved with the Department of Juvenile Services, how their educational achievement and health compares to their non-system involved peers, and for older foster youth who transition out of care, whether they have stable housing as adults.
    - Comply with the MOU in place between DHS and MSDE to allow for the sharing of data regarding foster youth since September 27, 2013 and the federal requirement pursuant to the Every Student Succeeds Act for states to track educational outcomes for foster youth.
    - Track the quality of the experience for foster youth while they are in care. Currently, we don't know basic information, such as: how often they change placements, how often they change schools, whether they are hospitalized, and whether they need in-patient psychiatric treatment.
    - Track when (from referral through risk of harm, investigative and alternative responses, foster care placement, reunification, and kinship and adoption) families are determined to need services, determine whether those services were received, and if not received, identify the reasons why not.[50]

12. Increase efforts that promote fathers' and mothers' male partners' emotional support, rather than solely financial support, of their children and families.

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[49] In the 5th Annual Child Welfare Accountability Report dated December 2011, DHR makes this recommendation repeatedly and the draft of the 6th Annual Child Welfare Accountability Report, includes this robust explanation:

Recommendation: Track entry cohorts over time. Prospective measures are preferable to measure child welfare outcomes. Following one population of children and youth through their child welfare experiences is the single best, least biased, method of measuring service receipt and outcomes (Wulczyn, 2007; Zeller & Gamble, 2007). Examining children's trajectory through the various levels of child welfare services is the best way to understand the effects of services on children and families. Entry cohort analyses are being successfully utilized in Maryland to examine welfare service utilization through a partnership between DHR/SSA and UM/SSW and should be expanded in the future. It is in Maryland's best interest to utilize the power available through the MD CHESSIE system to examine the trajectory of children through the child welfare system in a prospective manner. A prospective analysis will allow Maryland to follow children from report through investigation, to in-home or out-of-home child and family services, to the outcomes of safety, permanency, and well-being. (Maryland Child Welfare Performance Indicators (Draft), December 2012 p. 38)

[50] During the 2013 Legislative Session when the statute regarding substance exposed newborns (Md. Code Ann. Family Law § 5-704.2) was amended the General Assembly required the Department of Human Resources (DHR) to file an interim and final report analyzing implementation of the changes. DHR's data in those reports is telling for our purposes and underscores the importance of tracking when families receive services. The Preliminary Report from October 2014 documents 1,734 assessments of families with substance exposed newborns. According to the report, there were 400 and 89 instances of "'conditionally safe' (safe if the family accepts services)" and "unsafe" respectively. (Maryland Department of Human Resources, "Substance-Exposed Newborn Reporting in Maryland— Preliminary Report," p. 3 (October 1, 2014)) Yet, only **34% of these** individuals (168) are documented as receiving services. (Id. at p. 4. DHR's report states that MD CHESSIE might be undercounting who actually receives services.) Unfortunately, the October 2015 report documents an even smaller percentage of families receiving services. Only **26%** of families (347) identified as "conditionally safe" and "unsafe" received services. (Maryland Department of Human Resources, "Substance-Exposed Newborn Reporting in Maryland—Final Report," p. 4 (October 1, 2015)) **Given that DHR's 2015 report indicates that almost 75% of families assessed as needing services did NOT receive any, it is essential that we see why these families aren't getting the help LDSS determines that they need.**

- Collaborate with partners to further infuse fatherhood and male responsibility initiatives into settings with boys and men.
- Make deliberate and special efforts to include male caregivers in attachment and parenting skills programs (e.g., Circle of Security Parenting, home visiting sessions)

Social Services Administration

1. See Children's Cabinet recommendations above.

2. See Joint MDH-DHS recommendations above.

3. See DHS recommendations above.

4. Work with the Administrative Office of the Courts and MDH/BHA to expand Safe Baby Court Teams across the state, as evaluations have identified improved outcomes for children. [51]

5. Child Welfare data, including referrals, pathways, and service provision, should be disaggregated by race, ethnicity, gender, and socio-economic status. This data should be publicly available on a regular basis.

6. Implement Comprehensive Child Sexual Abuse Prevention Policy (see recommendations under General Assembly) to protect children in foster care. Ensure that all adults involved in the child welfare system are trained in the primary prevention of child sexual abuse, including: child welfare workers and supervisors, foster parents, people who work or volunteer in group homes and residential treatment centers, and licensed contractors involved with foster youth. Institute policies and codes of conduct for the prevention of child sexual abuse within state and local child welfare agencies.

7. Ensure that all children who are referred to the local DSS are screened for child sexual abuse and are referred and linked to service for treatment. Cases should remain open until linked to treatment services. Case records should indicate 1) child sexual abuse and 2) documentation that the child is receiving treatment.

8. Screen in all children under 3 as Risk of Harm cases and do an in-home assessment of risk. Provide services for families at risk for child fatality or near fatality.

9. Involve fathers in child welfare cases as a matter of course.

MDH

1. See Children's Cabinet recommendations above.

[51] *How does the Safe Babies Court Team™ approach improve outcomes for infants and toddlers?* Casey Family Programs Strategy Brief, November 2019.

2. See Joint MDH-DHS recommendations above.

3. Work with DHS and the Administrative Office of the Courts to expand Safe Baby Court Teams across the state, as evaluations have identified improved outcomes for children.[52]

4. Implement Comprehensive Child Sexual Abuse Prevention Policy (see recommendations under General Assembly) to protect children in the custody of the state. Ensure that all youth serving facilities licensed or funded with state funds are trained and institute child sexual abuse prevention policies.

5. Continue to collect BRFSS every three years and YRBS/YTS ACE module data in Maryland every two years. Resilience questions[53] similar to those being asked in Wisconsin's BRFSS should be added to Maryland BRFSS modules. The CDC YRBS ACE module data, including the 8 original ACE questions, 2 incidence ACE questions, 3 community ACEs, and 3 PCE questions should be collected regularly as part of YRBS/YTS[54].

6. Division of Health Promotion Administration should conduct a more in-depth analysis of Maryland's ACE data. At a minimum, a complete examination of the association between ACEs and health outcomes should be undertaken. Ideally, expanded analysis of ACE data should be completed. This should include:

    - Adjustment for age, race/ethnicity, income status
    - Analysis of chronic disease prevalence by type of ACE (e.g. Household mental illness, Physical abuse)
    - Summary of regional or county-level prevalence rates, to the extent possible given the small sample sizes for some counties.
    - Production of a large report or series of data briefs/fact sheets
    - The IBIS data portal for BRFSS data should be modified so that users can examine associations between ACEs and health outcomes themselves. The current configuration of the data only allows for examination of the likelihood of having a specific number of ACEs given the presence of a health outcome, rather than the likelihood of having a health outcome given the presence of ACEs.
    - The YRBS ACE questions should be expanded to include all 10 ACEs. Legislation that passed in the 2021 legislative session will require ongoing inclusion of ACE questions in the YRBS but will require only 5 questions. We recommend that ACE questions be alternated by YRBS year so that all 10 ACE questions are included during each 4-year interval. Data on protective factors should be examined for each Maryland jurisdiction.

7. Fund the baseline collection of child maltreatment Awareness, Commitment, and Norms Survey[55] initiated by the CDC's Essentials for Childhood and implemented by the five EFC funded states as well as, several unfunded states. Collection of this data in other states cost approximately $10,000.

8. Partner with the health care community to improve integration of behavioral and primary health care and identify and promote strategies to assess for and respond to ACEs.

[52] Ibid.
[53] See Appendix R
[54] See Appendix I
[55] See Appendix S

9. Ensure that all home visiting programs (MIECHV, MOTA grants, Community Health Specialists, etc.) engage fathers as well as mothers. Purposefully recruit fathers as home visitors.[56]

10. Maryland's Medicaid program should develop a system to generate a regularly updated list of all prenatal care providers serving Medicaid recipients and their MPRA (Maryland Prenatal Risk Assessment) completion rates for purposes of conducting ongoing provider education on MPRA procedures.[57]

11. Streamline the Postpartum Infant and Maternal Referral (PIMR) form and completion process in partnership with local health departments and birthing hospitals.[58]

12. Link completion of MPRA and PIMR and linkage to services to service provider fee payment.[59]

13. Medicaid should reimburse for psychosexual evaluation of youth. These should be considered medically necessary and key in the prevention of youth on younger child sexual abuse which is approximately 1/3 of all child sexual abuse perpetration.

14. Increase Infant and Early Child Mental Health workforce training in the core competencies. Integrate core competencies into evidence-based programs serving young children.

15. Amend Maryland's 1915i Waiver to eliminate the Medicaid barriers young children and their families face when trying to access behavioral health services for young children and their parents.

16. Medicaid should eliminate some of the billing barriers that behavioral health providers serving young children face including:

    - allowing behavioral health providers working with young children up to five appointments before they need to have a diagnosis since it takes longer than one visit to diagnose young children.
    - allowing behavioral health providers to use the DC:0-5 for diagnosing young children as it is better tailored for their developmental milestones.

17. Publish a formal report on BRFSS and YRBS/YTS ACEs data, similar to reports in other states. Proposed policy: The CDCYRBS ACE module data, including the 8 original ACE questions, 2 incidence ACE questions, 3 community ACEs, and 3 PCE questions should be collected regularly as part of YRBS/YTS[60].

18. Fund the baseline collection of child maltreatment Awareness, Commitment, and Norms Survey[61]

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[56] See MCANF preliminary observations under "Magnitude of the Problem in Maryland" section.

[57] Ibid.

[58] Ibid. Prenatal care providers are required by Maryland Medicaid regulations to submit an MPRA for each pregnant woman at her first prenatal care visit. Women are then outreached by nurses and home visitors, to further assess needs for care and eligibility for community services and link her to these services. Mothers and infants may also be outreached and referred following delivery; birthing hospitals are required by state regulations to submit a PIMR at postpartum discharge when Medicaid recipients have psychosocial risk factors (e.g., limited or and/or deliver infants who are born at low birth weight or have had a stay in the NICU.

[59] Ibid.

[60] See Appendix S

[61] See Appendix R

initiated by the CDC's Essentials for Childhood and implemented by the five EFC funded states as well as several unfunded states. Collection of this data in other states cost approximately $10,000.

MSDE

1. See Children's Cabinet recommendations above.

2. Support the collection of data on all ACE and resilience questions[62] recommended by the CDC through the Maryland YRBS/YTS for all middle schoolers and high schoolers.

3. Collect and make publicly available disaggregated data (race, gender, age, and geographic region) on the following indicators:
    i. The number and percentage of all Maryland children with a current individualized education plan
    ii. The number and percentage of children in out-of-home placement with a history of individualized education plans.
    iii. The number and percentage of children in out-of-home placement with a current individualized education plan.
    iv. The number and percentage of children in out-of-home placement with an individualized family services plan.
    v. Rate of college and postsecondary application, acceptance, and attendance amongst youth in out-of-home placement.

4. Implement Comprehensive Child Sexual Abuse Prevention Policy within all public schools as mandated by HB 1072 using evidence-based and promising programs, such as the Enough Abuse Campaign's ELearning for Educators.

5. Ensure that all home visiting programs (Office of Special Education-Healthy Families, etc.) engage fathers as well as mothers. Purposefully recruit fathers as home visitors.

DJS

1. See Children's Cabinet recommendations above.

2. Implement Comprehensive Child Sexual Abuse Prevention Policy within all facilities that serve children and youth. See recommendations under General Assembly.

3. Ensure that all adults employed by or volunteering at youth serving facilities licensed and/or funded with state funds are trained and institute comprehensive child sexual abuse prevention policy.

4. Ensure that all children are evaluated for child sexual abuse and those who may have been victimized by child sexual abuse are referred and linked to services for treatment. Cases should remain open until linked to treatment services. Case records should indicate 1) child sexual abuse and 2) documentation that the child is receiving treatment.

[62] See Appendices I & R

ADMINISTRATIVE OFFICE OF THE COURTS

1. Support implementation of the Workgroup to Study Child Custody Proceedings Involving Child Abuse and Domestic Violence Allegations' final report recommendations on how State courts can incorporate the latest science regarding the safety and well-being of children and other victims of domestic violence into child custody proceedings, including legislation on training judges and child's counsel similar to HB1036 nor SB675, Child Custody – Cases Involving Child Abuse or Domestic Violence – Training for Judges and Child's Counsel.

2. Work with DHS and MDH/BHA to expand Safe Baby Court Teams across the state, as evaluations have identified improved outcomes for children.[63]

[63] *How does the Safe Babies Court Team™ approach improve outcomes for infants and toddlers?* Casey Family Programs Strategy Brief, November 2019.

APPENDIX A

DHS RESPONSE TO SCCAN'S 2019 ANNUAL REPORT

The 2003 amendments to CAPTA require a written response from the state to the SCCAN Annual Report indicating *whether and how* the state will *incorporate each recommendation*: "[n]ot later than 6 months after the date on which a report is submitted by the panel to the State, the appropriate State agency shall submit a written response to State and local child protection systems and the citizen review panel that describes whether or how the State will incorporate the recommendations of such panel (where appropriate) to make measurable progress in improving the State and local child protection system."

In January 2017, SCCAN's Chair and Executive Director met with representatives from DHS to thank the Department for its response to the 2015 SCCAN Annual Report, follow up on recommendations that were not addressed, and develop a more consistent dialogue between DHS and SCCAN. It was noted that some of the recommendations to the Governor and General Assembly did not fall under the authority of DHS (the agency responsible for responding to the SCCAN recommendations) and needed to be acted on by other state agencies or a combination of state agencies. Since the 2016 report, SCCAN has categorized recommendations by the specific agent/agency that has the authority to make the recommended systems change. ***Despite agency-specific recommendations, DHS's response has failed to acknowledge and address many of those recommendations and they remain unaddressed.***

The Agency responded by enumerating current agency efforts that might collaterally address some Council recommendations in the 2019 report:

- SSA efforts on trauma, resiliency, and brain science
- SSA efforts to increase collaboration with families and systems
- SSA efforts to improve data sharing and reporting
    - In late 2019 DHS/SSA began roll out of a new electronic child and adult welfare case management system, the Child Juvenile Adult Management System (CJAMS).
    - The letter asserts that "Access to more robust data will allow DHS/SSA to have more timely and relevant data exchange in order to more effectively serve youth and families."
    - In August 2020, the child welfare module of CJAMS was implemented in all Maryland jurisdictions.

Significantly DHS SSA did not respond as to whether, how, and or when the following DHS and SSA-specific recommendations would be addressed, nor how they were coordinating with their fellow Children's Cabinet agencies on cross-agency recommendations:

- "Embed the brain, ACEs and resilience science and a multi-generational approach into policies across administrations at DHS. Implement strategies to prevent and mitigate ACEs (trauma-informed) and build resilience to create safe, stable, and nurturing environments for the children and parents receiving DHS services (Child Support Administration and Family Investment Administration, as well as SSA.)" *While SSA generally discusses its efforts to become a trauma-informed system, there is no mention of efforts within the sister administrations within DHS, nor any cross-agency work with the other child and family serving agencies in the state.*
- In support of effective implementation of HB 1582, Human Services-Children Receiving Child Welfare Services-Centralized Comprehensive Health Care Monitoring Program, 2018. *No mention is made of progress toward linking Medicaid and CRISP data to CJAMs, nor an electronic health passport*:

    - Establish an ongoing Child Welfare Health Coordination Expert Panel led by the Child Welfare Medical Director to ensure communication and coordination between the multiple agencies that provide health services to children with the child welfare system. *While there is mention that an expert panel is being considered, no timetable is offered for when a decision will be made on this proposal.*
- Child Welfare data should be disaggregated by race, ethnicity, gender, and socio-economic status. This data should be publicly available on a regular basis. *While there is a general mention in the DHS response that "Access to more robust data will allow DHS/SSA to have more timely and relevant data exchange in order to more effectively serve youth and families," DHS has been unable to provide accurate data on several of the requested indicators disaggregated by race for the current 2020-2021 report.*
- Implement Comprehensive Child Sexual Abuse Prevention Policy (see recommendations under General Assembly) to protect children in foster care. Ensure that all adults, including foster parents, group homes, residential treatment centers, and licensed contractors involved with foster youth are trained and institute policies in child sexual abuse prevention. *No mention.*
- Ensure that all children who are referred to the local DSS are screened for child sexual abuse and are referred and linked to service for treatment. Cases should remain open until linked to treatment services. Case records should indicate 1) child sexual abuse and 2) documentation that the child is receiving treatment. *No mention.*
- Increase efforts that promote fathers' and mothers' male partners' emotional support, rather than solely financial support, of their children and families. *DHS's response regarding "Increasing collaboration with families" notably does not address specific attention to fathers. As historically fathers' voices have been overlooked, it would be helpful to know the specifics of how DHS/SSA is remedying this critical systems issue.*
- Involve fathers in child welfare cases as a matter of course. *DHS's response regarding "Increasing collaboration with families" notably does not address specific attention to fathers. As historically fathers' voices have been overlooked, it would be helpful to know the specifics of how DHS/SSA is remedying this critical systems issue.*
    - Collaborate with partners to further infuse fatherhood and male responsibility initiatives into settings with boys and men.
    - Make deliberate and special efforts to include male caregivers in attachment and parenting skills programs (e.g., Circle of Security Parenting, home visiting sessions).
- Ensure that MD THINK makes data improvements listed below. *While DHS/SSA suggests that "Access to more robust data [through CJAMs] will allow DHS/SSA to have more timely and relevant data exchange in order to more effectively serve youth and families," there is no mention of any specifics and no response regarding the requests for improved data below:*
    - Integrate child-welfare, birth, and death data in order to analyze fatal maltreatment.
    - Collect longitudinal data on foster youth and their families so we can track both their long-term outcomes and the quality of their well-being while they are in care. This was a repeated recommendation included in DHS's Quality Assurance Processes in Maryland Child Welfare.
    - MD CHESSIE's focus on point-in-time data has been a significant barrier in having a true picture outcomes for children and their families who touch our child welfare system. We need to know how often foster youth end up involved with the Department of Juvenile Services, how their educational achievement and health compares to their non-system involved peers, and for older foster youth who transition out of care, whether, as adults, they have stable financial, employment, housing, and parenting (i.e., their children do not end up in child welfare) outcomes.
    - Comply with the MOU in place between DHS and MSDE to allow for the sharing of data regarding foster youth since September 27, 2013 and the federal requirement pursuant to

the Every Student Succeeds Act for states to track educational outcomes for foster youth.
    - Track the quality of the experience for foster youth while they are in care. Currently, we don't know basic information, such as: how often they change placements, how often they change schools, whether they are hospitalized, and whether they need in-patient psychiatric treatment.
    - Track when families are determined to need services, whether they receive those services, and if not, why not, and what follow up occurs.
- Screen in all children under 5 as Risk of Harm cases and do an in-home assessment of risk. Provide services for families at risk for child fatality or near fatality.
- As plans for the new hotline for reporting child abuse are implemented:
    - Ensure that de-identified aggregate data is collected and analyzed to inform decision-making to improve the reporting and screening system.
    - Ensure that local DSS have updated phone technology, sufficient staff, and standardized training to implement the statewide hotline.

As Council Members serve as a Citizens Review Panel collectively volunteering thousands of hours each year to develop thoughtful, specific, and implementable recommendations, the Council ***respectfully requests a specific response to each recommendation (i.e., whether or not DHS/SSA and/or sister agencies are or will act on the recommendation) in future reports so that barriers to implementation can be identified.***

APPENDIX B

State Council on Child Abuse and Neglect (SCCAN)

SCCAN Membership

15 MEMBERS APPOINTED BY THE GOVERNOR

Name	Representing	Jurisdiction	Email	Address
Wendy Lane, MD, MPH ***(SCCAN Chair)***	Clinical Associate Professor, University of Maryland (Epidemiology & Public Health, Pediatrics)	Baltimore County	wlane@epi.umaryland.edu	660 West Redwood Street Baltimore, MD 21201
Jena K. Cochrane	Personal experience	Anne Arundel County	jena_geb@verizon.net	1700 Basil Way, Gambrills, MD 21054
Janice Goldwater, LCSW-C	Executive Director, Adoptions Together	Montgomery County	jgoldwater@adoptiontogether.org	4061 Powder Mill Road Suite 320 Calverton, MD 20705
Elizabeth Letourneau, PhD	Director, The Moore Center for the Prevention of Child Sexual Abuse, Johns Hopkins University, Bloomberg School of Public Health	Baltimore City	eletourn@jhsph.edu	Johns Hopkins Bloomberg School of Public Health 615 N. Wolfe Street Baltimore, MD 21205

Name	Representing	Jurisdiction	Email	Address
Veto Anthony Mentzell, Jr.	Law Enforcement Officer, Harford County Sheriff's Department Program Director, Harford County Child Advocacy Center	Harford County	mentzellv@harfordsheriff.org	Harford County Sheriff's Office 45 South Main Street P.O. Box 150
Catherine Meyers	Director, Center for Children, Inc.	Charles County	meyers@center-for-children.org	Center for Children, Inc. 6100 Radio Station Road, P.O. Box 2924, La Plata, MD 20646
Linda Robeson	Business Community Representative	Anne Arundel County	lindasrobeson@gmail.com	306 Fairtree Drive Severna Park, MD 21146
Melissa Rock, Esq	Director, Child Welfare, Advocates for Children & Youth (ACY)	Baltimore City	mrock@ac y.org	Advocates for Children & Youth, One N. Charles Street, Suite 2400, Baltimore, MD 21201
Danitza Simpson	Director, Adelphi/Langley Family Support Center	Prince George's County	Dsimpson@pgcrc.org	Adelphi/Langley Family Support Center, 8908 Riggs Road Adelphi, Maryland 20783
Joan Stine	The Family Tree (Prevent Child Abuse, Maryland), Children's Justice Act Committee Liaison, Public health expert	Howard County	stinejg@yahoo.com	2614 Liter Court, Ellicott City, MD 21042-1729

8 POSITIONS FILLED BY DESIGNATION OF THEIR ORGANIZATIONS

Name	Representing	Email	Address
Stephanie Cooke, LCSW-C	Supervisor, Child Protective Services and Family Preservation, Social Services Administration, Maryland Department of Human Services	Stephanie.Cooke@maryland.gov	Maryland Department of Human Resources Social Services Administration, 5th Floor 311 W. Saratoga St. Baltimore, MD 21201
VACANT.	State's Attorney Association		
Delegate Susan K.C. McComas	Maryland House of Delegates	susan_mccomas@house.state.md.us	Maryland House of Delegates 9 West Courtland Street P.O. Box 1204 Bel Air, MD 21014
VACANT	Department of Juvenile Services		State of Maryland Department of Juvenile Services 120 W. Fayette St. #505 One Center Plaza Baltimore, MD 21201
The Honorable Karla Smith, Montgomery County Circuit Court	Representative of the Judicial Branch appointed by the Chief Judge of the Maryland Court of Appeals		Montgomery County Circuit Court 50 Maryland Avenue Rockville, MD 20850
John McGinnis	Pupil Personnel Specialist, Maryland Department of Education	john.mcginnis@maryland.gov	Pupil Personnel Specialist Maryland Department of Education 200 West Baltimore St. Baltimore, MD 21201
Courtney McFadden, MPH	Deputy Director, Prevention and Health Promotion Administration, Maryland Department of Health	courtney.mcfadden@maryland.gov	Maryland Department of Health 201 W Preston Street Baltimore MD 21201
VACANT	Maryland Senate		

SPECIALLY DESIGNATED MEMBERS OF CHILDREN'S JUSTICE ACT COMMITTEE

Name	Relevant Background	Email	Address
Ed Kilcullen	Executive Director, Maryland Court Appointed Special Advocates, Children's Justice Act Committee	Ed@marylandcasa.org	402 W. Pennsylvania Avenue, 3rd FloorTowson, MD 21204

SCCAN EXECUTIVE DIRECTOR

Name	Relevant Background	Email	Phone	Address
Claudia Remington, Esq.	Attorney, Mediator, and CASA volunteer	Claudia.remington@maryland.gov	Office: 410-767-7868 Cell: 240-506-3050	311 W. Saratoga Street, Room 405, Baltimore, MD 21201

APPENDIX C

ACHIEVING RACIAL EQUITY IN CHILD WELFARE WORKGROUP MEMBERS

CO-CHAIRS:

Erica Lemon, Maryland Legal Aid

Rachel White, Advocates for Children and Youth

MEMBERS:

Andrew Bell, JBS International

Stacey Brown, The Family Tree

Patricia Cobb-Richardson, Behavioral Health Systems Baltimore

Stephanie Cooke, SCCAN, DHS, SSA

Eiza Cooper, Thriving Communities Collaborative

Serafinam Cooper, MDH

Patricia Cronin, The Family Tree

Noy Davis, First Star

Courtney Dowd, Child Justice, Inc.

Janice Goldwater, SCCAN, Adoptions Together

Dr. Edwin Green, Jr., Citizens Review Board for Children

William Jernigan, GOCPYVS

Eileen King, Child Justice, Inc.

Vlada Kirilenko, SCCAN Intern, Johns Hopkins University student

Sara Lewis, MDH

Carletta Lundy, City of Bladensburg Council Member

Courtney McFadden, SCCAN, MDH

Amanda Odorimah, Hearns Law Group

Meghan Resler, Maryland CASA

Davina Richardson, Citizens Review Board for Children

Linda Robeson, SCCAN

Dr. Michael Sinclair, Morgan State University

Joan Stine, SCCAN, The Family Tree

Vanita Taylor, Office of the Public Defender

Denise Wheeler, Citizens Review Board for Children

D'lisa Worthy, MDH. BHA

APPENDIX D

COVID-19 CHILDHOOD RESILIENCE ACTION TEAM MEMBERS & ORGANIZATIONS

CHAIR:

Frank Kros, Kros Learning Group

COORDINATING COMMITTEE:

Quinton Askew, 211 Maryland

Dave Brown, Echo Resource Development

Kay Connors, University of Maryland, Taghi Modarressi for Infant Study

Marianne Gibson, Opioid Operational Command Center

Jessica Lertora, Frederick County Safe Babies Court Team

Amie Myrick, Amatus Health

Claudia Remington, SCCAN

Joan Stine, SCCAN, Maryland Essentials for Childhood

D'Lisa Worthy, Maryland Department of Health, Behavioral Health Administration, Child, Adolescent and Young Adult Services Unit, Early Childhood Services

MEMBERS:

Adoptions Together – Janice Goldwater

Allegany County Library System – John Taube

Behavioral Health Systems Baltimore – Stacey Jefferson, Patricia Cobb Richardson

Bricks4Kidz – Nana Ama Adom-Boakye

Cecil County Local Management Board – Jan Brewer

Child Advocacy Center of Frederick, ACEs Workgroup, Interagency Early Childhood Committee– Pilar Olivo

Citizens Review Board for Children – Denise Wheeler

Family Informed Trauma Treatment Center – Laurel Kiser

First Star Institute – Noy Davis

Franklin Law Group – Ashley Edwards, Cherie Jones

Governor's Office of Crime Prevention, Youth, and Victims Services – William Jernigan

Greater Baltimore Medical Center Healthcare – Gregory Shaffer

Maryland Chapter of the American Academy of Pediatrics – Scott Krugman, MD

Maryland Court Appointed Special Advocates (CASA) – Ed Kilcullen, Meghan Resler

Maryland Department of Health, Center for Harm Reduction Services, Infectious Disease Prevention and Health Services Bureau, Prevention and Health Promotion Administration – Marie Stratton

Maryland State Department of Education, Division of Student Support, Academic Enrichment, and Educational Policy – John McGinnis

Maryland Department of Health, Center for Injury and Sexual Assault Prevention – Sarafina Cooper

Maryland Department of Human Services, SSA – Marcia Morris, Tawanda Epps

Maryland Emergency Management Agency – Teresa Heath

No More Stolen Childhoods – Vanessa Milio

RENEW Your C.O.R.E. – Michelle Solloway

Roberta's House – Annette March-Grier, Veronica Land-Davis

Linda Robeson

St. Mary's County Health Department, Behavioral Health Division – Stephanie Scharmen

Sustainable Life Solutions, LLC – Naketta Lowery

TCYSB – Laurel James

Thriving Communities Collaborative – Eliza Cooper

The Family Tree – Stacey Brown, Patricia Barger, Pat Cronin

The Lourie Center for Children's Social and Emotional Wellness – Jimmy Venza

The Promise Resource Center – Kelly Hutter

University of Maryland Extension Program – Alexander Chan

University of Maryland Medical Center – Deborah Badawi, MD

University of Maryland School of Medicine, Department of Psychiatry and Taghi Modaressi Center for Infant Study, Division of Child and Adolescent Psychiatry – Kay Connors

University of Maryland School of Pharmacy, Pharmaceutical Health Services Research Department, Behavioral Health Resources and Technical Assistance Program – Nicole Sealfon

Walden Pyramid Healthcare – Breana Pearsall, Roy Maddox

Sponsored By: The Family Tree

MARYLAND essentials for childhood

SCCAN Maryland's State Council on Child Abuse and Neglect

APPENDIX E

THE ACE INTERFACE PROJECT
ACE INTERFACE MASTER TRAINERS & PRESENTERS LIST

1. Rachel Abbott-Gray, Somerset County Public Schools
2. Catherine Abrams, Eastern Correctional Institution/Salisbury University
3. Dorinda Adams, Maryland Department of Human Services-Adult Protective Services
4. Nana Ama Adom-Boakye, Health and Well-Being International/Bricks 4 Kidz
5. William Allen, Caroline County Public Schools
6. Staci Aperance, Worcester County Public Schools
7. Ulysses Archie, Jr., Community Advocate, Baltimore Gift Economy
8. Joy Ashcraft, Maryland Army National Guard
9. Vanessa Atterbeary, Maryland House of Delegates
10. Carol Auerbach, Baltimore City Department of Social Services
11. Jessica Baker, Talbot County Public Schools
12. Khadim Baluch, Baltimore City Public Schools
13. Patricia Barger, The Family Tree
14. Amy Beal, Maryland State Department of Education
15. Andrew Bell, JBS International, Inc.
16. Leah Bentfield, Outward Bound
17. Christina Bethell, Johns Hopkins Bloomberg School of Public Health
18. Wendy Blackwell, Center for Urban Families
19. Tara Blades, Talbot County Public Schools
20. Keisha Blake, I Am Me Project, Inc.
21. Latisha Bordley, Caroline County Public Schools
22. Jan Brewer, Harford County Community College
23. Stacey Brown, The Family Tree
24. Kimberly Buckheit, Maryland State Department of Education
25. Andrea Butler, Aetna Better Health of Maryland
26. Cara Calloway, Caroline County Public Schools
27. Shannon Cassidy, Washington County Public Schools
28. Kip Castner, United States Department of Health and Human Services, Health Resources and Services Administration (HRSA)
29. Alexander Chan, University of Maryland Extension
30. Chanei Clemons, Roberta's House
31. Sandra Colea, Citizens Review Board for Children
32. Vonda Colson, Baltimore City Health Department
33. Kristy Conklin, Voices of Hope
34. Nicole Conner, Queen Anne's County Public Schools
35. Kay Connors, University of Maryland, National Child Traumatic Stress Network
36. Eliza Cooper, Thriving Communities Collaborative
37. Miera Corey, Behavioral Health Systems Baltimore
38. Tracey Cottman, Somerset County Public Schools
39. Stella Lee Coulbourne, Caroline County Public Schools
40. Laverne Cray, Worcester County Public Schools

41. Charlene Creese, Worcester County Public Schools
42. Patricia Cronin, The Family Tree
43. Robin Davenport, Maryland Court Appointed Special Advocates Association (CASA)
44. Shekinah Davis, Maryland Court Appointed Special Advocates Association (CASA)
45. Rebecca DeHoff, Caroline County Public Schools
46. Stacy Doak, Washington County Public Schools
47. Michael L. Dorsey Sr., Maryland Department of Human Services
48. Kim Dumas, Washington County Public Schools
49. Barbara Dziedzic, Baltimore City Public Schools
50. Brittany Echols, Baltimore City Public Schools
51. Guli Fager, Independent Practice
52. Ann Ferkler, Caroline County Public Schools
53. Jennifer Fiechtner, Center for Children, Inc.
54. Nicole Fisher, Caroline County Public Schools
55. Doria Fleisher, Charles County Government
56. Leslie Follum, Queen Anne's County Public Schools
57. Stephanie Freeman, St. Mary's Health Department
58. Melita Friend, CARE 1st Wellness & MedMark Treatment Centers
59. Laurie Galloway, On Our Own of Carroll County, Inc.
60. Charles Gammons, Charles County Public Schools
61. Sandra Gammons, Charles County Public Schools
62. Elizabeth Garcia, Children's Guild
63. Ivy Garcia, For All Seasons
64. Denise Garman, Archdiocese of Baltimore City
65. Carmen Getty, Advanced Systems
66. J David Gibbons, Caroline County Public Schools
67. Michelle Gilliam, Charles County Public Schools
68. Heather Glass, APPLES for Children, Inc.
69. Myra Sturgis Glover, Anne Arundel County Public Schools
70. Julissa Gomez, University of Maryland-Baltimore County, The Choice Program
71. Keiona Gorham, Wide Angle Youth Media
72. Latrice Gray, Salisbury University
73. Angela Gray, Office on Mental Health
74. Tonya Green-Pyles, Baltimore County Health Department
75. Raymond Greene-Joyner, The Family Tree
76. Paul Griffin, Child Justice, Inc.
77. Euphemia Griffin, Restoration Community Development Corporation
78. Amber Guthrie, Maryland Network Against Domestic Violence
79. Sara Haina, Calvert County Behavioral Health
80. Jasmin Haley, University of Maryland Dental School/Beyond the Prophy
81. Nikki Ham, Bowie State University
82. Heather Hanline, Dove Center
83. Heather Harding, Caroline County Public Schools
84. Tarik Harris, Maryland State Department of Education
85. Joyce Harrison, Johns Hopkins Bloomberg School of Public Health
86. Lori Hauser, The Family Tree, Board Member
87. Candace Hawkins, Aetna Better Health of Maryland
88. Jay Hessler, Frederick County Health Department
89. Angela Holocker, Kent County Public Schools

90. Veronica Hopkins, Baltimore City Public Schools
91. Tyvon Horsey, Caroline County Public Schools
92. Jenny Howard, Worcester County Public Schools
93. David Humphries, Frederick County Public Schools
94. Stephanie Hutter-Thomas, Maryland Rural Opioid Training Assistance (MD ROTA)
95. Kelly Hutter, The Promise Resource Center
96. Kim Jackson, The Family Tree
97. Donna Jacobs, University of Maryland Medical System
98. Tasha Jamison, Wicomico County Health Department
99. Lauren Jenkins, Department of Juvenile Services
100. William Jernigan, Governor's Office of Crime Control and Prevention
101. Debra Johnson, Maryland Department of Transportation
102. Joan Johnson, Howard County Office of Children and Families
103. Chari Jones, Somerset County Public Schools
104. Lindsay Julius, Talbot County Public Schools
105. Jahneen Keatz, Baltimore City Public Schools
106. Susan Kerin, Capital Consulting Corporation
107. Allie Ketterman, Talbot County Public Schools
108. Diane King-Shaw, Lourie Center School
109. Melissa King, Kent County Health Department
110. Frank Kros, Kros Learning Group
111. Lucane LaFortune, Maryland Network Against Domestic Violence
112. Michelle Lancaster, St. Mary's County
113. Beth Anne Langrell, For All Seasons
114. Jessica Lertora, Zero to Three
115. Sadie Liller, Garrett County Health Department
116. Naketta Lowery, Sustainable Life Solutions LLC
117. Christine Lybolt, Caroline County Public Schools
118. Sarah Manekin, The Abell Foundation
119. Angela Martin, Maryland Community Action Partnership
120. Jennifer Martinez, St. Mary’s Health Department
121. Shelley Mason, Worcester County Board of Education
122. Shantay McKinily, University of Maryland School of Social Work Positive Schools
123. Kia McKinney, Caroline County Public School
124. Dillon McManus, Maryland Department of Health
125. Sheryl Menendez, Restoration Community Development Corporation
126. Veto Mentzell, Harford County Sheriff's Office
127. Denise Messineo, Thallo Leadership Consulting/Citizens Review Board of Children
128. Cathy Meyers, Center for Children, Inc.
129. Meredith Miller, Wicomico County Public Schools
130. Crystal Miller, Wraparound Maryland, Inc.
131. Erica Moltz, Adoptions Together
132. Emily Moody, Talbot County Public Schools
133. Patty Morison, Child Care Choices
134. Tina Morris, Talbot County Public Schools
135. Pat Mosby, Montgomery County Federation of Families for Children's Mental Health
136. Amie Myrick, Licensed Clinical Professional Counselor
137. Deborah Nelson, Maryland State Department of Education
138. Jess Nesbitt, Maryland Department of Health

139. Stephanie O'Hara, Somerset County Public Schools
140. Pilar Olivo, Frederick County Office for Children and Families
141. Jessica Oterson, Anne Arundel County Public Schools
142. Pam Brown, Anne Arundel County Partnership for Children, Youth, and Families
143. Ruby Parker, The Family Tree
144. Twanda Pickett, Baltimore City Public Schools
145. Donnell Pinder, Dorchester County Public Schools
146. Megan Pinder, Queen Anne's County Public Schools
147. Alexandra Podolny, Harm Reduction Community
148. Kathy Powderly, Hagerstown Religious Council
149. Melissa Prettyman, Caroline County Public Schools
150. Cherry Melissa Price, Prince George's County Public Schools
151. Jim Raley, Archway Station
152. Jennifer Redding, Family & Children's Services/Harford Counseling
153. Amber Reed, Boys and Girls Club of Metro Baltimore
154. Kristin Reel, Howard County Government
155. Claudia Remington, Maryland State Council on Child Abuse and Neglect
156. Victoria Rentz, Maryland State Department of Education, Juvenile Services Education
157. Kimberly Repass, Calvert County Public Schools
158. Kelly Reynolds, Outward Bound
159. Jennifer Roberts, The Family Tree
160. Lindsay Robeson, St. Mary's Public Schools
161. Sean Robinson, Johns Hopkins University Workforce Development
162. Steve Rohde, Maryland Family Network
163. Eric Rollins, Western Maryland Consortium
164. Martha Ruiz, Family Partnership of Frederick County
165. Matila Sackor-Jones, The Family Tree
166. Terrell Sample, Maryland State Department of Education
167. Alisha Saulsbury, For All Seasons
168. Stephanie Scharmen, St. Mary's County Health Department
169. Rob Schmidt, Talbot County Public Schools
170. Gail Schmidt, Talbot County Public Schools
171. Beth Schmidt, Maryland Coalition of Families
172. Robin Schrader, St. Mary's Public Schools
173. Chalarra Sessoms, Behavior Health Administration
174. Amy Shaffer-Post, Washington County Public Schools
175. Diane Shannon, Catholic Charities
176. Jamie Shepard, Foster Parent Community
177. Scott Showalter, Prince Georges County Public Schools
178. Teresa Simmons, University of Salisbury
179. Ernestina Simmons, Springboard Community Services
180. Michael Sinclair, Morgan State University
181. Desiree Shantai Smith, National Coalition of STD Directors
182. Harriet Smith, Baltimore Harm Reduction Coalition
183. Michele Solloway, Trauma Therapy and Health Services Research
184. Shepard W. Stephenson, St. Mary's Public Schools
185. Joan Stine, State Council on Child Abuse and Neglect
186. Marie Stratton, Maryland Department of Health
187. Ligia Teodorovici, Washington County Department of Social Services

188. Carmen Terrazas, Caroline County Public Schools
189. Jen Thomas, University of Pittsburg Medical Center
190. Cierra Thompson, The Clubhouse/H2O
191. Lacey Tsonis, Maryland Family Network
192. William Tucker, Circuit Court for Howard County
193. Stirling Ward, Queen Anne's County Public Schools
194. Kawana Webb, Dorchester County Public Schools
195. Merrideth Wile, Washington County Public Schools
196. Jonathan Williams, Shore Community Music Center/ Chesapeake College
197. Lauren Williams, Worcester County Public Schools
198. Joseph Windsor, Calvert County Sheriff's Office
199. D'Lisa Worthy, University of Maryland, Center of Excellence in Infant and Early Childhood Mental Health
200. Harold Young, Baltimore City Department of Social Services
201. Steve Youngblood, Washington County Department of Social Services
202. Robert Zellner, Awakenings Recovery Center
203. Rose Zollinger, Worcester County Public Schools

APPENDIX F

SCCAN & MARYLAND ESSENTIALS FOR CHILDHOOD BACKGROUND

SCCAN has its historical origins in the 1983 Governor's Task Force on Child Abuse and Neglect, appointed at the request of the General Assembly. The Task Force "found that child abuse, especially sexual abuse was far more widespread than originally estimated; [and,] the problems of child abuse and neglect require long term efforts for the implementation and monitoring of programs for the prevention, detection, and treatment of victims and offenders." In light of the task force findings, on April 29, 1986, the task force became the Governor's Council on Child Abuse and Neglect created by Executive Order. In 1999, the Maryland General Assembly established The State Council on Child Abuse and Neglect (SCCAN) as one of three citizen review panels[1] required by the Federal Child Abuse Prevention and Treatment Act (Title 42, Chapter 67, Subchapter I), known familiarly as CAPTA, and elaborated on its Federal responsibilities in the Maryland Family Law Article, Section 5-7A.

SCCAN consists of up to twenty-three members, most of whom are private citizens appointed by the Governor of Maryland, including representatives from the Maryland Chapter of the American Academy of Pediatrics, professional and advocacy groups, private social service agencies, and the medical, law enforcement, education, and religious communities. At least two members must have personal experience with child abuse and neglect within their own families or have been clients of the child protective services system. Eight members of SCCAN are designated representatives of their respective organizations including: the Maryland Senate, Maryland House of Delegates, Department of Human Services, Department of Health, Department of Education, Department of Juvenile Services, Judicial Branch, and the State's Attorneys' Association.[2]

SCCAN's mandate is defined in Federal and State law. CAPTA charges SCCAN and all citizen review panels "to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities"[3] and to "provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community and in order to meet its obligations."[4] The Maryland Family Law Article reiterates the CAPTA requirements and specifically charges SCCAN to "report and make recommendations annually to the Governor and the General Assembly on matters relating to the prevention, detection, prosecution, and treatment of child abuse and neglect, including policy and training needs".[5]

Prevention as a priority

For over a decade, the Council has focused its research, advocacy, and collective energies on activities to raise awareness of the science of the developing brain and adverse childhood experiences (ACEs) and build cross-sector collaboration to advocate for systems reform to promote child well-being and prevent child maltreatment and other adverse childhood experiences (ACEs)*before they occur*. *The profound impact that child maltreatment and other (ACEs) have on a child's well-being-- including short and long-*

[1] The other panels are the Citizens' Review Board for Children and the State Child Fatality Review Team.

[2] See Appendix D for current members.

[3] Section 5016a (c) (4) (A)

[4] Section 5016a (c) (4) (C)

[5] Section 5-7-09A (a)

term health, behavior and development; school success; future employment and earning potential; ability to form positive, lasting relationships and become productive citizens-- is well documented. Historically, most national, state, and local funding streams and responses to the problem of child maltreatment are directed at a case-by-case approach to detecting, investigating, prosecuting, and providing CPS or court supervised services to the "perpetrators" of abuse and neglect and to protecting children who have already been abused or neglected from future abuse and neglect by providing services to families or placing children in foster care.

A broader public health approach is needed to prevent child maltreatment *before it occurs.* The public health approach extends our criminal justice and case-based approaches by fostering a better understanding of the complex causes of child maltreatment in order to more effectively and preemptively intervene at all levels of the socio-ecological model (individual, family, community, and societal). Current prevention programs, policies, and practices in Maryland are fragmented across public and private agencies; and, vary both qualitatively and quantitatively from jurisdiction to jurisdiction. While many states, including Tennessee, Wisconsin, Iowa, Minnesota, Washington, Colorado, California, North Carolina, Massachusetts, among others are developing a coordinated approach to addressing childhood adversity and its impacts, **Maryland has no state agency that is specifically mandated to focus on primary prevention of child maltreatment. With the absence of mandated leadership, there is no formal cross-sector statewide strategy for promoting child well-being and preventing child maltreatment and other ACEs before they occur, leaving current prevention efforts are fragmented across agencies.** That is why SCCAN and its partners joined together to form Maryland Essentials for Childhood Initiative, a statewide collective impact[6] initiative that promotes safe, stable, nurturing relationships and environments for children and prevents, mitigates ACEs, and builds resilience in children, families, and communities.

Maryland Essentials for Childhood Initiative:

Maryland Essentials for Childhood (EFC) is a statewide collective impact initiative to prevent child maltreatment and other adverse childhood experiences (ACEs).[7] It promotes relationships and environments that help children grow up to be healthy and productive citizens so that *they*, in turn, can build stronger and safer families and communities for *their* children (a multi-generation approach). Maryland EFC includes public and private partners from across the state and receives technical assistance from the U.S. Centers for Disease Control. The initiative provides members the opportunity to learn from national experts and leading states. Using advances in brain science, epigenetics, ACEs, resilience and principles of collective impact, the EFC leadership and working groups are advancing the following goals:

1. Educate key state leaders, stakeholders, and grassroots on brain science, ACEs, and resilience; in order to, build a commitment to put science into action to reduce ACEs and create safe, stable, and nurturing relationships and environments for all Maryland children.
2. Identify and use Data to inform actions and recommendations for systems improvement
3. Integrate the Science into and across Systems, Services & Programs
4. Integrate the Science into Policy and Financing Solutions

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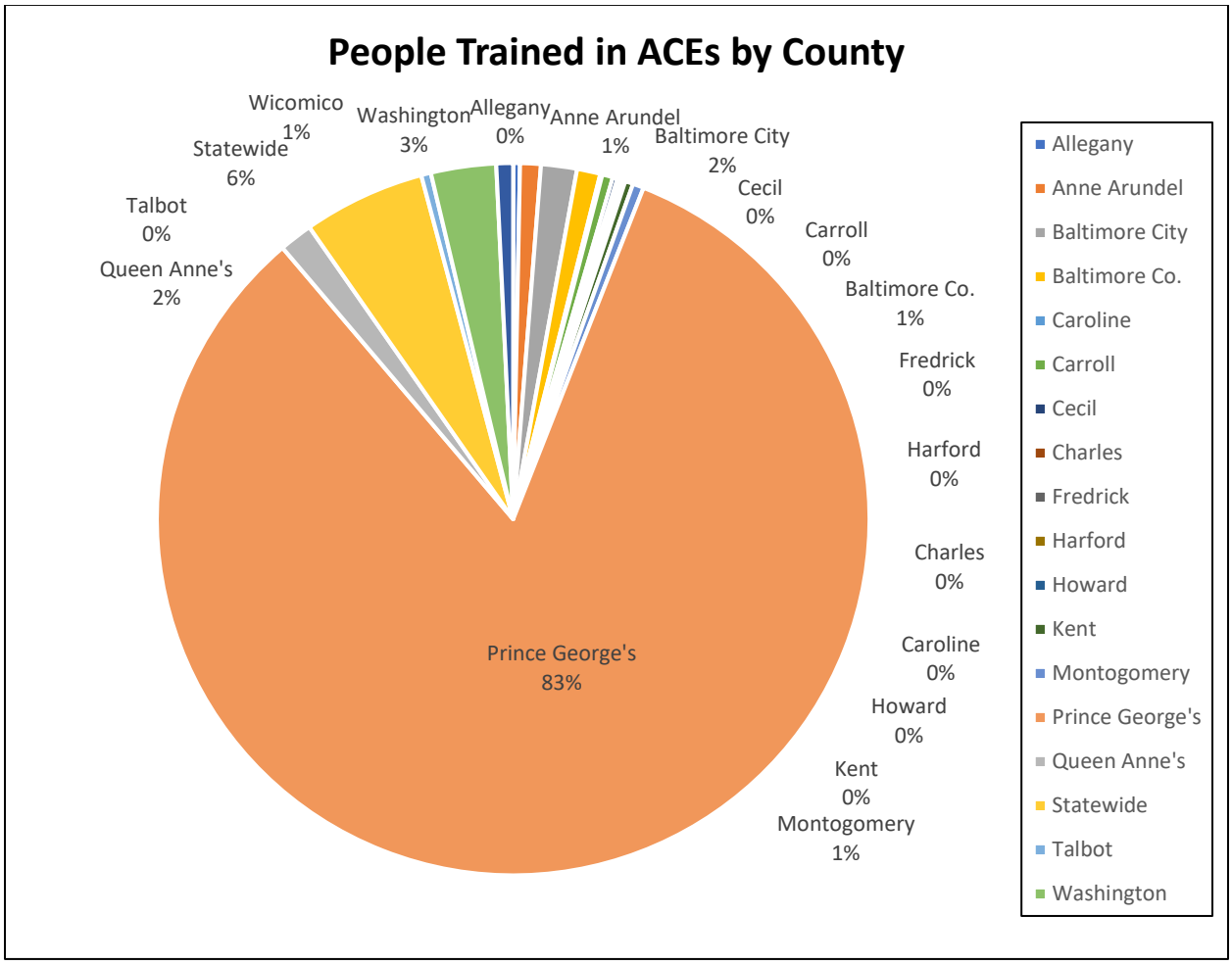
[6] Channeling Change: Making Collective Impact Work, Stanford Social Innovation Review, https://ssir.org/articles/entry/channeling_change_making_collective_impact_work

[7] Channeling Change: Making Collective Impact Work, Stanford Social Innovation Review, https://ssir.org/articles/entry/channeling_change_making_collective_impact_work

APPENDIX G:

ACE Interface Training Locations by Maryland County

Between March 2020 and April of 2021, ACE Interface Master Trainers have given 87 ACE Interface presentations to 15,012 attendees across all of Maryland's 24 jurisdictions. The graphs below show the percentage of trainings by number of people trained and number of trainings per jurisdiction.

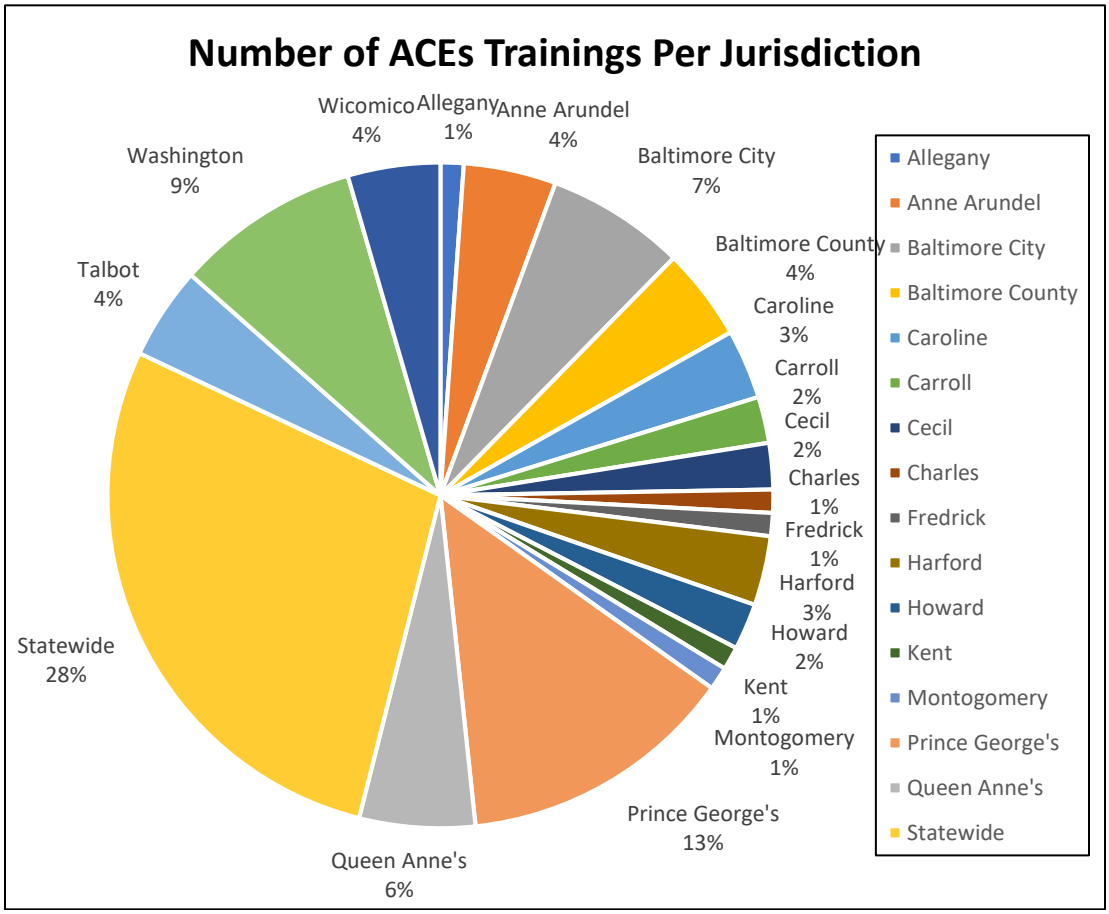


People Trained in ACEs by County (Participant Count)

Maryland County/Jurisdiction Served	Number of Participants
Allegany	46
Anne Arundel	141
Baltimore City	244
Baltimore County	159
Caroline	14

Carroll	73
Cecil	32
Charles	15
Fredrick	10
Harford	21
Howard	9
Kent	55
Montgomery	75
Prince George's	12,414
Queen Anne's	227
Statewide	830
Talbot	66
Washington	443
Wicomico	114

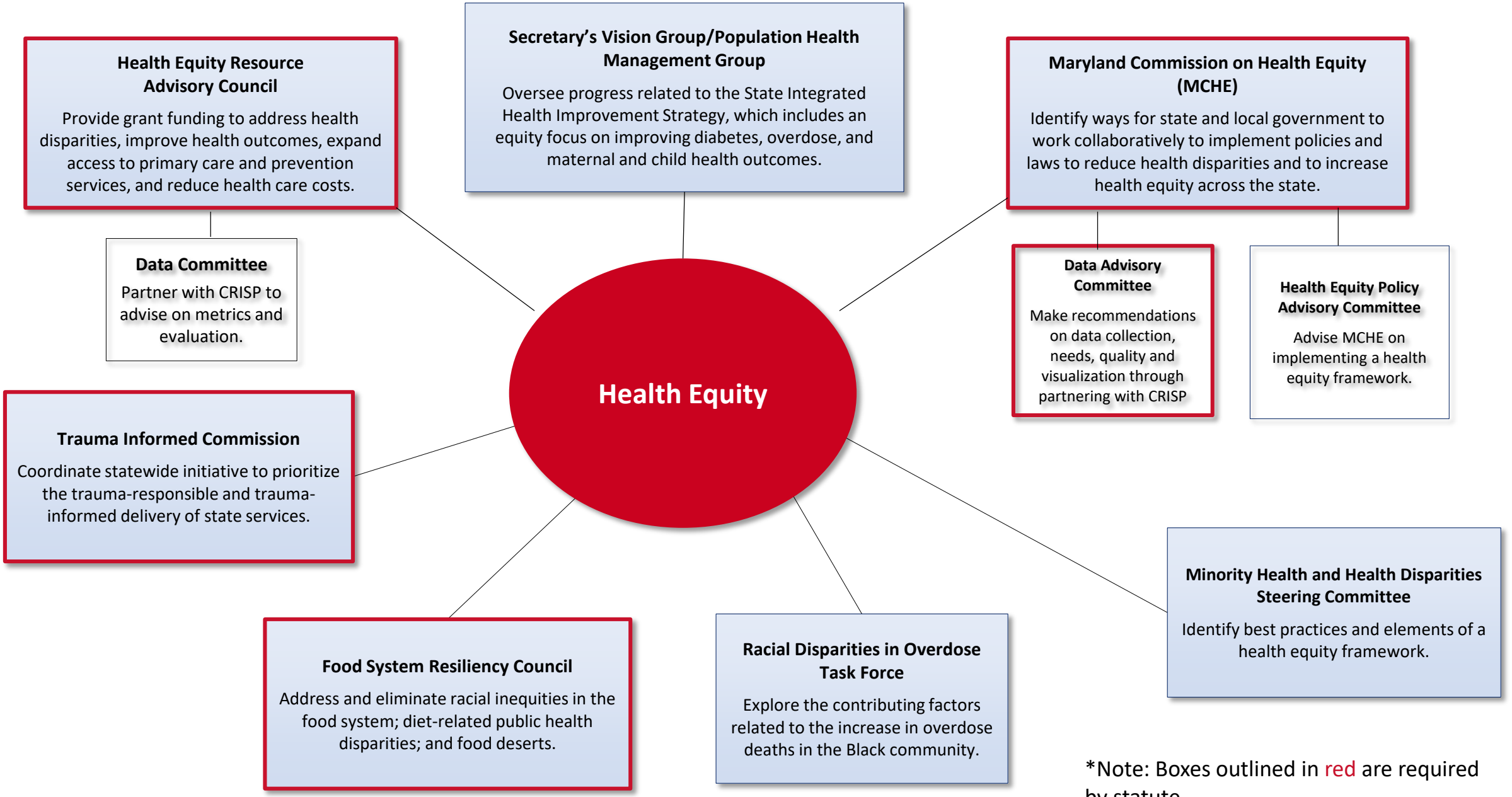
Number of ACEs Trainings Per Jurisdiction



Number of ACEs Trainings Per Jurisdiction (By Number of Occurrences)

Maryland County/Jurisdiction Served	Number of Participants
Allegany	1
Anne Arundel	4
Baltimore City	6
Baltimore County	4
Caroline	3
Carroll	2
Cecil	2
Charles	1
Fredrick	1
Harford	3
Howard	2
Kent	1
Montgomery	1
Prince George's	12
Queen Anne's	5
Statewide	25
Talbot	4
Washington	8
Wicomico	4

APPENDIX H - Health Equity Initiatives



*Note: Boxes outlined in red are required by statute.

Date: September 17, 2021

APPENDIX I

CDC ACES MODULES

Tier 1

Question	Construct	Question
1	*Lifetime prevalence of emotional abuse*	During your life, how often has a parent or other adult in your home sworn at you, insulted you, or put you down? A. Never B. Rarely C. Sometimes D. Most of the time E. Always
2	*Lifetime prevalence of physical abuse*	During your life, how often has a parent or other adult in your home hit, beat, kicked, or physically hurt you in any way? A. Never B. Rarely C. Sometimes D. Most of the time E. Always
3	*Lifetime prevalence of sexual abuse*	Has an adult or person at least 5 years older than you ever made you do sexual things that you did not want to do? (Count such things as kissing, touching, or being made to have sexual intercourse.) A. Yes B. No
4	*Lifetime prevalence of physical neglect*	During your life, how often has there been an adult in your household who tried hard to make sure your basic needs were met, such as looking after your safety and making sure you had clean clothes and enough to eat? A. Never B. Rarely C. Sometimes D. Most of the time E. Always
5	*Lifetime prevalence of witnessed intimate partner violence*	During your life, how often have your parents or other adults in your home slapped, hit, kicked, punched, or beat each other up? A. Never B. Rarely C. Sometimes D. Most of the time

		E. Always
6	*Lifetime prevalence of household substance abuse*	Have you ever lived with someone who was having a problem with alcohol or drug use? A. Yes B. No
7	*Lifetime prevalence of household mental illness*	Have you ever lived with someone who was depressed, mentally ill, or suicidal? A. Yes B. No
8	*Lifetime prevalence of incarcerated relative*	Have you ever been separated from a parent or guardian because they went to jail, prison, or a detention center? A. Yes B. No

Tier 2

Question	**Construct**	**Question**
9	*Lifetime prevalence of perceived racial/ethnic injustice*	During your life, how often have you felt that you were treated badly or unfairly because of your race or ethnicity? A. Never B. Rarely C. Sometimes D. Most of the time E. Always
10	*Lifetime prevalence of perceived sexual minority discrimination*	During your life, how often have you felt that you were treated badly or unfairly because of your sexual orientation? A. Never B. Rarely C. Sometimes D. Most of the time E. Always
11* *Note this question will be on the standard	*Lifetime prevalence of community level violence*	Have you ever seen someone get physically attacked, beaten, stabbed, or shot in your neighborhood? A. Yes B. No

question-naire, it will not need to be added and should not be deleted if applying for Tier 2 Funds.		
12	*Past 12-month incidence of physical violence*	During the past 12 months, how many times has a parent or other adult in your home hit, beat, kicked, or physically hurt you in any way? A. 0 times B. 1 time C. 2 or 3 times D. 4 or 5 times E. 6 or more times
13	*Past 12-month incidence of emotional violence*	During the past 12 months, how many times has a parent or other adult in your home sworn at you, insulted you, or put you down? A. 0 times B. 1 time C. 2 or 3 times D. 4 or 5 times E. 6 or more times
14	*Lifetime prevalence of feeling able to talk to adults about feelings*	During your life, how often have you felt that you were able to talk to an adult in your family or another caring adult about your feelings? A. Never B. Rarely C. Sometimes D. Most of the time E. Always
15	*Lifetime prevalence of feeling supported by friends*	During your life, how often have you felt that you were able to talk to a friend about your feelings? A. Never B. Rarely C. Sometimes D. Most of the time E. Always

16** **Note this question is the same question that is already required for DASH-funded LEAs	*Incidence of feeling a sense of belonging at school*	Do you agree or disagree that you feel close to people at your school? A. Strongly agree B. Agree C. Not sure D. Disagree E. Strongly disagree

APPENDIX J

State Council on Child Abuse and Neglect (SCCAN)
ANTIRACIST STATEMENT

Preamble

Evidently, the disparity in service offered and treatment of African Americans children has existed since the beginning of the child welfare system. In fact, prior to 1865, slavery was the primary welfare institution for African American s.[1] African Americans were not alone in tracing the history of the U.S child welfare system and the racist, discriminatory and disparate practices that have been used with children of color from the beginning of the system, to current times. Native American and Indigenous people have also been victims of biased practices and discriminatory procedures within the child welfare system. [2]

After slavery was abolished many White children were sent to orphanages, almshouses or sent west on "Orphan Trains" to live with foster families through indentured servitude. African Americans were largely excluded from that type of assistance with the exception being the Society of Friends. (an abolishment group in Philadelphia, PA). [3] The under-funded and short-lived Freedman Bureau provided direct relief for many African American children and their respective families. More often than not, most of the support services provided (i.e. day care, orphanages) to African American children were through self -help efforts offered through schools, churches, and other social organizations. [4] It was not until the National Urban League founded in 1910 began to advocate for equitable distribution of child welfare services.

By 1935, mothers' pension laws had been adopted in 46 states. Similarly, the Social Security Act established Title IV-A, known as Aid to Dependent Children (ADC). However, many states instituted "home suitability clauses" [5], "illegitimate child clauses" and "substitute father in the house clauses". These clauses were established to weed out "immoral homes" and often

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[1] Dettlaff, A. J., Weber, K., Pendleton, M., Boyd, R., Bettencourt, B., & Burton, L. (2020). It is not a broken system, it is a system that needs to be broken: The upEND movement to abolish the child welfare system. *Journal of Public Child Welfare*, *14*(5), 500-517. Barth, R. P., Jonson-Reid, M., Greeson, J. K., Drake, B., Berrick, J. D., Garcia, A. R., ... & Gyourko, J. R. (2020). Outcomes following child welfare services: what are they and do they differ for black children?. *Journal of Public Child Welfare*, *14*(5), 477-499.

[2] Bird, S. E. (2018). Introduction: Constructing the Indian, 1830s–1990s. In *Dressing in feathers* (pp. 1-12). Routledge. Berkhofer, R. F. (1979). *The white man's Indian: Images of the American Indian, from Columbus to the present* (Vol. 794). Vintage.

[3] Dettlaff, A. J., & Boyd, R. (2020). Racial disproportionality and disparities in the child welfare system: Why do they exist, and what can be done to address them?. *The ANNALS of the American Academy of Political and Social Science*, *692*(1), 253-274. Cénat, J. M., Noorishad, P. G., Czechowski, K., Mukunzi, J. N., Hajizadeh, S., McIntee, S. E., & Dalexis, R. D. (2021). The Seven Reasons Why Black Children Are Overrepresented in the Child Welfare System in Ontario (Canada): A Qualitative Study from the Perspectives of Caseworkers and Community Facilitators. *Child and Adolescent Social Work Journal*, 1-16.

[4] Burslem, R. R. (2021). TRANSFORMING OUTCOMES TO INCREASE PARTICIPATION IN THE INDEPENDENT LIVING PROGRAM SPONSORED BY SUNRISE CHILDREN'S SERVICES. Bremner, R. H. (1983). Other people's children. *Journal of Social History*, *16*(3), 83-103.

[5] Fong, K. (2020). Getting eyes in the home: Child protective services investigations and state surveillance of family life. *American Sociological Review*, *85*(4), 610-638. Piven, F. F., & Cloward, R. (2012). *Regulating the poor: The functions of public welfare*. Vintage.

excluded African Americans from receiving any public welfare benefits. Consequently, states like Mississippi, Florida and Louisiana were notorious for removing African American children from their families because their families were, in their opinion, too poor to take care of children.[6]

During the 1960's there was a major shift in America's conceptualization of the poor. The growing use of contraception and liberalized abortion laws increased social acceptability of many unwed, single parent households. The reduction of White children eligible for adoption led many private agencies to focus on African American children. African American children began to be over-represented in the child welfare system and experience disparate outcomes.[7] White culture maintaining the privilege of being the standard against which everyone else is compared perpetuates racial disparities.

Historically, Black children have experienced overrepresentation within the child welfare system throughout the U.S.. Maryland only began disaggregating child welfare data by race beginning in 2015. The data shows Black children and families continue to be disproportionately overrepresented year after year in Maryland.

In addition to overrepresentation, Black children also experience disparate outcomes. Black Youth are overrepresented in out-of-home foster care placements and are more likely to exit care without achieving permanency compared to their White counterparts. Of all youth emancipated (not being adopted, reunified, or placed in guardianship) Black youth comprise the overwhelming majority of cases.

As a society, it is our duty to ensure that every child has a bright future. Child welfare interventions require active and ongoing responsibility and accountability to minimize the potentially harmful effects of these interventions.

Achieving permanency prior to aging out of care is correlated to better outcomes in housing, education, employment, economic stability, physical and mental health, healthy relationships and connections to community. Providing research-informed guidance and support around housing, finances, relational stability, nutrition and the development of lifelong connections, builds resiliency and leads to personal well-being and healthy community members.

Additionally, experiencing racism is an Adverse Childhood Experience (ACE) that causes toxic stress and trauma.[8] We are actively building our knowledge, skills, and resources to increase equitable outcomes for all children and families. We are committed to being antiracist, to using an equity lens in our policy work, and to being intentional about addressing and eliminating racial inequities.

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[6] Lawrence-Webb, C. (2018). African American children in the modern child welfare system: A legacy of the Flemming Rule. *Serving African American Children*, 9-30. Simon, R. J. (1984). Adoption of black children by white parents in the USA. *Adoption: Essays in Social Policy, Law, and Sociology. New York/London, Tavistock Publications*.

[7] Hamilton, E., Samek, D. R., Keyes, M., McGue, M. K., & Iacono, W. G. (2015). Identity development in a transracial environment: Racial/ethnic minority adoptees in Minnesota. *Adoption quarterly*, *18*(3), 217-233.

[8] Research, Publications and Applications of the Expanded ACE Survey, The Philadelphia ACE Project; Philadelphia ACE Study; Racism and Discrimination as Risk Factors for Toxic Stress – Transcript, April 28, 2021.

SCCAN
ANTIRACIST STATEMENT

1. **Racism exists.**

Racism is prevalent in all institutions. Historic and systemic racism permeates the child welfare system and other child and family serving systems, including health, education, economic and justice systems. The State Council on Child Abuse and Neglect (SCCAN) unequivocally supports and stands in solidarity with all racially oppressed individuals and communities (African American, Black, Indigenous, and People of Color[9]) as an ally in the fight against racism, racial inequity, and racial discrimination.

In our role as a citizen review panel mandated by CAPTA, SCCAN *"evaluate[s] the extent to which State and local agencies are effectively discharging their child protection responsibilities."*[10] As an advisory body by Maryland law, we *"make recommendations annually to the Governor and the General Assembly on matters relating to the prevention, detection, prosecution, and treatment of child abuse and neglect, including policy and training needs."*[11] In these roles *SCCAN* is particularly allied with black children and families who are disproportionately represented in and impacted by the child welfare system.

2. **Racism is both conscious and unconscious.**

It is every individual's responsibility to learn the meaning and impact of how race influences and impacts everyone's interactions. Each of us must embrace the duty to understand our history, biases, prejudice, bigotry, and societal assumptions.

We acknowledge that racism can be unconscious or unintentional, and that identifying racism as an issue does not automatically mean that those involved in the act are racist or intend a negative outcome.

3. **Systematic racism exists, and we must distinguish intent from impact.**

We are committed to being actively antiracist. and we adopt Ibram X. Kendi's definition of racism, racial equity, racist policy, and racist ideas:

"Racism is a powerful collection of racist policies that [produce and normalize racial inequities] and are substantiated by racist ideas. **Antiracism** is a powerful collection of antiracist policies that lead to racial equity and are substantiated by antiracist ideas."[12] An antiracist idea is any idea that suggests the racial groups are equals in all their apparent differences—that there is nothing right or wrong with any racial group. Antiracist ideas argue that racist policies are the cause of racial inequities. Policies are any written and unwritten laws, practices, rules, procedures, processes, regulations, and guidelines that govern people.

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[9] We use the phrase "People of Color" to intentionally include individuals who may identify as Black, African-American, Asian, South Asian, Middle Eastern, Pacific Islander, Latinx, Chicanx, Native American, and multiracial. People of color are not a monolithic group. We specifically differentiate Black, African-American, and Indigenous people, as they have historically experienced overrepresentation in the child welfare system.

[10] 42 USC Ch. 67: CHILD ABUSE PREVENTION AND TREATMENT AND ADOPTION REFORM

[11] Family – General Article, Annotated Code of Maryland, § 5-7A-09, State Council on Child Abuse and Neglect (SCCAN)

[12] Kendi, Ibram X., How to Be an Antiracist. New York: One World, 2019.

SCCAN is committed to evaluating and reevaluating all Council recommendations regarding policies, procedures, services, and trainings to ensure that they are inclusive, equitable, accessible and antiracist.

4. **It is not the job of the oppressed to teach the oppressors about their mistakes.**

We understand it is not the job of the historically oppressed to educate the oppressors about oppression. We must teach ourselves to recognize the inappropriate assumptions that deny the humanity of the oppressed, based on our biases and accept responsibility for our role in perpetuating unfair advantages, disadvantages and racism. We pledge to be informed and promise not to be complicit or silent against racism. We are committed to identify and unlearn dominant narratives in the child welfare and other child and family serving systems.

5. **We need to validate and affirm members of our communities.**

We must do our absolute best to validate and affirm members of our community by ensuring that their voices are heard and valued. As a Council, it is our responsibility to actively elevate the voices of those unheard and marginalized by systems and structures. Silence normalizes oppression, bias, and other systemic issues, and as an entity committed to creating change in our society, we will not be silent. Until African American, Black, Indigenous, and People of Color communities are seen, heard, and valued, our work is not done.

6. **White Supremacy Exists**

White supremacy, white supremacy culture, and white privilege are prevalent today despite some advancements towards racial equity. The United States remains deeply embedded with the historical legacy of visible and invisible racist structures, policies and ideas. White people enjoy unfair advantages but are not a superior race and should not dominate society or serve as the standard of acceptability. We believe that equity is paramount.

7. **Acknowledgment**

SCCAN admits that while recommendations and advocacy efforts have been well-intended, we have not viewed our systems recommendations through an actively antiracist lens and towards antiracists solutions. We challenge and encourage our members and partners in child welfare and other child and family serving systems to address racist ideas and policies that perpetuate inequities.

8. **Reconciliation and Forward Progress**

SCCAN will hold itself accountable for promoting antiracist policies and ideas in child welfare and other child and family serving systems and commits to:

1. Recruit, interview and recommend to the Governor for appointment only individuals who have read, understood, and are committed to our antiracist statement. The interview process will consist of questions related to an understanding of the statement.
2. Ensure broader and consistent outreach to increase engagement in SCCAN's education and advocacy efforts and in order to recruit a more diverse membership.

3. Deliberately establish meaningful relationships and dialogue with impacted communities in order to inform our recommendations and advocacy efforts.
4. Actively build the knowledge, skills, and resources of Council members and partner organizations to increase equitable outcomes for all children and families.
5. Draft and review all recommendations to the Governor and General Assembly to ensure the recommended policy improvements address racial inequities.
6. All legislative proposals submitted for consideration of support by the Council must include information about racial impact and be reviewed by the Council using a racial equity lens.
7. Engage with our members and partners to exercise our collective influence with decision makers to promote antiracist ideas and policies, racial equity and develop antiracist solutions.

SCCAN's Antiracist Statement is a living document. We are committed to regular reviews and consistent accountability.

APPENDIX K

SCCAN ACHIEVING RACIAL EQUITY WORKGROUP

RESOURCES ON RACISM, RACIAL EQUITY AND CHILD WELFARE*

ORGANIZATIONS

- childwelfare.gov
- State Automated Child Welfare Information Systems (SACWIS)
- The Casey-CSSP Alliance for Racial Equity
- ABA https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/january---december-2019/race-and-poverty-bias-in-the-child-welfare-system---strategies-f/
- Implicit Association Test American Bar Association: https://www.americanbar.org/groups/litigation/initiatives/task-force-implicit-bias/implicit-bias-test/

RESOURCES ON RACIAL EQUITY

- Racial Equity Discussion Guide
- 3 Tools for Getting Started with the Race Matters Toolkit
- Continuum on Becoming an Anti-Racist Multicultural Organization
- [Infographic] Promoting Racial Equity Through Workforce & Organizational Actions
- NCWWI Innovations Exchange 2: Inclusivity, Racial Equity, and Community Engagement
- Racial Disproportionality and Disparity in Child Welfare
- [1-Pager] Microaggressions in the Child Welfare Workplace
- [1-Pager] Addressing Racial Disparity in Foster Care Placement
- Staff Core Competencies for Working to Achieve Racial Equity
- Implicit Bias in the Child Welfare, Education and Mental Health Systems
- Race Equity and Inclusion Action Guide
- Five guiding principles for integrating racial and ethnic equity in research
- AWAKE to WOKE to Work: Building a Race Equity Culture
- Tribal sovereign status: Conceptualizing its integration into the social work curriculum
- Communities Creating Racial Equity: Ripple Effects of Dialogues to Change

HUBS

National Association of Counsel for Children, Race Equity Hub

TOOLKITS

CASA Anti Racism Toolkit: https://marylandcasa.org/antiracism-toolkit/?emci=70d65f12-660d-eb11-96f5-00155d03affc&emdi=89a70bc9-140e-eb11-96f5-00155d03affc&ceid=3284581

[Type here]

WEBINARS

ABA WEBINAR 9-16-20

https://imprintnews.org/opinion/sad-omission-child-welfare-mainstream-discussion-race/46315

https://youthtoday.org/2020/02/mandatory-child-abuse-reporting-belongs-in-dustbin-new-research-makes-clear/

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2924920

https://drive.google.com/file/d/0B291mw_hLAJsUlRxVnB0SDlOUnM/view

https://www.nccprblog.org/2020/06/child-welfare-responds-to-racism-in.html

https://eastbayfamilydefenders.org/ebfd-founding-defense-parent-advocate-honored-with-2020-casey-excellence-for-children-award/

http://harvardlawreview.org/wp-content/uploads/2019/04/1695-1728_Online.pdf

American Bar Association- A Conversation about the Manifestation of White Supremacy in the Institution of Child Welfare Level 2
https://americanbar.zoom.us/webinar/register/WN_2jzyQQOFS4SnDnd1Ez_-3Q

VIDEOS & DOCUMENTARIES

Race: The Power of an Illusion Documentary This three-part documentary by California Newsreel is important for understanding the history of racialization in America and how racial categories came about that we often innacurately equate with biology. InterVarsity has purchased the rights to stream this documentary online for three years.

https://socialimpactexchange.org/initiative/2020-exchange-conference/#blackwell

To transform child welfare, take race out of the equation (Jessica Pryce | TED Residency)

https://www.ted.com/talks/jessica_pryce_to_transform_child_welfare_take_race_out_of_the_equation?utm_source=tedcomshare&utm_medium=email&utm_campaign=tedspread

Redlining Video from Dr. Fletcher's presentation:
https://www.youtube.com/watch?v=ETR9qrVS17g&feature=emb_logo

ARTICLES AND CITATIONS

Strategies to Reduce Racially Disparate Outcomes in Child Welfare
https://files.eric.ed.gov/fulltext/ED561817.pdf

Racial Disproportionality and Disparity in Child Welfare
https://www.childwelfare.gov/pubpdfs/racial_disproportionality.pdf

Strategies for Reducing Inequity
https://www.childwelfare.gov/topics/systemwide/cultural/disproportionality/reducing/

Achieving Racial Equity

https://cssp.org/wp-content/uploads/2018/08/achieving-racial-equity-child-welfare-policy-strategies-improve-outcomes-children-color.pdf

White Privilege and Racism in Child Welfare

http://cascw.umn.edu/wp-content/uploads/2013/12/WhitePrivilegeSubSum.pdf

Race and Poverty Bias in the Child Welfare System: Strategies for Child Welfare Practitioners

https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/january---december-2019/race-and-poverty-bias-in-the-child-welfare-system---strategies-f/

Institutional racism in child welfare
https://www.sciencedirect.com/science/article/abs/pii/S1090952404000403

Minority Children and the Child Welfare System: An Historical Perspective

https://academic.oup.com/sw/article-abstract/33/6/493/1941010

Systematic Inequality and Economic Opportunity
https://www.americanprogress.org/issues/race/reports/2019/08/07/472910/systematic-inequality-economic-opportunity/

Systemic Inequality: Displacement, Exclusion, and Segregation
https://www.americanprogress.org/issues/race/reports/2019/08/07/472617/systemic-inequality-displacement-exclusion-segregation/

A new take on the 19th-century skull collection of Samuel Morton
https://www.sciencedaily.com/releases/2018/10/181004143943.htm

Race and Class in the Child Welfare System
https://www.pbs.org/wgbh/pages/frontline/shows/fostercare/caseworker/roberts.html

Poverty, Homelessness, and Family Break-Up

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5760188/

Implicit Bias in the Child Welfare, Education and Mental Health Systems
https://youthlaw.org/publication/implicit-bias-in-the-child-welfare-education-and-mental-health-systems/

"This link has very helpful video resources and other advocacy tools for racial justice work: And this webpage has many resources

https://www.futureswithoutviolence.org/health/racism/

The link to Cracking the Codes of Racial Inequity is the one I referenced with a discussion guide."

BOOKS

Race Matters in Child Welfare: The Overrepresentation of African American Children in the System - by Dennette M. Derezotes (Editor), John Poertner (Editor), Mark F. Testa (Editor)

Shattered Bonds: The Color Of Child Welfare Paperback – by Dorothy Roberts

Stamped: Racism, Antiracism, and You, A Remix of the National Book Award-Winning Stamped from the Beginning, by: Jason Reynolds, Ibram X. Kendi

Post Traumatic Slave Syndrome https://www.joydegruy.com/post-traumatic-slave-syndrome

22 books on race and white privilege that will show you what's really happening in America right now

https://www.businessinsider.com/books-white-privilege-novels-racism-antiracism-black-scholars-2020-6#white-fragility-why-its-so-hard-for-white-people-to-talk-about-racism-by-robin-diangelo-3

Racial Equity and Housing Justice During and After COVID-19

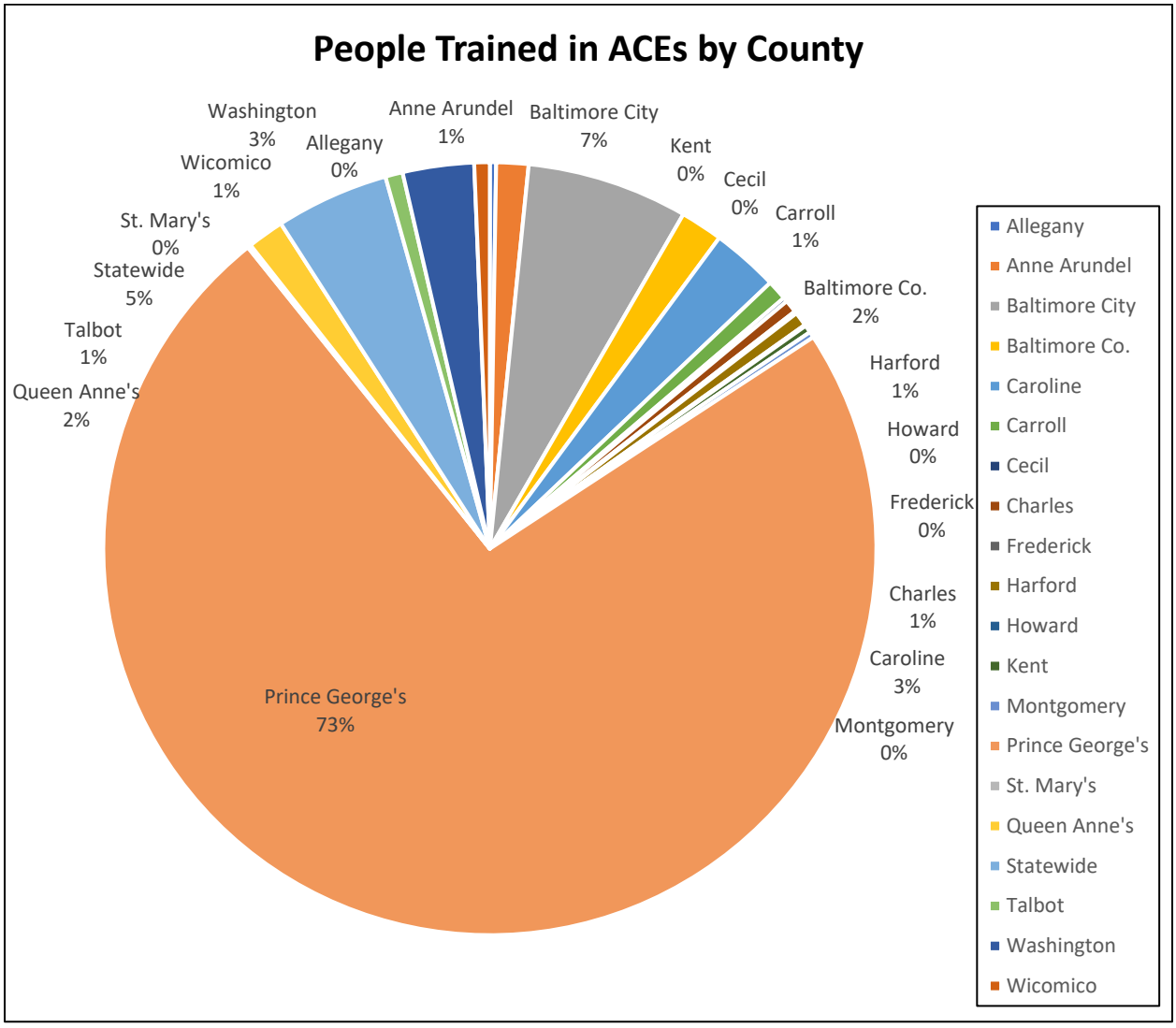
Ta-Nehisi Coates is a distinguished writer in residence at NYU's Arthur L. Carter Journalism Institute. He is the author of the bestselling books *The Beautiful Struggle*, *We Were Eight Years in Power*, and *Between The World And Me*, which won the National Book Award in 2015. Ta-Nehisi is a recipient of a MacArthur Fellowship. He is also the current author of the Marvel comics *The Black Panther* and *Captain America*.
As an author and thought leader, Ta-Nehisi has been a vital voice in shaping the discourse on race in the United States and globally. His seminal article in *The Atlantic*, "The Case for Reparations," discusses thirty-five years of racist housing policy that led to the inequities still plaguing housing in the U.S. Please join us for this conversation with Ta-Nehisi Coates on "Racial Equity and Housing Justice During and After COVID-19" on October 6 at 1 pm ET. Register at: https://bit.ly/32yRqi6

**This list contains a few resources. The resources are as expansive and complex as the subject matter.*

APPENDIX L

ACE Interface Training Locations by Maryland County

Between December 2017 and November 2021 ACE Interface Master Trainers have given 390 ACE Interface presentations to more than 24,883 attendees across all of Maryland's 24 jurisdictions. The graphs below show the percentage of trainings by number of people trained and number of trainings per jurisdiction.



Sponsored By: The Family Tree

MARYLAND essentials for childhood

SCCAN Maryland's State Council on Child Abuse & Neglect

APPENDIX M

Select strategic ACE Interface Presentations

January 2020-November 2021 included:

2020 Tuerk Conference on Mental Health and Addiction Treatment

2021 Healing City Baltimore Summit

2021 Healthy St. Mary's Partnership Annual Meeting

2021 Maryland CASA's 14th Annual Conference on Child Well-Being-Roads to Resilience

2021 Maryland Office of the Public Defender (MOPD) Conference

2021 Maryland Violence and Injury Prevention Conference

Aetna Better Health of Maryland

Amerigroup Maryland Incorporated

Anne Arundel County Maryland WIC Program

Baltimore County Public Schools

Boys and Girls Clubs of Maryland

Citizens Review Board for Children

Enoch Pratt Library

Fallston Volunteer Fire and Ambulance

Frederick Police Department

Harford County Council

Harford County Sheriff's Office

Leadership Southern Maryland

Maryland Coalition of Families

Maryland Department of Health LEAD Partners

Maryland Department of Rehabilitation Services (DORS)

Maryland Office of Administrative Hearings

Maryland Rural Opioid Training Assistance (MD ROTA)

Maryland State Department of Education

McDaniel College

Office of the State's Attorney for Anne Arundel County

Prince George's County Public Schools

Talbot County Department of Social Services

United States Department of Health and Human Services (HRSA), Federal Office of Rural Health Policy

Washington County Anti-Human Trafficking Collaborative

Weave: The Social Fabric Project- The Aspen Institute

Wicomico County Department of Social Services

Wicomico County Health Department

Wicomico Partnership for Families and Children

Youth Empowerment Source

Potential HealthySteps Financing Opportunities

HealthySteps National Office Policy and Finance Team

To ensure positive health and development of young children, the child-caregiver relationship and the caregiver's well-being must be foci of primary care interventions during early childhood. Evidence-based dyadic models, such as HealthySteps, have shown effectiveness in employing this two-generation lens to mitigate the effects of trauma and adverse childhood experiences, address social determinants of health, and support behavioral health prevention and connection to needed treatment through team-based integrated pediatric primary care.

State Medicaid agencies are finding innovative ways to support dyadic integrated pediatric primary care models by utilizing new billing codes, allowing flexibilities in how codes are used, and exploring the use of alternative payment models to support team-based care. Below are recommendations and examples of how states reimburse and provide funding for HealthySteps services under Medicaid. There are variations between state Medicaid agencies and benefits that would impact how these approaches could be implemented by state Medicaid agencies, possibly in partnership with Medicaid managed care organizations (MCOs) and other types of payers.

Billing and Coding Approaches

HealthySteps has eight core components as highlighted below.

In order to support ongoing sustainability of the model, states have used fee-for-service reimbursement opportunities to cover some of the model's core components and related services – a HealthySteps Specialist's salary and benefits are the main ongoing costs of implementing the model. Below are examples of ways states have provided payment for HealthySteps services by increasing billing opportunities.

Reimbursement for Ongoing Preventive Team-Based Well-Child Visits

HealthySteps Specialists are pediatric behavioral health professionals, available to address developmental and behavioral health concerns as soon as they are identified, bypassing the many obstacles families face when referred to external behavioral health services. HealthySteps Specialists provide services and supports for children in the context of the family so that caregivers' behavioral health and social needs are also addressed in the universally accessed pediatric primary care setting.

State Medicaid agencies could establish a diagnosis and procedure code that would capture and allow payment for a pediatric primary care preventive dyadic behavioral health visit.

Examples:

- San Francisco Health Plan (California) is now allowing credentialed behavioral health providers (including HealthySteps Specialists) to submit a Z-code (including Z00.11, Z00.12) as the primary ICD-10 code attached to any allowable CPT code, for a preventive behavioral health well-child visit. This is critically important, providing a mechanism for payment for prevention. The encounter can be paired with a physical health well-child visit occurring at the same time (e.g., a HealthySteps Tier 3 visit).
- California Medicaid (Medi-Cal) is exploring the potential to open HCPCS code H0025 (behavioral health prevention education service) for the reporting of preventive behavioral health well-child visits. This would establish a new statewide Medicaid benefit, circumventing the need for individual Medicaid MCOs to create their own billing pathways.
- A Colorado Medicaid payment pilot focuses on the use of H0025 for preventive psychosocial education services provided during well-child visits. Several HealthySteps sites are participating (including an FQHC) and using the enhanced payment to fund up to the full costs associated with HealthySteps Specialists' salaries.
- Ohio Medicaid is allowing reimbursement under a pilot program for preventive medicine counseling codes 99402-99404, with ICD-10 code Z71.89 (persons encountering health services for other counseling and medical advice, not elsewhere classified), when billed by a psychologist in 15-minute increments as part of a HealthySteps encounter. This is important because it creates a new payment pathway that recognizes the value HealthySteps Specialists can provide to families during brief interventions. With the addition of these codes, overall billing reimbursement is sufficient to cover the costs associated with HealthySteps Specialists' salaries.

Reimbursement for Child Development and Behavior Consults

Fortunately, the vast majority of young children do not qualify for a diagnosable behavioral health disorder. However, as a result, most dyadic health care services delivered by a behavioral health clinician in the pediatric setting are not reimbursable in the traditional health care delivery system.

Medicaid agencies could allow reimbursement for family therapy visits (90846, 90847, 90849) without a diagnosis or with a diagnosis of "at-risk" using social determinants of health Z-codes to support dyadic behavioral health interventions that take place within the pediatric primary care setting.

Examples:

- Medi-Cal recently expanded its family therapy benefit:
  - Recipients under age 21 who have risk factors for mental health disorders are eligible for family therapy (with no session limits).
    - Child risk factors include: separation from a parent/guardian due to incarceration or immigration, death of a parent/guardian, foster home placement, food insecurity, housing instability, exposure to domestic violence or other traumatic event, maltreatment, severe and persistent bullying, experience of discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences or disability.
    - Parent risk factors include: a serious illness or disability, a history of incarceration, depression or other mood disorder, PTSD or other anxiety disorder, psychotic disorder under treatment, substance use disorder, a history of intimate partner violence or interpersonal violence, or a teen parent.
- In July 2018, Colorado Medicaid created a new billing pathway for primary care based behavioral health services – a behavioral health diagnosis is not required, however, providers must use the most appropriate diagnosis supporting medical necessity. Behavioral health providers can bill Medicaid for short-term therapeutic services delivered in the primary care setting (up to six visits per year using a set of specific codes).
- In Philadelphia, behavioral health consultants working in FQHCs are reimbursed through the behavioral health MCO with the use of a non-specific diagnosis code as primary (R69-Illness, unspecified) and the following SDOH Z-codes as secondary:

Z55.9	Academic or education problem
Z60.3	Acculturation difficulty
Z60.4	Social exclusion or rejection
Z60.5	Target of (perceived) adverse discrimination or persecution
Z62.29	Upbringing away from parents
Z62.820	Parent-child relational problem
Z62.891	Sibling relational problem
Z62.898	Child affected by parental relationship distress
Z63.4	Uncomplicated bereavement
Z63.5	Disruption of family by separation or divorce
Z63.8	High expressed emotional level within family
Z64.0	Problems related to unwanted pregnancy
Z69.010	Encounter for mental health services for victim of child abuse by parent
Z69.010	Encounter for mental health services for victim of child neglect by parent
Z69.010	Encounter for mental health services for victim of child psychological abuse by parent
Z69.010	Encounter for mental health services for victim of child sexual abuse by parent
Z69.020	Encounter for mental health services for victim of non-parental child abuse
Z69.020	Encounter for mental health services for victim of non-parental child neglect
Z69.020	Encounter for mental health services for victim of non-parental child psychological abuse
Z69.020	Encounter for mental health services for victim of non-parental child sexual abuse

Z70.9	Sex counseling
Z71.9	Other counseling or consultation
Z72.810	Child or adolescent antisocial behavior

Reimbursement for Child and Family Needs Screenings

In order to support increased compliance with the American Academy of Pediatrics Bright Futures screening schedule, state Medicaid agencies could allow separate reimbursement for developmental screenings (96110), patient/caregiver focused health risk assessments (96160/96161), and maternal depression screenings (G8510, G8431, 96127) above the rate for a well-child visit.

Examples:

- The following 23 states reimburse for the CPT code 96110 for developmental screenings, separate from the well-child visit rate: Alaska, Delaware, Idaho, Iowa, Kansas, Kentucky, Massachusetts, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Vermont, Virginia, West Virginia, Wisconsin, and Wyoming.
- Colorado allows CPT code 96127 (Social-Emotional Screening) to be used for the billing of Autism screenings when the CPT code 96110 (Developmental Delay Screening) is reported on the same day of service, for a different screening (e.g., the ASQ). This allows the state to capture and reimburse for all screenings rendered on the same date of service.
- New York reimburses for 96160 and 96161 (health risk assessments) to reimburse providers for patient- and caregiver-focused ACEs screenings.
- California reimburses providers for completing ACEs screenings with children and adults through G9919 (positive screen with patient score of 4 or greater) and G9920 (negative screen with patient score of 0 to 3).
- Many states require or recommend screening and separate reimbursement for maternal depression screenings, utilizing CPT codes 96160 (Nevada) and 96161 (Michigan, Mississippi, South Carolina, Vermont, Washington, etc.).
- New York, California, and Colorado also allow billing for separate reimbursement for maternal depression screening, utilizing CPT codes G8510 (negative depression screening) and G8431 (positive depression screening). Colorado reimburses more for a positive screen because it requires additional follow-up.
- Minnesota allows reimbursement for up to six maternal depression screenings for each child who is less than 13 months old. The screens are also valid for paternal depression screening.

Reimbursement for Care Coordination and Systems Navigation

Care coordination and systems navigation are key components of integrated primary care. Reimbursing for the time spent by the HealthySteps Specialist helping connect families to needed services and supports that can address social determinants of health and behavioral health needs is a critical component of addressing overall health and well-being for the child and caregiver. Reimbursing for case management code 99484 for use in primary care is an opportunity to advance the goal of integrated physical and behavioral health.

Example:

- New York will reimburse for general behavioral health integration, including non-physicians, for services rendered within a month using 99484 (care management for a behavioral health condition for at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month). It allows for the work of clinical staff time, supervised by either a physician, psychologist or licensed clinical social worker, to be integrated into the time and care that is incorporated into this reimbursable code.
- California Medicaid is considering the use of case management code T1016 to provide reimbursement for the HealthySteps Specialist's time providing care coordination and systems navigation. The Medicaid definition of covered case management services for this code includes services to help beneficiaries gain access to needed medical, social, educational, and other services.

An Alternative Payment Model Approach

The HealthySteps National Office recently developed a framework to support states, MCOs, health systems, and providers in developing an alternative payment model (APM) that supports a payment and measurement structure based on the dyadic HealthySteps model. Three elements of HealthySteps make it well-positioned for an APM: 1) a clear set of eight core components organized into three service delivery tiers, 2) a robust evidence-base with demonstrated dyadic outcomes, and 3) quantifiable, annualized cost savings to state Medicaid agencies. Additionally, National Office fidelity monitoring ensures that all eight core components of the model are delivered as intended within three years of initial implementation. An APM could provide a flexible payment to providers that can support all HealthySteps core components (including those core components for which a fee-for-service reimbursement is not currently available such as the child development support line, positive parenting guidance and information, and early learning resources).

Payment

While there are many different approaches states and payers can consider when developing an APM for a pediatric primary care prevention program like HealthySteps, the framework recommends a specific payment structure which can be customized to align with site/state specific initiatives. The National Office recommends a phased approach that initially utilizes fee-for-service payments to allow time for data collection and infrastructure-building to help inform the structure of a longer-term APM payment.

Phase I:

The payment structure proposed for Phase I includes support for initial costs incurred by a participating HealthySteps site, and fee-for-service payments to support key program elements that are not traditionally reimbursable through state Medicaid programs:

Initial payment: A one-time payment to HealthySteps sites to support infrastructure costs such as enhanced electronic health record capacity to track universal screenings and referral follow up, provide additional data

supports, and bolster practice transformation efforts – all necessary components to operationalize a new model of care.[1]

Reimbursement for universal screenings: Separate payments to providers for each administered child, caregiver, and family-focused (health related social needs and SDOH) universal screening, all recommended by the AAP Bright Futures Guidelines. Reimbursement for each screening is critical to ensure screenings are completed, child/family needs are addressed, and utilization data is collected to help inform a future capitated payment.

Separate reimbursement for dyadic prevention, short-term behavioral health interventions, and care coordination services using expanded billing/coding opportunities: Many of these services are not currently reimbursed by state Medicaid agencies and MCOs without a patient diagnosis. Using innovative fee-for-service-based payment approaches to support the delivery of these services in pediatric primary care provides an opportunity to gather cost and utilization data to inform a more comprehensive payment in Phase II to more broadly encompass the dyad.

Examples of how payers can separately reimburse for dyadic prevention, short-term behavioral health interventions, and care coordination services include:

- Reimbursement for H0025 (preventative psychosocial intervention) to enable delivery and payment of behavioral health prevention education services. H0025 would allow behavioral health clinicians to provide behavioral health well-child visits aligned with medical well-child visits and would achieve parity for preventive/surveillance behavioral health services. H0025 could be used with a Z03.89 diagnosis deferred or alternatively a well-child visit code or behavioral health modifier to indicate a team-based well-child visit was conducted.

- Allow codes and established at-risk conditions to be used as the primary diagnosis for short-term behavioral health prevention services (e.g., family therapy CPT codes 90846 and 90847) targeting dyadic behavioral health services (including caregiver(s) and overall family well-being).

- Reimburse for 99484 when billed by a behavioral health provider for care coordination services using Z-codes as the primary diagnosis.

Phase II:

Fee-for-service-based payments made in Phase I would be used to inform a Phase II payment. Phase I payments would end once sufficient data is collected. Utilization data gathered on services provided and reimbursed in Phase I should be used to build a capitated payment. The *per member per month (PMPM)* payment should be *comprehensive, age-based, and risk-stratified (based on the HealthySteps model service tiers),* covering the provision of universal screenings by the practice and Tier 2 and Tier 3 services provided by the HealthySteps Specialist, including health promotion, interdisciplinary team-based well-child visits, care coordination, and preventive behavioral health services based on family needs.

Other potential payment options that could be implemented in Phase II include:

[1] This payment does not cover the cost of the one-time HealthySteps Institute for new sites and associated salary and fringe benefit costs of the HealthySteps Specialist(s).

- *Performance incentive payments:* Incentives and rewards for high-performance on quality metrics as determined by the state and/or payer (recommended quality measures are outlined below).

- *Shared savings:* Practices can share in demonstrated cost-savings calculated using the Manatt Health short-term cost-savings model, matched against Medicaid claims data.

Who Would the APM Serve?

The framework is designed to apply to all children ages birth to three in a primary care practice and their caregivers. Within the HealthySteps model, children/families are risk-stratified based on their needs. Children with significant medical complexity and/or special health care needs are not included in the proposed APM framework; however, it could be customized to develop an APM for a specific population such as children with special health care needs. The framework is also designed to be implemented in practices that employ a licensed behavioral health clinician as the HealthySteps Specialist (e.g., licensed clinical social worker, child psychologist, etc.), allowing for the delivery of short-term behavioral health interventions to children and caregivers in the primary care setting as needs are identified.

What Needs Are Addressed By the APM?

Child well-being:

- Preventive health care
- Development
- Social-emotional and behavioral health
- Early learning
- Positive parenting
- Oral health
- Early nutrition

Caregiver well-being:

- Breastfeeding
- Maternal mental health
- Access to preventive health care
- Healthy birth spacing
- Tobacco use

Family well-being:

- Health related social needs influenced by social determinants of health (SDOH) (e.g., intimate partner violence, food insecurity, housing stability, transportation needs, and substance use)

What Outcome Areas Will the APM Aim to Affect?

Improved health of the population:

- Well-child visit frequency
- Childhood immunization

- Developmental screening
- Social-emotional/behavioral screening
- Screening for social needs related to SDOH
- Closed-loop referrals
- Pediatric oral health
- Postpartum care
- Postpartum maternal depression

Improved patient experience of care:

- Patient satisfaction

Improved clinical experience:

- Provider satisfaction

Decreased total cost of care related to:

- Well-child visit and immunization rates
- Pediatric oral health
- Appropriate use of outpatient and emergency services
- Breastfeeding
- Postpartum maternal depression
- Intimate partner violence
- Healthy birth spacing
- Smoking cessation

Why Design an APM for HealthySteps?

Now, more than ever, with the impacts of the COVID-19 pandemic and subsequent economic downturn, states and health plans have an opportunity to achieve the quadruple aim of improving outcomes for young children, caregivers, and their families, saving money, and increasing patient and provider satisfaction by creating a true population health focused APM for young children. By explicitly focusing on prevention, screening and follow-up, and trusted relationships, the HealthySteps model can help create the foundation for creating an innovative, dyadic and early childhood pediatric primary care APM.

APPENDIX O

APPENDIX TO

Toward a More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient Communities, 2019

STATE LEGISLATIVE STRATEGIES TO PREVENT & MITIGATE ACES*

This document is a 2020-2021 update of the appendix to the legislative brief "Toward a More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Community Resilience", 2019. The legislation below has been compiled to demonstrate the range of approaches being utilized across the nation to prevent and mitigate ACEs, and to serve as food-for-thought for how legislators can move forward in addressing ACEs strategically. As such, individual pieces of legislation presented here are not necessarily endorsed by the authors of this document.

Section A of this document shows Maryland's and other states' developments across six different legislative mechanisms used to advance the science of ACEs and resilience within policy-making. These six mechanisms are:

1. Joint Resolutions and Executive Orders establishing statewide policy on ACEs
2. Funding for primary prevention of ACEs
3. ACE- or trauma-informed caucuses
4. ACE task forces/workgroups
5. Creation or use of an existing coordinating body for cross-sector collaboration
6. Collection and analysis of ACE related data

Section B of this document presents Maryland's and other states' policy developments across the CDC's "Six Research-Informed Policy Strategies to Prevent and Mitigate ACEs." These six policy strategies are:

1. Strengthen economic supports for families
2. Promote social norms that protect against violence and adversity
3. Ensure a strong start for children
4. Teach skills to caregivers, children, and youth
5. Connect children and youth to caring adults and activities
6. Intervene to lessen immediate and long-term harms of ACEs.

SECTION A: CREATING INFRASTRUCTURE TO TACKLE ACEs - FIVE LEGISLATIVE MECHANISMS

I. JOINT RESOLUTIONS & EXECUTIVE ORDERS ESTABLISHING STATEWIDE POLICY ON ACES

MGA COMMITTEE: Joint Committee on Children Youth & Families | All Standing Committees

Rationale: While resolutions may not require specific action, recognition by federal, state, and local legislative bodies increases awareness of ACEs in households, communities, and the government alike. This is a crucial step in getting the science into the hands of the general public, in developing innovative legislative strategies to prevent and mitigate ACEs, and in creating a system of public services that is ACE-Trauma-& Resilience- Informed.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
JOINT RESOLUTIONS ESTABLISHING STATEWIDE POLICY ON ACES	Governor's Executive Order 01.01.2021.06	*Passed:* Alaska: HCR 21 (2016). Urges Governor Bill Walker to join with the Alaska State Legislature to respond to the public and behavioral health epidemic of adverse childhood experiences by establishing a statewide policy and providing programs to address this epidemic. S105 (2018). Revises licensure of marital and family therapists and creates a state policy directive that "policymakers, administrators, and those working within state programs and grants make decisions based on the principles of early childhood and youth brain development and, whenever possible, consider the concepts of early adversity, toxic stress, childhood trauma, and the promotion of resilience through protective relationships, supports, self-regulation, and services." California: CA ACR 140 and CA ACR 145 (2020) Designates the month of January 2020 as Positive Parenting Awareness Month In California, and proclaims January 23, 2020 as Maternal Health Awareness Day, to recognize that positive parenting can prevent or mitigate the effects of adverse childhood experiences and to draw attention to the efforts that have improved maternal health in the state. ACR155 (2014) Recognizes ACEs and urges Governor to identify evidence-based solutions to reduce exposure to ACEs, address the impacts of ACEs, and invest in prevention of ACEs. And, ACR 235 designates a specified date as Trauma Informed Awareness Day, in conjunction with National Trauma Informed Awareness Day, to highlight the impact of trauma and the importance of prevention and community resilience through trauma informed care. Minnesota: HF892/SF1204 (2015) "Resolution on Childhood Brain Development and ACEs". Calls on the Governor to create a cross-sector task force and to support a voluntary tax checkoff on the income tax return form, other dedicated appropriations, or other state

		resources designated for child abuse prevention services with a percentage set aside for program evaluation. New Jersey: SCR100, (2019). Urges Governor to develop strategies to reduce children's exposure to ACEs. Utah: Concurrent Resolution 10 (2017), "Identification and Support of Traumatic Childhood Experiences Survivors". Encourages state officers, agencies, and employees to become informed regarding well-documented detrimental short-term and long-term impacts to children and adults from serious traumatic childhood experiences; and to implement evidence-based interventions and practices that are proven to be successful in developing resiliency in children and adults currently suffering from trauma-related disorders. Wisconsin: SJR59 (2013) Recognizes the effects of ACEs and resolves that the legislature will consider principles of early childhood brain development, toxic stress, adversity, buffering relationships, and the importance of early intervention when creating policy. SJR59 (2013) Recognizes the effects of ACEs and resolves that the legislature will consider principles of early childhood brain development, toxic stress, adversity, buffering relationships, and the importance of early intervention when creating policy. SJR59 (2013) Recognizes the effects of ACEs and resolves that the legislature will consider principles of early childhood brain development, toxic stress, adversity, buffering relationships, and the importance of early intervention when creating policy. *Executive Orders:* Delaware: Executive Order 24 (2018), "Making Delaware a Trauma-Informed State." Declares Delaware a trauma informed state and recognizes the significance of early intervention for children and caregivers exposed to ACEs. *Proposed Policies*: Michigan: MI HCR 2 (2020) Would declare Adverse Childhood Experiences a critical health issue, commits the Legislature to action and encourages the governor to direct agencies to assess and report progress on reducing ACEs.

II. FUNDING FOR PRIMARY PREVENTION OF ACES

MGA COMMITTEE: Appropriations | Budget & Taxation | Finance

Rationale: Most states across the country have developed robust prevention trust funds with combined annual revenues in excess of $100 million dedicated to prevention. Robust Funds generate $1-18 million annually from the corpus of their Funds. Children's Trust Fund Boards actively raise funds to support statewide prevention efforts. This is a gap in Maryland's infrastructure to support prevention.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
CHILDREN'S PREVENTION TRUST FUNDS	Maryland Code, Health General, Sec. 13-2207, (2010) Established Maryland's Children's Trust Fund.	Hawaii: HI Rev Stat § 350B-4 (2016). Kansas: Children's Trust Fund Statute. Massachusetts: S2130, General Laws Sec. 202 (1987) and Sec. 50. Oklahoma: Act No. 231 (2018). Creates the Children's Endowment Fund to stimulate new programs, activities, research or evaluation that will improve the well-being and reduce the ACEs of Oklahoma's children. South Carolina: SC Code § 63-11-910 (2012) through SC Code § 63-11-960. *Proposed Amendments to current Trust Funds:* Colorado: H1044 (2018). Would amend current statutory language in the ""Colorado Children's Trust Fund Act"" to place a greater priority on preventing child maltreatment fatalities and continuing to prevent child maltreatment. This includes reducing the occurrence of prenatal drug exposure and drug endangerment and reducing the occurrence of other adverse childhood experiences.
APPROPRIATE FUNDING FOR STATE & LOCAL ACE INITIATIVES ***"Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings"***[1]		*Passed:* Washington RCW 70.190.010 (1994.) Establishes the Washington Family Policy Council to facilitate services at the local level. Despite significant improved outcomes for children and families, this program was eliminated during the Great Recession.
APPROPRIATE FUNDING FOR ACE EVIDENCE BASED PROGRAMS (EBPs) AND INNOVATION		*Passed:* California S1004 (2018). Provides that the Mental Health Services Oversight and Accountability Commission, on or before January 1, 2020, will establish priorities for the use of

		prevention and early intervention funds. These priorities will include childhood trauma prevention and early intervention to address the early origins of mental health needs. A1812 (2018). Establishes the Youth Reinvestment Grant Program. Provides funds to local jurisdictions and Indian tribes for the implementation of trauma-informed diversion programs for minors. Indiana H 766 (2019) Appropriates $40,000 to support the Iowa effort to address the needs of children who experience adverse childhood experiences. Pennsylvania: S1142 (2018). Establishes the School Safety and Security Grant Program and related Fund. Funds can be used for the administration of evidence-based screenings for adverse childhood experiences and to provide trauma-informed counseling services as necessary to students based upon screening results. Washington S 6259 (2020) Improves the Indian behavioral health system, revises provisions relating to the Indian Health Improvement Reinvestment Account, requires funds in the Account to be expended on programs that address the ongoing suicide and addiction crisis among American Indians and Alaska Natives. *Proposed Policies:* Colorado: S10 (2019). Would allow grant funds to be used for behavioral health care services, including services to support social-emotional health, at recipient schools or through service contracts with community providers.

III. ACE or TRAUMA-INFORMED CAUCUS

MGA COMMITTEE: Joint Committee on Children Youth & Families | All Standing Committees

Rationale: ACEs, Trauma-Informed, or Children's Caucuses have been developed to cultivate a legislature dedicated to advancing NEAR Science promising and evidence-informed public policy that improves the life of every child, from the prenatal stages through young adulthood.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE

ACE OR TRAUMA-INFORMED CAUCUS		Hawaii: Keiki (Children) Caucus, 2019. The Legislative Keiki Caucus is sponsoring 24 senate and house bills focusing on the education, health and well-being of children in Hawai'i. Wisconsin: https://legis.wisconsin.gov/topics/childrenscaucus/. The caucus was founded in 2015 in a joint effort to create a sustainable forum to educate legislators and build bi-partisan support for promising, evidence-informed investments in children and families.

IV. ACE TASK FORCES/WORKGROUPS

MGA COMMITTEE: Joint Committee on Children Youth & Families | All Standing Committees

Rationale: Policy-related Task Forces and Workgroups operate to review and analyze the research, both scientific and policy, to develop coordinated and strategic policy recommendations to address ACEs as a public health epidemic.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
ACE/ TRAUMA- INFORMED TASK FORCES ***"Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings"***[2]	State Council on Child Abuse and Neglect (SCCAN) focuses its' efforts and recommendations on ACEs. *Passed:* SB 567 (2019). Establishes a Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations. Requires the Workgroup to study available science and best practices pertaining to children in traumatic situations, including trauma-informed decision making. and make	*Passed:* Illinois H2649 (2019.) Amends the Code of Criminal Procedure, creates the Task Force on Children of Incarcerated Parents, provides that the Task Force shall review available research, best practices, and effective interventions to formulate recommendations. Maine Act 63 (2019). Convenes a task force to develop guidance for kindergarten-12th grade educators and administrators on appropriate training for and responses to addressing childhood trauma, including ACEs training, trauma informed care, health screenings, and a social-emotional curriculum from K-8th grade. H 851 (2019.) Directs the Commissioner of Education to convene a task force, inviting the participation of experts and interested parties, to develop guidance for kindergarten to grade twelve administrators on appropriate training and responses to childhood trauma. ME H 851 (2019) Directs the Commissioner of Education to convene a task force, inviting the participation of experts and interested parties, to develop guidance for kindergarten to grade twelve administrators on appropriate training and responses to childhood trauma.

	recommendations about how State courts could incorporate the science into child custody proceedings. HB 548 (2021). Establishes the Commission on Trauma Informed Care Task Force to coordinate a statewide initiative to prioritize trauma-response informed delivery of State services that affect children, youth, families, and older adults. Requires the Commission to study developing a process and framing for implementing an Adverse Childhood Experiences (ACEs) Aware Program in the State.	New Hampshire H 111 (2019) Establishes a committee to study the effect of the opioid crisis, substance misuse, adverse childhood experiences, and domestic violence as a cause of post-traumatic stress disorder syndrome, and other mental health and behavioral problems in children and students. Oklahoma Act 112 (2018). Establishes the Task Force on Trauma-Informed Care to identify, evaluate, recommend, maintain, and update a set of best practices for youth who have experienced/ are at risk of experiencing trauma (ACEs). Vermont No.42 (2017). "An Act Relating to Building Resilience for Individuals Experiencing Adverse Childhood Experiences". Establishes an Adverse Childhood Experiences Working Group of key legislators to consider future legislation. Four bills were introduced as a result of the report and Act 204 passed in 2018 based on the report. Washington H1482 (2018). Establishes the Work First Poverty Reduction Oversight Task Force, which will collaborate with an advisory committee to develop and monitor strategies to prevent and address adverse childhood experiences and reduce intergenerational poverty. Wisconsin S5903 (2019). Creates the Children's Mental Health Workgroup to identify barriers to accessing mental health services, monitor the implementation of legislation and policies relating to children's mental health and consider strategies to improve coordination between education and health systems. H 2116 (2020) Establishes a task force on improving institutional education programs and outcomes, the task force shall examine several issues, including goals and strategies for addressing adverse childhood experiences of students in institutional education and providing trauma-informed care. West Virginia H 4773 (2020) Creates a workgroup to investigate and recommend screening protocols for adverse childhood trauma in this state. *Proposed Policies:* Georgia HR421 (2019). Would create the Committee on Infant and Toddler Social and Emotional Health. Massachusetts HP 122 (2019) Would relate to establishing a working group on adverse childhood experiences and childhood trauma.

		New York A2451(2019). Would establish a task force to identify evidence based and evidence informed solutions to reduce children's exposure to adverse childhood experiences.

V. CREATION OR USE OF AN EXISTING COORDINATING BODY FOR CROSS-SECTOR COLLABORATION

MGA COMMITTEE: Health and Government Operations | Finance | Budget & Taxation

Rationale: Achieving improved outcomes for children requires coordination across public and private systems that serve children and families and must include a multi-generational approach and strengthening adult core capabilities. Coordination must take place at both the state and local levels.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
ESTABLISHED COORDINATING BODY FOR ACE SCIENCE WORK **"Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings"[3]**	Governor's Executive Order 01.01.2021.06	*Passed:* California: Executive Order N-02 (2019). Solidifies the state's promise to address ACEs by creating the position of the Surgeon General, which allows for the creation of health-informed legislation. A887, (2019). Requires the Office of Health Equity to advise and assist other state departments in their mission to increase the general well-being of all state residents and to work toward eliminating adverse childhood experiences. Prescribes the qualifications of the Surgeon General. Eliminates the position of Deputy Director of the Office of Health Equity. Colorado: S195 (2019). Creates the Office of Children and Youth Behavioral Health Policy Coordination in the office of the Governor, creates the Children and Youth Behavioral Health Policy Coordination Commission and the Children and Youth Behavioral Health Advisory Council in the office, provides for the duties, powers, and composition of the commission and the council, makes an appropriation. DC R 865 (2020.) Declares the existence of an emergency with respect to the need to amend the Data Sharing and Information Coordination Amendment Act to allow the disclosure of health and human services information to aid in the development of the report on the root causes of youth crime and the prevalence of adverse childhood experiences among justice involved youth. B 810 - DC B 811 (2020) Amends, on an emergency basis, the Data Sharing and Information Coordination Amendment Act to allow the disclosure of health and human services information to aid in the development of the report on the root causes of youth crime and the prevalence of adverse childhood experiences among justice involved youth.

		B 927 (2020) Allows the disclosure of health and human services information to aid in the development of the report on the root causes of youth crime and the prevalence of adverse childhood experiences among justice-involved youth, allows the disclosure of mental health information when necessary. R 958 (2020) Declares the existence of an emergency, due to congressional review, with respect to the need to amend certain Acts to allow the disclosure of health and human services information to aid in the development of the report on the root causes of youth crime and the prevalence of adverse childhood experiences among justice-involved youth. Vermont: Act 204 (2018). Creates the permanent position of Director of Trauma Prevention and Resilience Development within the Office of the Secretary in the Agency of Human Services. The role of the Director is to direct public health approaches to address ACES, toxic stress, and resilience. HB1965 (2011) "An Act Relating to Public and Private Partnership in Addressing Adverse Childhood Experiences". Creates the Washington State ACEs Public Private Initiative
		Passed: Oklahoma S 446 (2019) Relates to schools, directs the State Department of Education and the Department of Mental Health and Substance Abuse Services, in certain consultation, to develop and make available to school districts certain information, training and resources regarding the mental health needs of students. *Proposed Policies:* Indiana S 273 (2020) Would establish the Indiana behavioral health commission and directs it to conduct a series of reports that assess behavioral health in Indiana. Michigan H 5396 (2020) Would provide omnibus budget appropriations, including for the development and operation of a resiliency center for families and children to address the multifaceted needs of those experiencing trauma, toxic stress, chronic disability, neurodevelopmental disorders, or addictions. Washington RCW 70.190.010 (1994.) Would establish the Washington Family Policy Council to facilitate services at the local level. Despite significant improved outcomes for children and families, this program was eliminated during the Great Recession.

VI. COLLECTION AND ANALYSYS OF ACE RELATED DATA

MGA COMMITTEE: Education, Health and Environmental Affairs

Rationale: The original ACE study and decades of research since have linked ACEs to an increased risk of developing chronic diseases and behavioral challenges. The greater the number of ACEs, the greater the risk for negative outcome. Analyzing ACE data, we can work together to help create neighborhoods, communities, and a world in which every child can thrive.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
	Passed: HB 258 / SB 592 (2021) Alters the information the Department of the Human Service (DHS) must report to the General Assembly and publish on the DHS website regarding children and foster youth in the State child welfare system. HB 771 / SB 548 (2021) Requires the Maryland State Department of Education (MSDE), in coordination with the Maryland Department of Health (MDH), to include at least five questions from the Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey (YRBS) on adverse childhood experiences (ACEs) or positive childhood experiences in the Youth Risk Behavior Surveillance System survey. People with ACE exposure may show signs of behavioral and mental health challenges. They may be irritable, depressed, display acting-out behaviors, and show other traumatic stress symptoms. Continued exposure to violence and other adversity increases the risk that these patterns will continue affecting their own future and their children's future. Timely access to	*Passed:* Washington State S 6191 (2020) Assesses the prevalence of adverse childhood experiences in middle and high school students to inform decision making and improve services, provides for the Healthy Youth Survey.

	assessment, intervention, and effective care, support, and treatment for children and families in which ACEs have already occurred can help mitigate the health and behavioral consequences of ACEs, strengthen children's resilience, and break the cycle of adversity. *Proposed Policies:* HB666 (2020) Establishes a Workgroup on Screening Related to Adverse Childhood Experiences; requiring the Workgroup to update, improve, and develop certain screening tools, submit screening tools to the Maryland Department of Health, and study and make recommendations on the actions primary care providers should take after screening a minor for mental health disorders that may be caused by or related to ACEs.	

SECTION B: THE CDC'S SIX RESEARCH INFORMED POLICY STRATEGIES TO PREVENT OR MITIGATE ACEs[4]

I. STRENGTHEN ECONOMIC SUPPORTS FOR FAMILIES

MGA COMMITTEE: Economic Matters | Finance

Rationale: Policies that strengthen economic supports to families (increasing the minimum wage, paid family leave, paid sick and safe leave, earned income tax credits, child care subsidies, affordable housing, temporary cash assistance, flexible and consistent work schedules, and other family-friendly work policies) have been shown to increase economic stability and family income, increase maternal employment, increase parental ability to meet children's basic needs, and reduce parental stress, including financial stress, maternal

depression, and conflict in family relationships[5] [6] [7] [8]. Parental stress compromises effective parenting and increases the risk of family violence and other ACEs. Furthermore, 4 in 10 children live in low-income households[9],1 in 10 live in deep poverty[10], and research consistently links low incomes to ACE exposure and poor long-term health, educational, and social outcomes[11] [12].

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
LIVING WAGE **Research has shown that increased wages can lead to lower instances of child abuse and neglect, as releasing families of financial burden can reduce parental stress and allow parents to provide for their children.[13]**	Increased Minimum Wage *Passed:* HB166 / SB 280 "Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen)" in 2019, Raises the minimum wage to $15/ hour by 2024.	*Passed:* Illinois SB81 (2018). Increases minimum wage to $15/hour by 2025. Massachusetts: H4640 (2018) Increases minimum wage to $15/ hour over five years. *Proposed:* New Jersey: A15 (2019.) The bill would raise minimum wage to $15/ hour by 2024, with tipped workers earning a minimum of $9.87 by 2024.
PAID FAMILY LEAVE **The time after the birth or adoption of a baby is an essential time of development for babies and families. Because early relationships nurture early brain connections that form the foundation for all learning and relationships that follow, parents and caregivers are on the front line of preparing our future workers, innovators, and citizens.** **Paid Family Leave supports babies' health & development. Newborns reap the benefits of paid family leave, including:** **better bonding with parents,[14]** **increased breastfeeding and health benefits for mother and child,[15]** **vaccination completion,[16] decreased**	*Passed:* SB 859 / HB 775 "State Employees – Parental Leave" in 2018. Provides up to 12 weeks of paid leave for State employees following the birth or adoption of a child.[20] *Proposed Policies:* HB 34 (2021) Would establish the Family and Medical Leave Insurance (FAMLI) program and FAMLI Fund to provide up to 12 weeks of benefits to a covered individual taking leave from employment due to specified personal and family circumstances. Research shows that parents facing financial hardships are more likely to experience stress, depression, and conflict in their relationships and family, all of which increase the risk for violence and other	*Passed:* Massachusetts: H4640 (2018). Provides family leave to individuals to bond with their newborn, foster or adoptive child for up to twelve weeks; to provide care in the case of a family member's deployment; or to care for a family member who is a covered service member. The bill also provides medical leave to anyone with a serious health condition for up to 20 weeks. New Jersey: A3975 (2019). Paid family leave was established in 2014 and expanded in 2019. Provides paid family leave in order to "to maintain consumer purchasing power, relieve the serious menace to health, morals and welfare of the people caused by insecurity and the loss of earnings, to reduce the necessity for public relief of needy persons, to increase workplace productivity and alleviate the enormous and growing stress on working families of balancing the demands of work and family needs, and in the interest of the health, welfare and security of the people" New York: Chapter 54 (2016). Provides paid family leave, allotting 10 weeks for paid family leave at 55% average earnings, and 12 weeks at 67% average earnings beginning in 2021. Washington: SP.L.5975 (2017). Provides paid leave finding if it is associated with health benefits, including reduced infant mortality and increased well-baby visits,

infant mortality,[17] increased placement in high quality stable childcare,[18] and a reduction in child abuse.[19]	ACEs. Parents facing financial hardship are also have fewer resources to invest in their children and face difficult choices when trying to balance work and family responsibilities. About 4 in 10 children under the age of 18 in the United States live in a low-income household including more than half African American and Hispanic children. Addressing social and economic underpinnings of ACEs is critical to achieve lasting and sustainable effects. Policies that strengthen household financial security and family-friendly work policies can prevent ACEs by increasing economic stability and family income, increasing maternal employment, and improving parents' ability to meet children's basic needs and obtain high-quality childcare.	increased child development and reduced child health problems, as well as increased paternal engagement with children. Provides a paid family and medical leave insurance program for placement of a child/ birth of a child, care of a family member with a serious health condition, and for one's own serious health condition. Maximum leave is 12 times the typical amount of workweek hours per 52 weeks. *Proposed:* California: Act 686 (2017). Establishes aid family leave and disability insurance across the state.
PAID SICK & SAFE LEAVE	*Passed:* HB1 (2018) "Maryland Health Working Families Act." Employers with fewer than 15 employees must provide unpaid sick and safe leave.	None known or reported by NCSL that reference N.E.A.R. Science.
INCREASED EARNED INCOME TAX CREDITS (EITC) **Research has shown that tax credits, such as EITCs increase income for working families, lift millions of families above the poverty line, offsets the costs of child care, decreases infant mortality, maternal stress and mental health problems, and child behavioral problems (e.g., aggression, anxiety, and hyperactivity that impact later perpetration of violence) ;and,**	*Passed:* HB 810 / SB 870 "Income Tax – Child and Dependent Care Tax Credit - Alteration" in 2019. Expands Maryland's Child and Dependent Care Tax Credit for the first time in nearly two decades—increasing the income threshold from $50,000 to $143,000 for married couples (and to $92,000 for individuals), indexing these limits annually for inflation, and making the credit refundable for low-income filers.[22]	*Passed:* Colorado: HB17-1002 (2017). Grants an earned income tax credit expansion for childcare expenses for families who earn an adjusted gross income of $25,000 or less. The tax credit is equal to 25% of childcare expenses during the tax year up to $500 for one child and $1,000 for two or more children. South Carolina: Act 40 (2018). Establishes an earned income tax credit, which is shown by research to encourage workforce participation and increase earnings. Virginia: Chapter 29 (2016). Provides annual notice to recipients of state benefits of the availability of federal and state earned income tax credit to increase outreach and claiming of the tax credit.

increases health insurance coverage, school performance, and parents' ability to provide for their children physically and emotionally.[21]		
AFFORDABLE EARLY CHILD CARE *Increased Child Care Subsidies* **Childcare subsidies tend to promote parents accessing higher quality childcare. This increases the likelihood that children will experience safe, stable, nurturing relationships & environments.** **Access to affordable childcare reduces parental stress and maternal depression, key risk factors for child abuse and neglect and other risk behaviors associated with ACEs.[23]**	*Passed:* SB 379 / HB 430 (2018) Increases childcare subsidy rates, establishing mandatory funding levels so that rates never again fall so low. HB 248 / SB 181 (2019). Accelerates the mandated increase of childcare subsidy rates. Beginning July 2020, subsidy rates must equal or exceed and remain at 60 percent of market rates.	*Passed:* California A-108 (2018). Creates county-based child care subsidy plan to decrease the cost of child care for low income families. District of Columbia: A22-0453 (2018). Expands the income eligibility for subsidized child care to increase access to child care and develops a competitive compensations scale for educators in child development centers to increase quality of care. Louisiana: Act 354 (2015). Establishes an Early Childhood Education Fund to provide funding for early childhood care placements for low-income families through childcare assistance programs.
FLEXIBLE AND CONSISTENT WORK SCHEDULES **Provide parents with a predictable pattern of work, making it easier to access quality childcare. Children whose parents work unpredictable schedules have more cognitive deficits. Parents with irregular shift times are also more prone to work-family conflict and stress, which are risk factors for multiple forms of violence.**		None known or reported by NCSL that reference N.E.A.R. Science.
AFFORDABLE HOUSING **A major component of creating family stability is ensuring that each family and child has a safe, stable place to live. Affordable housing policies, such as rent controls and inclusionary zoning. which requires a specified percentage of new housing construction to be affordable to people**		*Passed:* Louisiana: RS33 (2006). Permits municipalities to use inclusionary zoning to promote development of affordable housing for low-income families, given the lack of affordable housing and the health and wellbeing concerns that come with it.

with low or moderate incomes, help ensure that each child has a safe place to live.[24]		
MULTI- GENERATIONAL APPROACH TO HUMAN SERVICES BENEFITS		*Passed:* Hawaii: SB1227 (2019). Recognizes the connection of intergenerational poverty and ACEs and requires the Human Services agency implement an integrated and multigenerational approach designed to improve the social well-being, economic security, and productivity of the people of the State, and to reduce the incidence of intergenerational poverty and dependence upon public benefits. (pending) Massachusetts H 4808 (2020) Makes appropriations for the current fiscal year to authorize certain coronavirus spending in anticipation of federal reimbursement.

II. PROMOTE SOCIAL NORMS THAT PROTECT AGAINST VIOLENCE & ADVERSITY

MGA COMMITTEE: Joint Committee on Children Youth & Families |Ways & Means | Appropriations | Finance | Budget & Taxation | Health & Government Operations

Rationale: "Norms are group-level beliefs and expectations about how members of the group should behave. Changing social norms that accept or allow indifference to violence and adversity is important in the prevention of ACEs.[25] [26] [27] [28] [29]" Pieces of legislation that promote community norms around a shared responsibility for the health and well-being of all children[30]; support parents and positive parenting, including norms around safe and effective discipline[31]; foster healthy and positive norms around gender, masculinity, and violence to protect against violence towards intimate partners, children, and peers[32] [33] [34]; reduce stigma around help-seeking[35]; and enhance connectedness to build resiliency in the face of adversity[36] [37], help families and communities prevent ACEs and other forms of childhood trauma.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
PUBLIC EDUCATION CAMPAIGNS have been shown to help parents understand the cycle of abuse; Campaigns targeting child physical abuse positively impact parenting practices,		*Passed:* California ACR 140 (2020) Designates the month of January 2020 as Positive Parenting Awareness Month In California, partially in recognition

reduce children's exposure to parental anger and conflict and reduce child behavior problems.[38]		that positive parenting can prevent or mitigate the effects of adverse childhood experiences.
LEGISLATIVE APPROACHES TO REDUCE CORPORAL PUNISHMENT are associated with decreases in the use of harsh physical punishment to discipline children and help to establish social norms around safer, more effective discipline strategies.[39] [40] **Experiencing harsh physical punishment as a child increases mental health problems, weakens school performance, lowers self-esteem and increases risk for involvement in crime and violence in adolescence and later perpetration of violence toward a partner and one's own children.**[41]		None known or reported by NCSL that reference N.E.A.R. Science.
BYSTANDER APPROACHES & EFFORTS TO MOBILIZE MEN & BOYS AS ALLIES "Bystander approaches and efforts to mobilize men and boys as allies in prevention change the social context for violent and abusive behavior. Programs such as Green Dot and Coaching Boys into Men®, for instance, have been shown to reduce violence against dating partners, negative bystander behaviors (such as laughing at sexist jokes or encouraging abusive behaviors), as well as sexual violence perpetration and victimization."[42]		None known or reported by NCSL that reference N.E.A.R. Science.

III. ENSURE A STRONG START FOR CHILDREN

MGA COMMITTEE: Ways & Means | Appropriations | Finance | Budget & Taxation | Health & Government Operations

Rationale: The knowledge and understanding of core concepts of neuroscience, ACEs, and resilience should serve as a foundation for public policies that affect the lives of children, their families, and their communities. Building strong healthy families and communities requires that we make investing in early childhood a high priority to ensure social, emotional, behavioral, cognitive, and physical health throughout the lifespan. It is much easier and less expensive to support caregivers, families and communities to build a strong foundation in early childhood than to wait and address weaknesses in the foundation later. Waiting to address symptomatic behaviors (e.g., youth disconnection, homelessness,

school failure, substance abuse, etc.) and illness (e.g., depression, anxiety, suicide, etc.) until children enter school, their teen years, or adulthood requires expending more resources and producing less satisfactory results for both the individuals and the communities in which they live.[43]

High quality early investments (e.g., evidence-based home visiting, early child care and education, pre-K, and infant mental health programs, all with an effective family engagement component) in children prenatal to 5, i.e.," going upstream," is essential to healthy brain development and preventing the intergenerational transmission of the impact of childhood trauma. Evidence-based (EBP) and promising home visitation program models. Effective programs include services such as parent-child therapy to build the parent-child relationship, which has been shown to be a key factor in decreasing early stress and adversity, developing supportive parental practices, which are associated with positive child behavior and development. Because no child or family is immune to ACE exposure, extensive, universal home visitation programs which allow service providers to identify the needs of families and refer them to the proper resources, as well as provide education and support to families, can drastically decrease instances of childhood trauma, particularly exposure to a parent with mental health disorders, substance abuse disorder, or domestic violence in the home.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
EVIDENCE- BASED & PROMISING HOME VISITING PROGRAM MODELS **Not only have home visitation programs been shown to be effective in reducing ACEs, but they have also been shown to offer a high rate of return on investment, offsetting the costs of implementing the programs themselves.[44]** **Studies show that, when provided with home visitation services, families with children between three and six years of age who had been exposed to multiple ACEs were two times less likely to have referrals to child protective services, four times more likely to develop at an age appropriate pace, and five times less likely to show signs of aggression compared to families that did not participate in any home visitation programs. [45]**	*Passed:* HB 699 / SB 566-The Home Visiting Accountability Act of 2012., Requires - the state fund only evidence-based and promising home visiting models; and, that 75% of funding go to evidence-based models. SB 373 / HB 547 "Education – Head Start Program – Annual Funding (The Ulysses Currie Act)" in 2018. Restores a $1.2 million budget cut imposed in 2009, potentially increasing services for more than 2,100 Head Start children. SB 912 / HB 1685 "Maryland Prenatal and Infant Care Coordination Services Grant Program Fund (Thrive by Three Fund)" in 2018. Creates a grant program to expand the coordination of direct services for jurisdictions with a high percentage of births to Medicaid-eligible mothers.	*Passed:* Arkansas: Act 528 (2013). Establishes a statewide voluntary home visiting service to promote prenatal care and healthy births, requires that state agencies develop protocols for collecting and sharing program data with providers to include in child welfare and health data systems. California S 98 Extends the date for completion of a standardized English language teacher observation protocol by the State Department of Education. Requires the Superintendent of Public Instruction to administer childcare and development programs that offer a full range of services and to reimburse contracting agencies for certain state subsidized childcare programs due to the ongoing impacts of closures and low attendance due to the coronavirus pandemic. Kentucky: Chapter 118 (2013). Provides voluntary home visit for at-risk parents during the prenatal period-3rd birthday, establishes goals for statewide home visiting system, and requires programs to adhere to research based or promising models. Maine: Chapter 683 (2011). Requires that the Department of Health and Human Services offers voluntary universal home visiting for new families regardless of family income. Texas: Chapter 421 (2013). Establishes the voluntary Texas home visiting program for pregnant women and families with children under the age of 6, requiring that home visit programs be evaluated and submit reports biannually.

		Proposed Policies: Hawaii SR 16 (2020) Would urge the Department of Health to expand and improve Hawaii's home visiting program. Vermont: H500 (2019). Would establish a universal home visiting program and parenting classes for families caring for a newborn infant and calls for the evaluation of current home visiting services in each district to determine where there are unmet needs and which evidence-based and home visiting models are appropriate. The bill also provides $100,000 in grants to three parent child centers for the creation of pilot programs offering parenting classes, with the hope of preventing multigenerational childhood trauma.
ACCESSIBLE HIGH QUALITY CHILD CARE *Invest in early childhood development: Reduce deficits, strengthen the economy.*, Heckman, J. J. (2013). **High quality childcare programs with family engagement help children build a strong foundation for future learning and help build physical, social, emotional, and cognitive skills. They buffer young children from ACEs by creating safe, stable, nurturing, and supportive environments for the child and parent or caregiver.**[46]	*Passed:* SB 379 / HB 430 (2018) Increases childcare subsidy rates, establishing mandatory funding levels so that rates never again fall so low. HB 248 / SB 181 (2019). Accelerates the mandated increase of childcare subsidy rates. Beginning July 2020, subsidy rates must equal or exceed and remain at 60 percent of market rates.	*Passed:* Colorado H 1053 (2020) Concerns measures to support the early childhood educator workforce, directs the department to develop a statewide professional development plan to support mental health consultants, requires the plan to include training related to trauma and trauma-informed practices and interventions, adverse childhood experiences, and the science of resilience, among others. New York (2019) S 4990 (2019) Amends the Social Services Law, requires training with respect to adverse childhood experiences, focused on understanding trauma and on nurturing resiliency, for day care providers.
HIGH QUALITY AFFORDABLE PRE-K **High quality affordable Pre-K help children build a strong foundation for future learning and help build physical, social, emotional, and cognitive skills. They buffer young children from ACEs by creating safe, stable, nurturing, and supportive environments for the child and parent or caregiver.**[47]	*Passed:* SB 1030 (2019). As part of "The Blueprint for Maryland's Future," requires a 3 year "down payment" on the implementation Kirwan Commission recommendations totaling approximately $1 billion of State funding for pre-kindergarten will expand by $31.7 million in FY 2020 and an estimated $53.6 million in FY 2021. [48]	*Passed:* Maine S 287 Requires the Commissioner of Education to implement a statewide voluntary early childhood consultation program to provide support, guidance, and training to families, early care and education teachers, and providers working in public elementary schools, child care facilities, family child care settings, and Head Start programs serving infants and young children who are experiencing challenging behaviors that put them at risk of learning difficulties and removal from early learning.

	HB 1415 (2018). Preserves $22.3 million in pre-K expansion dollars that might otherwise have been lost when a federal grant expired.	

IV. TEACH SKILLS TO PARENTS, CAREGIVERS, CHILDREN, & YOUTH

MGA COMMITTEE: Ways & Means | Finance | Health & Government Operations | Judiciary | Judicial Proceedings

Rationale: Policies that promote healthy parenting, keep children, parents, and families connected rather than separated, and provide evidence-based skill building for parents, family members, and community caregivers (home visitors, medical providers, childcare workers, educators, after-school child and youth serving providers and mentors) have been proven to improve developmental outcomes in children and decrease instances of abuse and neglect. It is also crucial that lawmakers focus on policies which recognize the importance of building awareness in families and communities about NEAR Science and the need to prevent ACEs and mitigate their effects by addressing trauma and its impacts.

Opportunities in all child and family serving systems that help adults to develop and practice executive function skills, including impulse control, emotional control (self-regulation), flexible thinking, working memory, self-monitoring, planning and prioritizing, task initiation, and organization help to provide the experiences that strengthens parts of the brain that tend to be less developed in adults who have experienced childhood trauma. Through effective training and coaching, executive function skills may be strengthened and lead to improved outcomes in relationships (people skills), parenting, money management, educational attainment and career success.[49] Coaching parents who have been impacted by ACEs, in turn helps ensure the development of those skills in their children and subsequent generations.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
EVIDENCE-BASED (EBP) & PROMISING HOME VISITATION PROGRAMs **Studies show that, when provided with home visitation services, families with children between three and six years of age who had been exposed to multiple ACEs were two times less likely to have referrals to child protective services, four times more likely to develop at an age appropriate pace, and five times less likely to show signs of aggression compared to families that did not participate in any home visitation programs.** [50]	*Passed:* HB699/SB566-The Home Visiting Accountability Act of 2012. Requires the state fund only evidence-based and promising home visiting models; and, that 75% of funding go to evidence-based models. [51]	*Passed:* Arkansas: Act 528 (2013). Establishes a statewide voluntary home visiting service to promote prenatal care and healthy births, requires that state agencies develop protocols for collecting and sharing program data with providers to include in child welfare and health data systems. Colorado CO S 10 (2019) Allows grant funds to be used for behavioral health care services, including services to support social-emotional health at recipient schools or through service contracts with community providers. CO H 1053 (2020) Concerns measures to support the early childhood educator workforce, directs the department to develop a statewide professional development plan to support mental health consultants, requires the plan to include training related to trauma and trauma-informed practices and interventions, adverse childhood experiences, and the science of resilience, among others.

		IN H 1283 (2020) Relates to trauma response instruction for teachers, requires a teacher preparation program to include training on trauma response instruction and recognition of social, emotional, and behavioral reactions to trauma that may interfere with students' academic functioning. Kentucky: Chapter 118 (2013). Provides voluntary home visit for at-risk parents during the prenatal period-3rd birthday, establishes goals for statewide home visiting system, and requires programs to adhere to research based or promising models. (I did not find this bill) Maine: Chapter 683 (2011). Requires that the Department of Health and Human Services offers voluntary universal home visiting for new families regardless of family income. New York S 4990 (2019) Amends the Social Services Law, requires training with respect to adverse childhood experiences, focused on understanding trauma and on nurturing resiliency, for day care providers. Texas: Chapter 421 (2013). Establishes the voluntary Texas home visiting program for pregnant women and families with children under the age of 6, requiring that home visit programs be evaluated and submit reports biannually. *Proposed Policies* Vermont: H500 (2019). Would establish a universal home visiting program and parenting classes for families caring for a newborn infant and calls for the evaluation of current home visiting services in each district to determine where there are unmet needs and which evidence-based and home visiting models are appropriate. The bill also provides $100,000 in grants to three parent child centers for the creation of pilot programs offering parenting classes, with the hope of preventing multigenerational childhood trauma.
EB & PROMISING PARENTING AND FAMILY SKILL BUILDING PROGRAMS **Shown to decrease early stress and adversity and develop supportive**		*Passed:* Vermont: H500 (2019). Provides $100,000 in grants to three parent child centers for the creation of pilot programs offering parenting classes, with the hope of preventing multigenerational childhood trauma.[53]

parental practices, which are associated with positive child behavior and development.[52]		
EB & PROMISING PROGRAMS FOR PARENTS WITH A HISTORY OF SUBSTANCE USE DISORDER **Providing comprehensive care to parents who struggle with substance use disorder has been shown to increase parent and child welfare.**[54]		None known or reported by NCSL that reference N.E.A.R. Science.
EB & PROMISING PROGRAMS & VISITATION PROGRAMS FOR INCARCERATED PARENTS AND THEIR CHILDREN **Research has shown strong links between parent-child relationships and childhood development, meaning that it is crucial to enact programs that allow for visitation between children and their incarcerated parents when possible.**[55]		*Passed:* Hawaii: SCR7 (2019). Establishes that human services and public safety work to develop a plan for the establishment of visitation centers at all state correctional facilities and jails for children to visit their incarcerated parent. The resolution recognizes that the incarceration of a parent is seen as an ACE and can lead to adverse outcomes for children and that parental bonding is essential for children's development. Illinois: H2444 (2019). Amends code of corrections to expand consideration of factors such as whether the defendant is the parent of a child or if the defendant serves as a caregiver to someone who is ill, disabled, or elderly in sentencing, recognizing the parental incarceration is an ACE and can have adverse effects on the child. Missouri: Chapter 217 (2018). Creates a women offender program to ensure that female offenders are provided with trauma-informed and gender responsive supervision strategies, including physical and mental health care, child visitation, and more.

Teach skills to caregivers, children, and youth		Oregon: SB241 (2017). Establishes a bill of rights for children with incarcerated parents, including the right to be protected from additional trauma at the time of parental arrest, the right to remain informed about their parent's arrest in an age-appropriate manner, the right to see, speak with and touch their incarcerated parent, and more. Texas: S1356 (2013). Requires all juvenile probation and supervision officers receive training on trauma informed care administered by the Department of Human Resources. In H650 (2019). Requires correctional officers to be trained on issues relating to the physical and mental health of pregnant inmates, including appropriate care, the impact of incarceration on a pregnant inmate and the unborn child, the use of restraints, the placement of administrative segregation, and invasive searches. The Act also includes provisions for reviewing visitation policies and evidence-based visitation practices that enhance paternal bonding and engagement and allow for age-appropriate visiting activities for children who visits their parents in correctional facilities. *Proposed Policies:* New York NY A 4268 (2020) Would provide for mandating training of direct care workers in adverse childhood experiences. Oregon: SB241 (2017). Would establish a bill of rights for children with incarcerated parents, including the right to be protected from additional trauma at the time of parental arrest, the right to remain informed about their parent's arrest in an age-appropriate manner, the right to see, speak with and touch their incarcerated parent, and more. Tennessee TN H 2588 (2020) Would require that a video on adverse childhood experiences be shown to parents attending a parent educational seminar. Texas: H2168 (2019). Would require screening of each inmate during the diagnostic process to determine whether the inmate has experienced ACEs or other significant trauma and refer the appropriate care when needed. The bill also requires screening and care for defendants. Washington: S5876 (2019). Would create a women's division of correctional system to develop a system of gender responsive, trauma informed practices

		within the department of corrections, informed by individuals with training in ACEs and trauma informed practices.

V. CONNECT CHILDREN & YOUTH TO CARING ADULTS & ACTIVITIES

MGA COMMITTEE: Ways & Means | Education, Health, & Environmental Affairs | Finance | Appropriations | Health & Government Operations | Judiciary | Judicial Proceedings

Rationale: Research suggests that mentoring and after school programs improve outcomes across behavioral, social, emotional and academic domains[56]. Opportunities to develop and practice executive function skills, including impulse control, emotional control (self-regulation), flexible thinking, working memory, self-monitoring, planning and prioritizing, task initiation, and organization help to provide the experiences that strengthens parts of the brain that tend to be less developed in children who experience chronic adversity. Experiences that improve executive function, improve the leadership, decision-making, self-management, and social problem-solving skills of children and youth and are important components of mentoring and after-school programs with documented success; and, help kids to be attain success in relationships, in school, and in their careers.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
MENTORING PROGRAMS		None known or reported by NCSL that reference N.E.A.R. Science.
AFTER SCHOOL PROGRAMS CONNECT CHILDREN AND YOUTH TO CARING ADULTS AND COMMUNITIES	Project Bounce Back An initiative of the Governor, Project Bounce Back creates a public-private partnership to help Maryland youth to recover from the devastating impacts of the Covid – 19 pandemic. It will provide strategic mental health services, expand the footprint of youth development programs and develop new solutions to build post Covid resilience among Maryland's youth.	None known or reported by NCSL that reference N.E.A.R. Science.

VI. INTERVENE TO LESSEN IMMEDIATE & LONG-TERM HARMS OF CHILDHOOD TRAUMA & ADVERSITY

MGA COMMITTEE: All Standing Committees

Rationale: Recognizing and effectively responding to lessen the immediate and long-term harms of childhood trauma and adversity is the responsibility of all adults in the community, as well as state and local child and family serving agencies. Primary care, mental and behavioral health, Medicaid and private insurance, public health, schools and other youth serving organizations, higher education, child welfare, juvenile and criminal and civil justice systems, along with neighborhood and businesses and faith-based communities, should align their policies and practices with NEAR Science. Children and youth with ACE exposure are at risk for school failure, behavior problems, suspension and expulsion, teen pregnancy, depression, anxiety, suicide, youth violence, as well as physical health problems. Early family centered interventions with evidence-based and promising treatments for children and parents, trauma-informed policies and practices within child and family serving systems, as well as connection to at least one safe, stable, and nurturing adult has been proved to reduce ACEs and their impacts in communities across the country.

EVIDENCE BASE FOR SPECIFIC LEGISLATIVE STRATEGY	MARYLAND LAW	STATE INNOVATIONS NATIONWIDE
ENHANCED PRIMARY CARE CREATION OF STATE SURGEON GENERAL		*Passed:* California: Executive Order N-02 (2019). Solidifies the state's promise to address ACEs by creating the position of the Surgeon General, which allows for the creation of health-informed legislation. A887 (2019). Requires the Office of Health Equity to advise and assist other state departments in their mission to increase the general well-being of all state residents and to work toward eliminating adverse childhood experiences. Prescribes the qualifications of the Surgeon General.
ENHANCED PRIMARY CARE TRAINING FOR MEDICAL PROFESSIONALS	*Passed:* HB 78- SB 52 (2021) – Maryland Commission on Health Equity - Creates an advisory committee, requires state agencies to maintain and provide data sets on race. Race is a social construct with no biological basis that artificially divides people into distinct groups based on characteristics such as physical appearance, ancestral heritage, cultural affiliation, and the social, economic, and	*Passed:* CA: AB 1340 (2017). Requires Medical Board to consider including a course for primary care providers on integrated mental and physical health care, expressly to identify and treat mental health issues in children and young adults. Medi-Cal (Medicaid) Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT). *Proposed Policies:* New York: A2754 (2019). Would require doctors to complete education regarding screening for ACEs in children before they can re-register to practice medicine. This bill is still pending in the legislature.

	political needs of a society at a given period. Racism has been declared as a public health crisis. There are several strategies that can prevent ACEs from happening. ACE task forces and workgroups is one of the strategies that can be implemented to fight racism. Organizing group meetings and discussing the impact of racism on accessibility of public health is the small step that could help to fight systematic racism. . *Proposed Policies:* HB1036-SB 675 (2021). The bill would require the Judiciary, in consultation with domestic violence and child abuse organizations, to develop a training program for judges presiding over child custody cases involving child abuse or domestic violence. The training must include numerous specific topics that prevent adverse childhood experience. The judges will learn about typical brain development of infants and children, the dynamics and effects of child sexual abuse, physical and emotional child abuse, and domestic violence as well as the impact of exposure to domestic violence on children and the importance of considering this impact when making child custody and visitation decisions.	
ENHANCED PRIMARY CARE EARLY SCREENING & DETECTION OF ACES **may be used to identify and address ACE exposures with brief screening assessments and referral to intervention services and supports.[57] [58] [59] For children, assessments are completed with parents/caregivers to identify risks such as parental substance**	*Passed:* HB 771 / SB 548 (2021) Requires the Maryland State Department of Education (MSDE), in coordination with the Maryland Department of Health (MDH), to include at least five questions from the Centers for Disease Control and	*Passed:* California: AB340 (2017). Establishes a working group to address the provision of trauma screening under Medi-Cal. Chapter 843 (2018). Requires the Mental Health Services Oversight Commission to create a plan to implement and monitor mental health and trauma screening and detection services. Since then, the state has approved

use, intimate partner violence, depression, stress and the use of harsh punishment. [60] Screening and assessing adults would identify a history of ACE exposures and help mitigate risk and improve treatment outcomes.[61] [62] Strong policies would ensure that intervention services are tailored to assessment findings and coordinated with and between community agencies.[63]	Prevention (CDC) Youth Risk Behavior Survey (YRBS) on adverse childhood experiences (ACEs) or positive childhood experiences in the Youth Risk Behavior Surveillance System survey. People with ACE exposure may show signs of behavioral and mental health challenges. They may be irritable, depressed, display acting-out behaviors, and show other traumatic stress symptoms. Continued exposure to violence and other adversity increases the risk that these patterns will continue affecting their own future and their children's future. Timely access to assessment, intervention, and effective care, support, and treatment for children and families in which ACEs have already occurred can help mitigate the health and behavioral consequences of ACEs, strengthen children's resilience, and break the cycle of adversity.	an allocation of $45 million for the 2019-2020 fiscal year to reimburse pediatricians for participating in ACE screening of their patients, and another $50 million to train pediatricians in conducting the screenings. In this way, doctors are encouraged to screen their patients for ACEs and other traumatic events, which will allow them to refer patients to the proper behavioral and mental health services if necessary to prevent the onset of long-term negative health outcomes as a result of high trauma exposure. District of Columbia: Act 179 (2018). Requires that the Mayor for Health and Human Services expand and coordinate health care for infants and toddlers under three years of age, including early screening for ACEs and related health outcomes. A22-0453 (2018). Requires the Department of Health to implement Healthy Steps, a primary care program which promotes healthy development and provides parenting support, medical care, and resources for mental health, domestic violence, food and shelter, and more to ensure that the needs of children ages 0-3 are met. Hawaii: HB908 (2013). Establishes a statewide hospital-based home visiting program to identify families of newborns at risk for poor health outcomes and to promote healthy child development through universal screening of newborns and referral of high-risk families to evidence-based home visit services. Maine: Act 63 (2019). Convenes a task force to develop guidance for kindergarten-12th grade educators and administrators on appropriate training for and responses to addressing childhood trauma, including ACEs training, trauma informed care, health screenings, and a social-emotional curriculum from K-8th grade.
EXPANSION OF INSURANCE COVERAGE TO MENTAL, BEHAVIORAL, & SOCIAL-EMOTIONAL HEALTH CARE TREATMENTS, INCLUDING MULTI-GENERATIONAL PROVISION OF SERVICES (INFANT MENTAL HEALTH) **Various forms of counseling, including Trauma Informed Cognitive Behavioral Therapy, have proven to be successful in**		*Passed:* California: Chapter 855 (2018). Modifies the definition of "medically necessary services" to include early screening, diagnosis and treatment programs such as screening for mental health disorders, behavioral health disorders, and trauma. Connecticut: S1085 (2015). Requires health insurance policies to cover mental and nervous conditions, maternal, infant and early childhood home visitation services, and other home-based interventions for children.

mitigating the harmful impacts of ACE exposure, both in children and adults. However, often services are not covered by insurance plans, including Medicaid. By expanding Medicaid and Insurance program coverage to support behavioral and mental health services, more people will be able to access needed services. Behavioral and mental health services designed to address trauma exposure show considerable long term saving on many public service programs, as they work to prevent chronic health conditions, response to domestic abuse and substance abuse, and more.		North Carolina: Act 57 (2019). Provides Medicaid and NC Health Choice coverage for home visits to improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development. Washington WA S 6259 (2020) Improves the Indian behavioral health system, revises provisions relating to the Indian Health Improvement Reinvestment Account, requires funds in the Account to be expended on programs that address the ongoing suicide and addiction crisis among American Indians and Alaska Natives. *Proposed Policies:* New Jersey: A3035 (2017). The Mental Health Access Act of 2017 would increase Medicaid reimbursement rates for evidence-based behavioral health services.
FUNDING EVIDENCE – BASED PROGRAMS IN PRIMARY CARE – SEEK (Safe Environment for Every Kid) MODEL **"Randomized trials of the *Safe Environment for Every Kid (SEEK)* model (which screens for ACE exposures in the family environment), have demonstrated a number of positive effects including fewer reports to child protective services, fewer reported occurrences of harsh physical punishment by parents, better adherence to medical care, and more timely childhood immunizations.[64] *SEEK* is also associated with less maternal psychological aggression,[65] fewer minor maternal physical assaults,[66] and improvements among providers in addressing depression, substance misuse, intimate partner violence, and serious parental stress.[67]"[68]** PREVENTING & MITIGATING THE HARMS OF CHILD SEXUAL ABUSE	SEEK is a model created and tested in Maryland by Dr. Howard Dubowitz, MD and his team at the University of Maryland, School of Medicine. No Criminal SOL	None known or reported by NCSL that reference N.E.A.R. Science. In 2019 alone, nineteen states have passed statute of limitations reforms to better reflect the average age of disclosure.

STATUTE OF LIMITATIONS REFORM **Eliminating the Statute of Limitations for Child Sexual Abuse, including a "look back window"** **promotes community norms against violence toward children, provides justice and healing for victims of child sexual abuse, and exposes hidden predators still living in communities.**[69] **Child sexual abuse affects one in four girls and one in six boys across the United State-s. In 2019 alone, 21 states have passed statute of limitations reforms to better reflect the average age of disclosure. Seventeen states (nine this year) have passed civil SOL "windows of justice "to allow civil claims previously barred to proceed for a set period of time. Civil SOL Windows also present an opportunity to prevent incidents of child sexual abuse by exposing hidden predators**	Civil SOL: *Proposed Policies:* SB 134 /HB 263 (2021), HB 974 (2020), HB 687, (2019). Hidden Predator Act. Passed the House unanimously and failed in the Senate Judicial Proceedings Committee. It would eliminate the civil statute of limitations for child sexual abuse and provide a two-year lookback window for survivors.	*Passed:* Arizona (2021) HB 2116 Adds a civil cause of action with no SOL for sex trafficking of minors and adults with liability for perpetrators, other individuals and entities that benefited from participating in a trafficking venture. Arkansas SB 676 (2021) Extends the civil SOL for sexual abuse of minors from age 21 to age 55 and opens a 2-year revival window for expired claims. The SOL extension and window is also applicable to victims who were disabled adults at the time of the sexual abuse. California: AB218 2019. 3-year window: 3-year window will open on January 1,2020 for expired claims against perpetrators, private organizations and government. Colorado SB 73 (2021) Eliminates the civil SOL for sexual assault of minors and adults. Adds a new civil cause of action for sexual misconduct against a minor with no SOL, allowing claims to be brought at any time. The cause of action also applies retroactively and opens a 3-year window for any sexual misconduct against minors occurring from 1960 to 2021. Claims against public entities/perpetrators are limited by a damages cap of $350,000. Claims against non-public entities/perpetrators are limited by a damages cap of $500,000, with exceptions for negligence or excessive injury which raise the cap to $1,000,000. (SB 88) Connecticut: SB3 (2019). Extends the civil statute of limitations for sexual abuse victims to thirty years after age twenty-one. The law also extends the criminal statute of limitations for offenses involving sexual abuse, sexual exploitation, and sexual assault of a victim under sixteen years of age and extends the criminal statute of limitations for victims ages eighteen-twenty to fifty-one years old. Louisiana HB 492 (2021) Eliminates the civil SOL for child sex abuse claims and opens a 3-year revival window for all previously expired claims. Maine LD 589 (2021) Opens a permanent revival window for all expired claims of child sexual abuse.

		Nevada SB 203 (2021) Eliminates the civil SOL for claims against a perpetrator or someone criminally liable for sexual abuse or exploitation of a minor (including trafficking, prostitution, and pornography) and a promoter, possessor, or viewer of CSAM (child sexual abuse material) and opens a permanent revival window for expired claims. New York S 672 (2021) Extends the civil SOL for sex trafficking and compelling prostitution of minors from 10 years to 15 years after the victim is freed, 15 years after discovery of the cause of action, or age 33 (age of majority, 18, plus 15 years). Pennsylvania HB 14 (2021) A resolution proposing an amendment to the Pennsylvania Constitution to add a 2-year revival window for victims of child sex abuse and explicitly lift sovereign immunity for actions against the government. Rhode Island: H5171 (2019) Extends the statute of limitations from seven to thirty-five years in cases of child sexual abuse, including a seven-year discovery window to allow victims more time to commence action against their abuser.

TRAUMA-INFORMED CARE FOR VICTIMS **CHILD ADVOCACY CENTERS** **Child Advocacy Centers are a crucial component of trauma-informed care for children who have experienced abuse. CACs bring together a myriad of services, including child protective services, law enforcement, medical and mental health professionals, and prosecutors in a child-friendly, trauma-informed environment to allow for an inter-agency investigation and response to instances of child and family abuse.**	*Passed:* Sb739 ((2019). Child Advocacy Centers (CACs)Expansion bill defined and strengthened CACs across the state to ensure trauma-informed services to child victims of child sexual and physical abuse.	*Passed:* Florida: Act 151 (2017). Provides for trauma informed care for children who have been sexually exploited. Establishes an accountability system for residential group care providers based on quality standards, including promotion of high-quality services and accommodations, considerations of the level of availability of trauma informed care and mental and physical health services, the level of provider's engagement with school and extra circular activities, and a following report on the findings and how they will be used to improve residential group care. Currently, over 34 states, including Maryland, have some form of legislation surrounding CACs. Legislation on CACs that is supported by the National Children's alliance includes legislation which defines child advocacy centers and their role in the investigation process, the expansion of services and resources for CAC, and state funding for CACs through government funds. *Proposed Policies:* New Jersey: A3558 (2019). Children Animal Assisted Therapy Pilot Program which would establish a pilot program in Department of Children and Families providing animal-assisted therapy to victims of childhood violence, trauma, or children with behavioral health care needs, appropriates funds.
INCREASE MENTAL & BEHAVIORAL HEALTH SERVICES IN SCHOOLS: **Children with an ACE score of four or more are:** • **4 times more likely to develop depression** • **12 times more likely to attempt suicide** • **32 times more likely to experience behavioral problems in the classroom than children who have an ACE score of zero.[70] Providing mental and behavioral health services in schools allows access to resources to address the impact of ACEs in a familiar, easily accessible environment that is comfortable and easily accessible.[71]**		*Passed:* Colorado: H1017 (2019). Requires the department of education to select a school district to partake in a pilot program that provides a social worker dedicated to each grade from kindergarten to 5th grade to prevent, reduce, and resolve ACE exposure and ACE- related stress. Illinois: SB565 (2017). Requires health examinations for school entrance to include age appropriate social, emotional, and developmental screenings; performed by the child's primary care provider; proof of examination must be provided to the child's school annually. The examination form is not required to disclose the results but may include suggested services based on the results of the evaluation that may be provided by the school with parent's consent.

Studies show that the implementation of mental health services in schools has: • **increased academic success and graduation rates** • **decreased rates of truancy and discipline** • **improved overall school climate and community.**[72]		Iowa: Chapter 225.54 (2015). Provides state block grants for school- based mental health projects and crisis intervention services in schools offered through partnerships with community mental health organizations. Utah: H264/ Act 412 (2018). Provides grants for school-based counselors and social workers to provide school-based mental health supports in elementary schools, including for trauma-informed care. Washington: S5903/ Act 360 (2019). Creates a Children's Mental Health Workgroup to identify barriers to accessing mental health services, monitor the implementation of legislation and policies relating to children's mental health and consider strategies to improve coordination between education and health systems. The Act also mandates that educators have additional professional days to cover trauma-informed care, social-emotional learning, and ACEs training.
TRAUMA INFORMED SCHOOLS: TRAINING, PRACTICES, CURRICULUM, POLICIES, AND DISCIPLINE **When children have experienced trauma, they are more likely to act impulsively, have problems focusing, and regulating their emotions, leading to serious behavioral problems or lack of engagement. Creating trauma -informed schools has been shown to result in positive outcomes for students and teachers, including fewer disciplinary incidents and office referrals. Oftentimes, toxic stress and anxiety which results from ACE exposure causes adverse physical and emotional responses, such as violent behavior or aggressive outbursts by children in the classroom. This response, in turn, leads to punishment and disciplinary action, which only adds to the stress experienced by the child. Multiple studies of trauma-informed programs in schools have found that these programs reduce aggressive behavior, crime, and conduct problems,**	*Passed:* HB277 (2020) State Department of Education – Guidelines on Trauma-Informed Approach The bill establishes a pilot project to create trauma-informed schools and requires MSDE, DHS, and MDH to establish and publish guidelines for a trauma-informed approach.	*Passed:* District of Columbia: Act 22-398 (2018). Requires the Department of Education to implement measures to reduce out of school suspension and expulsion and foster trauma informed, positive school environments. Indiana IN H 1283 (2020) Relates to trauma response instruction for teachers, requires a teacher preparation program to include training on trauma response instruction and recognition of social, emotional, and behavioral reactions to trauma that may interfere with students' academic functioning. HB1421 (2018). Requires schools to reduce out of school suspension and expulsion and requires a legislative committee to be assigned the task of studying the use of positive discipline and restorative justice in schools and determine the extent to which these forms for discipline are utilized in schools currently. Iowa: S2133/ Act 1051 (2018). Requires school districts to implement employee training and establish rules and best practices on suicide prevention, the identification of ACEs, and strategies to reduce toxic stress. Tennessee: S1386 (2018). Requires the Department of Education to develop an evidence-based training program on ACEs for school teachers and leadership.

results which also produce large returns on the investments made in the programs themselves.		Resolution 166, (2019) was enacted to urge local education agencies to provide the training developed by the Department of Education to all teachers. Tennessee: S64 (2019). Requires local boards of education to adopt a policy requiring all K-12th grade teachers, principals, and assistant principals to be part of an ACEs training on an annual basis. Massachusetts: HB4376 (2014). Within the context of reducing gun violence, establishes a framework for safe and supportive schools, which considers the findings of the ACEs study and utilizes trauma informed practices. The framework aims to create schools that foster healthy relationships between children and the peers and teachers, provide mental, physical and behavioral health services, and integrate practices and services that promote social and emotional learning and reduce instances of truancy, suspension and expulsion, and dropout. Pennsylvania: S1142 (2018). Establishes School Safety and Security Grant Program and Fund, to be used for the administration of ACEs screening and trauma-informed counseling services for students based on screening results. HB1415 (2019). Defines trauma-informed approaches, requires development training for school administrators and staff on trauma informed approaches, and amends the requirements for post-baccalaureate certification to teach primary and secondary education to include coursework on trauma informed approaches. Tennessee: Act No 421 (2019). Requires local Boards of Education to adopt a policy requiring schools to perform an ACEs screening before taking disciplinary actions against a child, including suspension, in-school suspension, expulsion, or transfer to an alternative school. Washington: Act 231 (2018). Directs the Department of Children, Youth and Families to develop a 5-year strategy on expanding training in trauma informed child care for early learning providers and reducing expulsion from early learning environments. Act 386 (2019). Creates the Social-Emotional Learning Committee to promote social emotional learning that will help students build awareness and skills in managing emotions, setting goals, establishing relationships, and supporting student success. The legislation also notably includes benchmarks which

		educators must meet regarding training for trauma informed practices and consideration of ACEs. S5903/ Act 360 (2019). Creates the Children's Mental Health Workgroup and mandates that educators have additional professional days to cover trauma-informed care, social-emotional learning, and ACEs training. Wisconsin: A843/ Act 143 (2018). Creates Office of School Safety and requires the office to train school staff on school safety, trauma-informed care and how adverse childhood experiences have an impact on children and increase the need for support. Maine H 851 (2019) Directs the Commissioner of Education to convene a task force, inviting the participation of experts and interested parties, to develop guidance for kindergarten to grade twelve administrators on appropriate training and responses to childhood trauma. Maine ME H 851 (2019) Directs the Commissioner of Education to convene a task force, inviting the participation of experts and interested parties, to develop guidance for kindergarten to grade twelve administrators on appropriate training and responses to childhood trauma. *Proposed Policies:* New York: A11081 (2019). Requires ACEs training for licensed day care providers.
		Passed: Arkansas: Act 1064 (2019). Recognizes Arkansas has the highest percentage of ACEs in its students and requires that the University of Arkansas for Medical Sciences establish a pilot program that creates a school safety and crisis line that can be accessed by phone, text, application, or program participation, providing students with the ability to report anonymously unsafe activity, abuse, bullying, thoughts of suicide, drug issues, and other threatening behaviors in order to address the problems associated with high ACE scores. Also, provides

		for crisis intervention services, such as counseling. Texas: Act 464 (2019). Requires all schools to develop a plan of improvement, which includes assessment of need for various groups of students, district performance objectives for programs including suicide prevention, violence prevention, conflict resolution, and training on how trauma can affect student behavior and trauma-informed strategies to support affected students. The Act also includes provisions for teaching students about mental health and providing mental health services in schools. Utah: Act 446 (2019). Authorizes the State Board of Education to distribute money to local education agencies for personnel who provide school-based mental health support. The Act also establishes the Safe UT Crisis line to provide means for anonymous reporting of unsafe, violet, or criminal actives, bullying, physical or sexual abuse by a school employee/volunteer, and crisis intervention.
FAMILY-CENTERED SUBSTANCE USE TREATMENT FOR PARENTS **Growing up in a home where a parent experiences a substance abuse disorder was one of the ten ACEs in the original ACE study, as it often leads to dysfunction and instability within the family.[73] States have created family-centered programs that offer assistance to parents with substance use disorder to help them recover, provide EBP parenting support and provide programming for the children to buffer them from the negative consequences of parental substance use.**		*Passed:* Florida: Act 151 (2017). Creates a pilot program for shared family care residential services to families that have a member experiencing substance use disorder. Establishes an accountability system for residential group care providers based on quality standards, including promotion of high-quality services and accommodations, considerations of the level of availability of trauma informed care and mental and physical health services, the level of provider's engagement with school and extra circular activities, and a following report on the findings and how they will be used to improve residential group care. Indiana: SB446 (2017). Creates an opioid addiction recovery pilot program to assist pregnant women and new mothers that have a substance abuse disorder by providing residential facility treatment and home visitation services. *Proposed Policies:* Massachusetts: H4742, (2018). Would establish the Community Behavioral Health Promotion and Prevention Trust Fund to issue grants to community organizations establishing or supporting evidence-based programs relating to substance abuse disorder for children and adults. Programs will be selected for

		funding based on the program's use of the science of prevention, ACEs, and trauma informed care.
STATE POLICY DIRECTIVE TO ADDRESS CHILDHOOD TRAUMA **All State Child & Family Serving Systems to Address Childhood Trauma**		*Passed:* Alaska: S105 (2018). Revises provisions on licensure of martial and family therapists. Additionally, it establishes a state policy directive to policymakers, administrators, and those working within state programs and grants to make decisions that "take into account the principles of early childhood and youth brain development and, whenever possible, consider the concepts of early adversity, toxic stress, childhood trauma, and the promotion of resilience through protective relationships, supports, self-regulation, and services."
BILL OF RIGHTS OF CHILDREN OF INCARCERATED PARENTS **Preventing and mitigating ACEs caused because of system involvement by parents. Parental incarceration is one of the ten ACEs initially identified in the original ACEs study, as separation from the parent for prolonged periods of time disrupts the relationship between the child and the parents, hindering the child's development and often causing toxic stress for the child. Ensuring support for children when a parent is incarcerated, including arrest, sentencing, visitation and parent-child contact policies, and mentoring programs, help to buffer children from the negative consequences of parental incarceration.**		*Passed:* Hawaii HI HCR 205 (2019) Requests the Department of Human Services, in consultation with the Department of Public Safety, to work with the family reunification working group and other community stakeholders to develop a plan to establish visitation centers at all state correctional facilities and jails. Illinois: H2444 (2019). Expands consideration of factors such as whether the defendant is the parent of a child or if the defendant serves as a caregiver to someone who is ill, disabled, or elderly in sentencing, recognizing that parental incarceration is an ACE for the child and can have negative impacts on the child. H2649 (2019). Amends the Code of Criminal Procedure, creates the Task Force on Children of Incarcerated Parents, provides that the Task Force shall review available research, best practices, and effective interventions to formulate recommendations. SCR7 (2019). A resolution requesting that human services and public safety work to develop a plan for the establishment of visitation centers at all state correctional facilities and jails for children to visit their incarcerated parent. It recognizes that the incarceration of a parent is an ACE and can lead to adverse outcomes for children and that parental bonding is essential for children's development. Oregon: SB241 (2017). Establishes a bill of rights for children of incarcerated parents, including the right to be protected from additional trauma at the time of parental arrest, the right to remain informed about their parent's arrest in an

		age-appropriate manner, the right to see, speak with and touch their incarcerated parent, and more. Missouri: Chapter 217 (2018). Creates a women offender program to ensure that female offenders are provided with trauma-informed and gender responsive supervision strategies, including physical and mental health care, child visitation, and more. Texas: S1356 (2013). Requires all juvenile probation and supervision officers receive training on trauma informed care administered by the Department of Human Resources. H650, (2019). Requires correctional officers to be trained on issues relating to the physical and mental health of pregnant inmates, including appropriate care, the impact of incarceration on a pregnant inmate and the unborn child, the use of restraints, the placement of administrative segregation, and invasive searches. It also includes provisions for reviewing visitation policies and evidence-based visitation practices that enhance paternal bonding and engagement and allow for age-appropriate visiting activities for children who visits their parents in correctional facilities. *Proposed:* Texas H2168 (2019). Would require screening of each inmate during the diagnostic process to determine whether the inmate has experienced ACEs or other significant trauma and refer the appropriate care when needed. The bill also requires screening and care for defendants. Washington S5876 (2019). Would create a women's division of correctional system to develop a system of gender responsive, trauma informed practices within the department of corrections, informed by individuals with training in ACEs and trauma informed practices.
POLICIES & PROGRAMS FOR CHILDREN WHO WITNESS DOMESTIC VIOLENCE		*Passed:* Illinois HR751 (2018). Declares domestic violence a public health priority given the trauma caused both to victims and their children and urging the state to provide all the necessary resources to prevent and address domestic violence.

POLICIES & PRACTICES TO ENSURE TRAUMA-INFORMED RESPONSE IN CHILD CUSTODY COURT PROCEEDINGS **Recognizing that divorce and separation, all forms of child abuse and neglect, and witnessing domestic violence are ACEs for the child, the court, in order to meet "the best interest of the child" standard," must ensure that custody and visitation proceedings and decisions are informed by ACE science and do not exacerbate harm to the child.**	*Passed:* SB 567, (2019). Establishes a Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations. Requires the Workgroup to study available science and best practices pertaining to children in traumatic situations, including trauma-informed decision making. and make recommendations about how State courts could incorporate the science into child custody proceedings. ***September 2020 Workgroup's Final Recommendations*** http://dls.maryland.gov/pubs/prod/NoPblTabMtg/CmsnChdAbuseDomViol/FinalReport_Workgroup_to_Study_Child_Custody_Court_Proceedings_Involving_Child_Abuse_or_Domestic_Violence.pdf HB 78 / SB 52 (2021) Establishes the Maryland Commission on Health Equity to employ a "health equity framework" in specified examinations; provide advice on issues of racial, ethnic, cultural, or socioeconomic health disparities; facilitate coordination of expertise and experience in developing a comprehensive health equity plan addressing the social determinants of health; and set goals for health equity and prepare a plan for the State to achieve health equity in alignment with other statewide planning activities. The commission must establish an advisory committee on data collection.	*Passed:* Florida FL H 1105 (2020) Relates to child welfare, requires the Court Educational Council to establish certain standards for instruction of circuit court judges for dependency cases, including regarding the benefits of a secure attachment with a primary caregiver, the importance of stable placement, and the impact of trauma on child development. Virginia VA H 744 (2020) Relates to sentencing of a juvenile tried as adult, in which case the court shall consider the juvenile's exposure to adverse childhood experiences, early childhood trauma or any child welfare agency.

	Proposed: HB 748 / SB 57 (2021) Would alter statutory provisions that require a court to deny custody or visitation rights to a party in specified circumstances involving the abuse or neglect of a child. Would require a supervised visitation arrangement that assures the safety and physiological, psychological, and emotional well-being of the child. These requirements would intervene to lessen immediate and long-term harm of ACE's. HB 1036 / SB 675 (2021) Would require the Judiciary, in consultation with domestic violence and child abuse organizations, to develop a training program for judges presiding over child custody cases involving child abuse or domestic violence. The training would include numerous specific topics that prevent adverse childhood experiences. Judges would be educated about typical brain development of infants and children, the dynamics and effects of child sexual abuse, physical and emotional child abuse, and domestic violence as well as the impact of exposure to domestic violence on children and the importance of considering this impact when making child custody and visitation decisions. SB355 (2020) Would establish specified requirements regarding the education, licensure, experience, and training of "custody evaluators." The evaluator must have experience in the impact of interpersonal loss and chronic stress on an individual and family system as well as	

	experience in mental health diagnoses, including current substance abuse issues relevant to the capacity of an individual to provide health, protective, or restorative parenting, etc. Skill-based learning is an important part of a comprehensive approach to prevent ACEs. Learning how to handle stress, resolve conflicts, and manage emotions and behaviors can prevent violence victimization and perpetration, as well as substance misuse.	
POLICIES & PRACTICES TO ENSURE NEXT GENERATION PREVENTION & TRAUMA-INFORMED RESPONSE IN CHILD WELFARE	*Passed:* HB 548 / SB 299 (2021) Establishes the Commission on Trauma-Informed Care as an independent commission in the Department of Human Services (DHS) to coordinate a statewide initiative to prioritize the trauma-responsive and trauma-informed delivery of State services that affect children, youth, families, and older adults. ACEs are potentially traumatic events that occurs in early childhood. ACEs can include violence, abuse, and growing up in a family with mental health or substance use problems. 1 in 6 adults experience four or more types of ACEs. 75.6 % of the chronically depressed patients reported clinically significant histories of childhood trauma. Preventing	*Passed:* Arizona: 8-471(2014). Requires that child welfare workers and child safety workers receive training on the impact of ACEs and interventions to prevent negative outcomes associated with ACE exposure. California CA A 2944 (2020) Expands the locations where a child or nonminor dependent may be placed, on and after a specified date, to be eligible for AFDCFC to include a residential family based treatment facility for substance abuse that meets specified requirements in which an eligible child is placed with a parent in treatment. Provides a one-year extension for the payments of specified established interim rates. California: S1460 (2014). Requires that recruitment include efforts to find adoption and foster care individuals who reflect the ethnic, racial and cultural diversity of foster children and adoptive children. A819 (2019). Amends child welfare code to require that core services be trauma informed and include specialty mental, physical, behavioral, transitional, and educational services be provided to children as needed. Replaces previous

ACEs could reduce the number of adults with depression by as much as 44%.
Passed:

HB 78 / SB 52 (2021) Public Health – Maryland Commission on Health Equity – (The Shirley Nathan-Pulliam Health Equity Act of 2021). Requires the creation of the Maryland Commission on Health Equity to address health equity and systemic racism. Race is a social construct with no biological basis that artificially divides people into distinct groups based on characteristics such as physical appearance, ancestral heritage, cultural affiliation, and the social, economic, and political needs of a society at a given period. Racism has been declared as a public health crisis. Exposure to racism and discrimination act as risk factors for the development of the toxic stress response. Racism and the resulting systemic inequities create conditions that lead to ACEs, such as disproportionate incarceration rates among people of color. Exposure to racism can act as a direct and chronic stressor and can lead to a prolonged activation of the body's biological stress response and disrupt the normal functioning of neuro-endocrine, immune, metabolic and genetic regulatory system systems.

licensing process for foster families with unified resource family approval process and requires that resource family applicants are trained in trauma informed practices to support children impacted by ACEs.

Oklahoma: S141 (2019).Establishes the Successful Adulthood Act, which is meant to ensure that all eligible individuals who have been or are in the foster care program due to abuse or neglect receive the protection and support necessary to allow those individuals to become self-reliant and productive citizens and break the cycle of abuse and neglect through services such as transitional planning, education, housing, medical care, and tuition waivers.

Washington WA H 2525 (2020) Establishes the family connections program to facilitate interaction between a parent of a child found to be dependent and in out-of-home-care and the individual with whom the child is placed. The program is intended to put the child first, prevent future child trauma, reduce family trauma and support the child by helping adults learn.

Proposed Policies:

New Jersey NJ A 3558 (2019) Would establish a pilot program in Department of Children and Families providing animal-assisted therapy to victims of childhood violence, trauma, or children with behavioral health care needs, appropriates funds.

ENDNOTES

*This list is an example of legislation being introduced and/or passed by states to prevent and mitigate ACEs and promote resilient communities. It is not intended to be a comprehensive list of legislation and will be updated periodically as more is learned about ACE-informed policy initiatives in Maryland and sister states.

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APPENDIX P

MARYLAND GUIDELINES AND BEST PRACTICES FOR THE DESIGN, ASSESSMENT AND MODIFICATION OF PHYSICAL FACILITIES AND SPACES TO REDUCE OPPORTUNITIES FOR CHILD SEXUAL ABUSE

Developed Jointly by
The Interagency Commission on School Construction and
The Maryland State Council on Child Abuse and Neglect
pursuant to MD Code Ann., Education, § 6-113.1(e)

May 2020

Interagency Commission on School Construction (IAC)

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Ellington Churchill, Secretary, Maryland Department of General Services
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EXECUTIVE SUMMARY

In 2018 the Maryland General Assembly passed HB 1072 (MD Code Ann., Education, § 6-113.1) in order to prevent child sexual abuse and sexual misconduct by school employees *before it occurs.*

§ 6-113.1 defines sexual misconduct and child sexual abuse and requires schools to train all employees in the primary prevention of child sexual abuse, as well as develop policies and codes of conduct to prevent child sexual abuse and misconduct by employees. Additionally, it requires that:

- COUNTY SCHOOL BOARDS DEVELOP POLICIES AND PROCEDURES ON THE USE AND MODIFICATION OF PHYSICAL FACILITIES AND SPACES TO REDUCE OPPORTUNITIES FOR CHILD SEXUAL ABUSE.
- THE INTERAGENCY COMMITTEE ON SCHOOL CONSTRUCTION and THE STATE COUNCIL ON CHILD ABUSE AND NEGLECT JOINTLY DEVELOP GUIDELINES AND BEST PRACTICES FOR THE ASSESSMENT AND MODIFICATION OF PHYSICAL FACILITIES AND SPACES TO REDUCE OPPORTUNITIES FOR CHILD SEXUAL ABUSE;

After several meetings between the staff from IAC, MSDE- School Facilities Branch, staff and members of SCCAN, study of the literature, and consultation with experts in the field of child sexual abuse prevention and Crime Prevention Through Environmental Design (CPTED), the enclosed guidelines and best practices were identified.

It should be noted that each of the provisions of § 6-113.1 work together and not in isolation to create schools safe from child sexual abuse and misconduct, e.g., modifying physical facilities to provide windows in classroom doors must be supported by creating and enforcing policies and codes of conduct that prohibit covering up those windows and training that supports understanding and adherence to the policies and codes of conduct for the modifications to be effective.

INTRODUCTION

Creating safe and supportive school environments is necessary not only to help all students to learn and grow but to prevent child sexual abuse and the multiple forms of violence that disrupt learning and lead to social, emotional, physical, relational, academic, health, economic issues across the lifespan.[i] Investing in safe and supportive school environments also provides a safe, healthy, less stressful and more rewarding work environment and reduces teacher turnover rates.[ii] Additionally, since an incident of child sexual abuse associated with a school, or any organization, typically attracts media attention and a lawsuit, adherence to these guidelines and best practices, the other provisions of § 6-113.1, and careful employee screening processes ensures that schools are able to demonstrate that they have taken every step to protect the

children in their care.

The Magnitude of Child Sexual Abuse & Sexual Misconduct in Schools

- *Child sexual abuse is a preventable public health problem*. Unfortunately the exact magnitude of the problem is unclear, as most school systems, including Maryland's, are not required to collect data on the incidence of child sexual abuse and misconduct by school employees. One review of existing studies found that rates of children experiencing misconduct ranged from 3.7% to 50.3%.[iii] The most comprehensive study, with national data, found that[iv]: 9.6 percent of students in grades 8 to 11 experienced contact and/or noncontact educator sexual misconduct during some point in their school career;
- 8.7 percent report only noncontact sexual misconduct and 6.7 percent experienced only contact misconduct. (These total to more than 9.6 percent because some students reported both types of misconduct.)

As child sexual abuse is correlated with higher levels of depression, guilt, shame, self-blame, eating disorders, somatic concerns, anxiety, dissociative patterns, repression, denial, sexual problems, relationship problems, physical health problems,[v] and poorer academic achievement,[vi] it is imperative that schools and other youth-serving organizations have policies and procedures in place to *prevent child sexual abuse before it occurs*. In addition to the human suffering of child sexual abuse, the economic cost is estimated to be more than $280,000 per victim.[vii] The estimated economic impact of child sexual abuse in the U.S. is $9.8 billion.[viii]

Student-on-student sexual abuse and assault is also a significant problem in schools, with roughly 17,000 official reports of sex assaults by students in the United States between 2011 and 2015.[ix] While Title IX requires colleges and universities to report sexual violence annually, elementary and secondary schools are not required by national or state law to track and disclose such incidents. Unfortunately, due to this lack of tracking and disclosure of school employee and student-on-student sexual abuse and assault, the true extent of the problem is unclear.

This document will introduce several research-based guidelines and best practices: The Situational Prevention Approach (SPA)[x], Crime Prevention Through Environmental Design (CPTED)[xi], and Centers for Disease Control and Prevention Guidelines (CDC)[xii]. Correctly applying such easily demonstrated strategies will enable schools to better protect their students.[xiii, xii]

Resources on Best Practices and Guidelines for the Design and Modification of Physical Facilities to Prevent Child Sexual Abuse

The following are best practices and guidelines for the design and modification of physical facilities to prevent child sexual abuse in schools:

1. **Centers for Disease Control and Prevention's (CDC) Recommended Policies and Procedures for *Preventing Child Sexual Abuse Within Youth-Serving Organizations*[xiv]** This document provides best practices, developed by a panel of experts and relevant literature, to help prevent child sexual abuse in youth-serving organizations, including schools. Key elements include:
   - *VISIBILITY – building or choosing spaces that are open and visible to multiple people to create an environment where individuals at risk for sexually abusive behaviors do not feel comfortable abusing*
   - *PRIVACY - when toileting, showering, changing clothes*
   - *ACCESS CONTROL – monitoring who is present at all times*

2. **Situational Prevention Approach** – *For environmental design assessment.* A number of Situational Approach Recommendations are considered best practices.[xv] Those not specifically related to design and construction are included in Appendix A. For environmental design/school construction, the Four Step Safety Assessment Process is recommended, and discussed in detail in the recommendations. This process allows schools to identify and address risks for child sexual abuse, sexual assault, and sexual misconduct, as well as other risks to student safety that are inherent in the school environment.

3. **Crime Prevention Through Environmental Design (CPTED)[xvi]** – *For designing, assessing, and modifying environmental facilities.* CPTED is a well-established and well-researched field of crime prevention used throughout the world. It employs proven methods that increase the responsible, positive use of property while decreasing the likelihood of criminal behavior. CPTED principles incorporate strategies that take into consideration physical features, social activities, and people in order to encourage positive and discourage negative human behavior as people interact with their environment. Additionally, the Centers for Disease Control and Prevention (CDC) has recognized that communities applying CPTED principles report decreases in gun violence, youth homicide, disorderly conduct, and other violent crime, as well as positive impacts on residents' stress, community pride, and physical health.[xvii]

   The overarching goals for implementing CPTED principles is to design, retro-fit, and maintain the physical space in a way that:
   - Empowers people to notice and intercept problems at an early stage; and,
   - Discourages offenders from acting because they are more likely to be noticed and apprehended.

   CPTED's four guiding principles of design are:
   - *NATURAL SURVEILLANCE - maximizes observations and visibility of unacceptable behavior by the design and placement of physical features and persons. The goal is to both eliminate hiding or hard-to-see places and increase the ability of authorized adults to monitor and respond.*
   - *ACCESS CONTROL - uses real or perceived barriers and other features to orient and guide people and vehicles along appropriate paths and to restrict inappropriate access. The*

objectives are to increase comfort and decrease prohibited behaviors by providing safe routes and restricting unauthorized access.

- *TERRITORIALITY –uses physical features to define space and to demonstrate a sense of ownership and pride. The goal is to convey that an area is not only owned and cared for, but that prohibited behavior will not be tolerated.*
- *MAINTENANCE (both physical and order) - supports the first three design principles by ensuring the repair, replacement and general upkeep of the physical space and attention and response to minor inappropriate behaviors.*[xix]

Balancing School Design Efforts to Prevent Multiple Safety Threats

Given the increase in number of school shootings over the past several decades, there have been recent discussions about how to configure schools to maximize safety in the event of an active shooter situation. It is important to note that while school shootings generate significant media attention, active shooter events within school settings thankfully remain uncommon. The probability of being sexually abused is much higher.

It should also be noted that strategies and tactics intended to prevent school shootings and those intended to prevent child sexual abuse in schools should be complimentary. For instance, during lockdown procedures designed to be carried out swiftly, the school's interior windows, installed to enhance natural surveillance and discourage child sexual abuse, can be readily covered by blinds or shades, reducing visible targets for the active shooter. The use of electronic locks with card readers not only controls an unauthorized person's access to isolated areas, it also creates an audit trail to discourage staff from being isolated with a child. Surveillance cameras, primarily used to identify trespassers, vandals and intruders, can be equally effective at discouraging student-on-student sexual abuse by recording who enters and exits group restrooms and at what time.

The following operational strategies are useful for both preventing child sexual abuse and preventing or mitigating active shooter incidents and other emergencies when visual refuge is of higher importance.

- Documenting who comes and goes on facility property;
- Having a single point of entry for the public and controlling the use of all exits and secondary entries;
- Applying a visitor management system to identify registered sexual offenders attempting to enter;
- Ensuring all locations are monitored by staff, especially group restrooms;
- Clearly mark off-limits areas;
- Posting safety rules and regulations.
- Use of cameras and surveillance to deter or monitor youth-on-youth and youth-staff/volunteer interactions and to be able to track location of an armed intruder;

- All doors that remain locked should have a vision panel or sidelight to permit natural surveillance into the room. These panels or sidelights should only be covered during a Hide-in-Place emergency.

    - Keep unused areas/rooms secured and locked;
    - Keep all areas well lit.

Additionally, minimum standards for encouraging a safe physical environment in schools can be overridden with technology or simpler design innovations during an emergency situation:

- Having windows or sidelights at doors to allow monitoring of youth-on-youth and youth-staff/volunteer interactions;
- Ensuring that meetings between staff and children are in unlocked rooms where they are visible to others via windows or sidelights at doors, but have a means to protect students and staff in case of an armed intruder entering the school (window coverings, locking system for emergency response, and policies and enforcement practices that prohibit the use of window coverings and locking systems except in emergency situations).

GUIDELINES FOR IMPLEMENTING BEST PRACTICES

Below are design review best practices that can be converted into a checklist for Capital Improvement Projects and a survey assessment for existing schools. Note that these best practices for the design of the school environment must be supported by the school policies and its employees' adherence to them. This is particularly important when school policies, on one hand, require that interior glass areas be covered during a Hide-in-Place emergency but, on the other hand, policies require that the same glass areas remain visible during normal times. For that reason, it is useful to publish and enforce clear protocols that deter a person from having unchallenged access, privacy and control over a child. For example:

- If any doors are to remain locked at all times, then vision panels or sidelights should be part of new building or renovation designs.
- Vision panel and sidelight should *not* be permanently covered with posters or decorations that make it difficult to observe activity in the room.
- Interior blinds should *not* be drawn except the brief period of a Hide-in-Place emergency.
- Supervisors should have a key or keycard to open and inspect any locked room that cannot be readily surveilled.

School systems should also collect comparable incident data (see Appendix B). on where and when abuse occurs and between what type parties (male/female, staff/student, visitor/student, etc.). Data collection is critical to the understanding of what is most important to address.

GENERAL STANDARDS

1. The organization acknowledges child sexual abuse (adult-child and child-child) as an inherent threat.

2. The organization adopts recognized prevention strategies to address each type of threat.
3. The organization demonstrates its commitment to each prevention strategy.
4. The organization regularly evaluates the effectiveness of each prevention strategy.

I. DEVELOP A CLEAR DESIGN PROCESS

Use the best practice Situational Prevention Approach **Four Step Safety Self-Assessment Process** to identify and respond to safety risks in the physical environment:

- **STEP 1 - Brainstorming Safety Risks for specific Locations.**
  Staff, older students, and parents should be engaged in this process, and it should be specific for each location. Risks are brainstormed in seven key areas: high risk locations; characteristics of high-risk youth; facilitators; organization and community policies; lifestyle and routine activities; the larger community environment; and health, safety, and accident prevention (See Appendix B).
- **STEP 2 – Developing Solutions for Each Identified Safety Risk**.
  For each identified risk, practical strategies should be implemented to eliminate or reduce the risk. Examples include limiting access to the front door that takes visitors past the receptionist and prevents entry by unknown visitors or requiring all visitors to sign in and wear a visitor badge.
- **STEP 3- Prioritization of Safety Risks to Address & Logistical Considerations**.
  This step is typically completed by the school leadership with consultation from higher level administrators since resources may be needed to implement particular safety solutions. Considerations for prioritization include how concerned the leadership is about the risk as well as costs and staffing issues associated with solutions.
- **STEP 4 – Developing Solution Implementation Plans & Taking Action**.
  Schools are asked to work on resolving **five** risks at a time (i.e., three from their "Less Challenging" to solve list and two from the "More Challenging" list). A simple implementation plan is developed for each of the top five risks and the school administration guides the process of taking action to resolve each of these risks.

In the context of implementing these Guidelines on physical facilities and spaces it is especially important to consider ***High Risk Locations***[xx] which refer to specific rooms, hallways or spaces within or around the school setting. These locations may increase the chances of a safety incident due to a variety of reasons including a place's isolated nature (e.g., a remote baseball diamond), difficulty providing adequate supervision for this location (e.g., bathrooms, stairs, locker rooms) or even a place where the large number of other people present make supervision very difficult. High Risk Locations include any part of the school building or grounds as well as any setting that

participants travel to as part of their school involvement (e.g., field trips).

Additional best practices in the design process, include:

- Review the educational specifications and design documents with school resource officers and local police officials throughout the entire planning, design, and construction process to incorporate best practices for safety and security.
- Request that the design team include a specialist with CPTED training.
- Survey staff, students, and parents. This is an important part of this assessment, as students especially know the places they feel less safe.
- Follow the four design principles of Crime Prevention through Environmental Design (CPTED):
- Ensure the design process is connected to your training, policies, practices, and codes of conduct.

II. ASSESS CURRENT FACILITIES, SITES & CAPITAL PROJECT DESIGN USING CPTED PRINCIPLES TO FOCUS ON SUCH AREAS AS:*

SITE:

- **Signs clearly establish the limitations on the use of building and grounds.**
  Examples:
  - Posting trespassing warnings at regular intervals along a fence line
  - Signs limiting the use of parking areas and playgrounds during off-hours
  - Signs directing all visitors to enter buildings through a designated entry
- **Outdoor concealment areas are minimized.**
  Examples:
  - Plantings and hedges are trimmed low and trees are trimmed high
  - Dumpster enclosures are locked when not in use
  - Door alcoves are fully lit
- **Sidewalks and parking areas are made safe for pedestrians.**
  Examples:
  - Shadows are eliminated for pedestrians
  - Persons can be seen from 100 feet away at night
  - Timers or photoelectric cells adjust outdoor lights to seasonal fluctuations
- **Exterior gathering and play areas are made safe for children.**
  Examples:
  - Gathering and play areas are clearly designated by fencing, signs, lines or lines
  - Visual obstructions to monitoring are removed or mitigated
  - Monitoring vantage points are identified for staff and volunteers
- Provide clear views around the exterior of the school, including parking lots, play and sports areas to facilitate supervision after hours and at night.

- Eliminate potential hiding places created by landscaping and site walls near to the building. Solid walls should not be of a height that affords easy concealment. Consider using open fencing instead that allows supervision from either direction.
- Avoid deep recesses in the building form or open courtyards with limited views from the street.
- Provide a clear view of all parking lots and sports areas from one location to facilitate supervision.
- Provide a clear view of all play areas from one location to facilitate supervision during recess.
- Provide a separate enclosed outdoor play area for prekindergarten and kindergarten children.

EXTERIOR BUILDING SKIN:

- **Roof access is controlled.**

  Examples:

  - Exterior downspouts, columns and building features are modified to prevent climbing
  - Large items adjacent to buildings, such as dumpsters or storage buildings are relocated
  - Ladders and hatches leading to the room remain locked when not in use.
- Consider replacing or modifying existing doors and windows to withstanding an attempted forced entry. This might include strengthening the door or window, the frame, the locking mechanism and adding intrusion resistant security film to glass areas that could serve as entry points.
- Ensure that door hinges or hinge pins cannot be removed from the outside.
- Locate windows in exterior walls to increase natural surveillance in remote areas beside and behind the building.
- Consider tinting the glazing or installing exterior sunshade devices for windows that are critical for oversight of the exterior in order to reduce the need for blinds to block glare.
- Consider using interior solar shades that permit viewing the exterior but block views into the interior. On areas of the building that are less easily seen from the road, utilize exterior lighting on motion sensor so unauthorized activity in the area is more noticeable.
- Ensure all recessed secondary entry and exit doors are lighted to eliminate hiding areas.

BUILDING ENTRANCE:

- **Exterior building entries and exits are control at all times.**

  Examples:

  - There is a primary entry into a building for the general public
  - Visitors, vendors and contractors are identified and approved before entering a building
  - Building exits and secondary entries are controlled at all times by locks, alarms or direct supervision

- Provide a single point of entry to the school that is clearly identified to persons approaching the building. Incorporate a controlled access system that routes all visitors for clearance from administrative reception area.
- Provide clearly seen signage to direct visitors to the school entry.
- Provide visual supervision of the main entrance from the main administrative office as well as the main lobby.
- Provide the school receptionist with the ability to remotely lock the main entry and to institute a lockdown with the touch of a button.
- Monitor the entry and exit points at all times if possible. If not possible, have clear policies and procedures for how to control who has access.
- Provide an area to post safety rules and regulations for all occupants and visitors to follow.
- Consider providing natural surveillance of secondary entry points to the school or grounds by locating a staff office or work space adjacent, to that entry area with visual oversight.

THROUGHOUT BUILDING:

- **Interior building rooms remain locked when not in use.**
  Examples:
    - Program areas, such as classrooms, media centers and gymnasia
    - Service areas such as kitchens, mechanical rooms and janitor closets
- **Interior building blind spots and hiding areas are eliminated or mitigated.**
  Examples:
    - Objects blocking supervision sightlines are removed or relocated
    - Monitoring vantage points are identified for staff and volunteers
    - Rooms for instruction or activities can be monitored from outside the room
    - Restrooms and dressing rooms are designed or modified to facilitate frequent monitoring by staff
    - Room lighting is controlled to prevent hiding in unoccupied rooms
    - Surveillance cameras, sensors and other security technology support the supervision of remote areas, such as stairwells and corridors
- Provide the ability to close off sections of the building to control access after school hours.
- Design circulation and congregation spaces so that they are open and visible to multiple people. Maintain clear lines of sight as much as possible, e.g. minimize “blind corners” and “blind spots” where behaviors cannot be observed.
- All areas of a classroom or teaching space should be easily visible to staff from any point in the room. Avoid designing classrooms with nooks, alcoves or long entry halls that are hard to monitor and supervise from other parts of the room, especially for the younger grades. Use convex safety mirrors if needed to ensure visibility.
- Provide vision panels or sidelights, positioned and sized to permit a complete view into offices, classrooms, meeting rooms, and other rooms that may be occupied by more than one person.
- Consider providing vision panels on all cross-corridor and stair doors to ease monitoring the facility after hours.
- Install lockable partitions or cages to prevent top and bottom stair landings from becoming hiding

areas.

- Provide motion-activated, day/night cameras in stairwells to cover the entire length of the path, with no dead spots.
- Provide signage to clearly identify areas that are off-limits or can only be used with adult/staff supervision.
- Utilize strict key or keycard control to limit access to the most remote locations, such as roofs, attics and mechanical rooms or consider installing a motion-activated camera to document the use of the door.

TOILET ROOMS:

- Establish separate bathrooms for adults and children/youth. Prohibit adults from using a bathroom at the same time as children/youth, and clearly post rules.
- To prevent adults from sharing the group toilet rooms with students, consider providing a toilet room for staff or visitors in the main lobby near the major public spaces that can also be accessed during after-hours school use.
- Address potential contact between young children and older youth who are using bathroom facilities at the same time, paying special attention to circumstances where they may be a significant age differential between them.
- Entrances to boys' and girls' toilet rooms should be designed in such a way as to allow visual supervision by staff from the corridor.
- Screen the urinal area in the boys' toilet room from direct views from the corridor.
- Post rules inside the restrooms to reinforce acceptable, unacceptable and prohibited behaviors.
- Secure windows to prevent unauthorized entry from the outside.
- Consider zoning access within large group restrooms to promote rapid turnover and reduce loitering
- If multiple restrooms are on the same floor, consider temporarily locking access to those restrooms that are the most isolated and least frequented areas.
- Install a motion-activated, security camera to monitor the entry into group restrooms.

LOCKER ROOMS:

- Make Locker Rooms easy to find and identify with colors, signs and displays
- Clearly distinguish male, female and gender-neutral entries
- Distinguish between common areas and off-limit areas with signs and colors.
- Post rules to reinforce appropriate, inappropriate and prohibited behavior.
- Organize the locker room for easy surveillance, particularly gathering areas and possible areas of isolation. Avoid dead-end spaces that can be used for entrapment. Consider limiting the lockers in the middle of the space to only 4' tall.
- The PE instructor's office should be located near the main entry and exit of the locker room and provided with glazing to monitor the locker area.
- Block access to areas that are difficult to supervise.
- Use tamper-resistant locks to prevent easy access to off-limit areas
- Install a motion-activated security camera to monitor the entry into locker rooms.

HEALTH SUITE:

- For better supervision of the health suite, provide glazing in the walls and door of the health professional's office to allow full views of the waiting, treatment and rest areas, including when the door is closed for acoustical privacy.
- Separate rest areas for male and female students are recommended at the secondary school level. Consider providing a wall between the rest areas for male and female students.
- The rest area should not be completely enclosed and self-contained as it cannot be easily monitored, both visually and acoustically. Consider the use of privacy curtains and partial walls that do not block views from the nurse's workstation.

***NOTE THAT ITEMS IN BOLD ARE CONSIDERED MINIMUM STANDARDS**[xxi]

III. MONITOR, EVALUATE, & REVISE THE PLAN

Monitoring and evaluation are critical components of the public health approach to prevention of child sexual abuse and misconduct. Schools must collect timely and reliable data to monitor the extent of the problem and to evaluate the impact of prevention efforts. Planning, implementation, and assessment to prevent sexual abuse and misconduct in schools all rely on accurate measurement of the problem.[xxii]

In order to measure whether implementation of best practices in designing and retro-fitting the physical environment result in desired outcomes (i.e., reducing incidents of child sexual abuse and misconduct), it is critical that schools collect and report standard de-identified incidence data. Collection of incidence data on other negative behaviors like sexual assault, bullying, vandalism, and gang violence may reveal additional gains from implementation of improved design of physical spaces. Evaluating data, produced through program implementation and monitoring, is essential to providing information on risk and protective factors and what does and does not work to reduce child sexual abuse, sexual assault and sexual misconduct rates.
Collecting de-identified data is critical to understanding and prioritizing which problems are most important to address.

A checklist for tracking specific incidents is included in Appendix B. On an annual basis, schools should analyze the data and make called for adjustments to physical space, policies and practices.

APPENDIX A: SITUATIONAL PREVENTION APPROACH

The following Situational Approach Recommendations are considered best practices:

- School develops a clear statement about the need to set and maintain professional relationships with children;
- School personnel delineates the line between ethical or appropriate behavior from unethical/inappropriate behavior across specific situations;
- School specifically prohibits certain behaviors that constitute child sexual abuse/misconduct;
- ***School identifies and addresses higher risk situations/locations for child sexual abuse/misconduct;***
- The school's code of conduct and trainings regarding child sexual abuse/misconduct prevention apply to everyone in the organization, including administrative leadership, teachers, staff, and volunteers.
- Skills for prevention of child sexual abuse/misconduct are developed through trainings for all school staff and volunteers prior to the beginning of the school year, and trainings address the following:
    1. Knowledge about how to prevent and respond to child sexual abuse;
    2. Self-awareness that child sexual abuse can result from escalating boundary violations;
    3. Skills to keep children safe;
    4. Education to prevent, recognize, and report child sexual abuse;

Four Step Safety Self-Assessment Process[xxiii]

Applying the Situational Prevention Approach's (SPA) Four Step Safety Self-Assessment Process to school settings provides a process by which schools can ***identify and address risks for child sexual abuse, sexual assault, sexual misconduct, as well as other risks to student safety that are inherent in the school environment.*** According to Dr. Keith Kauffmann, PhD, a leading expert in preventing child sexual abuse in youth-serving organizations, the SPA process allows for brainstorming of safety risks, creating a prevention or a risk-reduction solution for each identified risk, prioritizing the order of risks to be addressed, and creating a brief implementation plan to guide taking effective action to resolve identified risks. The Four Step Safety Self-Assessment Process, fleshed out in the specific guidelines below, include:

- **STEP 1 - Brainstorming Safety Risks for specific Locations.**
- **STEP 2 – Developing Solutions for Each Identified Safety Risk**.
- **STEP 3 - Prioritization of Safety Risks to Address & Logistical Considerations**.
- **STEP 4 – Developing Solution Implementation Plans & Taking Action**.

APPENDIX B: CHECKLIST FOR TRACKING SPECIFIC INCIDENTS

Based on variables collected by the National Child Abuse and Neglect Data System (NCANDS)[xxiv], evidence-based child sexual abuse prevention programs[xxv], and the Responsible Behavior with Younger Children Survey[xxvi]; variables identified in *A Standard of Care for the Prevention of Sexual Misconduct by School Employees*[xxvii]; and variables identified through consultation with researchers and practitioners in the field[xxviii], the Maryland State Council on Child Abuse and Neglect (SCCAN) recommends that instances of child sexual abuse and sexual misconduct, as well as student-on-student sexual abuse or assault be tracked and recorded within the following data elements:

- Did the alleged incident include:
  - sexual comments, jokes, gestures, or looks?
  - showed, gave or left sexual pictures, photographs, messages or notes to victim?
  - sexual messages or graffiti about victim on bathroom walls, in locker rooms, or other places?
  - Spread sexual rumors?
  - Unwanted touching?
  - Kissing?
  - Touching the victim's private parts?
  - Having the victim touch the perpetrators private parts?
  - Oral sex?
  - Intercourse?
  - Sodomy?
- Date of Incident
- Date Incident reported to School Authorities
- Who reported/disclosed to school administration?
  - Student,
  - Teacher,
  - Administrator,
  - Other staff,
  - Parent,
  - Volunteer
- Who reported to CPS and/or Law Enforcement?
- Age of Victim
- Gender of Victim
- Race of Victim
- Ethnicity of Victim
- Victim disability
- Age of Perpetrator
- Gender of Perpetrator
- Race of Perpetrator
- Ethnicity of Perpetrator
- Role of Perpetrator within School (administrator, teacher, cafeteria worker, bus driver, parent, volunteer, student etc.)
- Was there a witness/es?
- Age of Witness/es
- Gender of Witness/es
- Race of Witness/es

- Ethnicity of Witness/es
- Role of Witness/es within the School
- Time Period:
    - Before school
    - After school
    - Planning period
    - Lunch
    - Field trip
    - Overnight trip
    - Other
- Location:
    - On or off school property?
    - Main building
    - Portable building
    - Playground
    - Sporting facility
    - Classroom
    - Office,
    - Closet,
    - Hallway,
    - Stairwell,
    - Restroom,
    - Playground,
    - Gym,
    - Locker room,
    - Cafeteria,
    - Auditorium,
    - Theater dressing rooms,
    - Backstage,
    - Outside space
    - Bus
    - Private vehicle
    - Other
- Method/s of obscuring sight lines:
    - Door closed
    - Door locked
    - Window/s obscured
    - Furniture (desks, bookcases, etc.) used to obstruct view
- Date Incident was Addressed:
- Manner of Handling Incident:
- Disciplinary Action for Incident:
- Which policies violated?
- Which tenet of the Code of Conduct was violated?
- Were drugs or alcohol involved in the incident?

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[xiii] Key information interview, R. Leslie Nichols, MSSA, CPP,October 16, 2018.
[xiv] Saul J, et,al.,2007.
[xv] Kaufman K, 2015.
[xvi] Lawrence Fennelly, Timothy Crowe, M.S., Crime Prevention Through Environmental Design, 3rd Edition, July 2013, p. 3.
[xvii] Centers for Disease Control and Prevention. Crime Prevention Through Environmental Design (CPTED) School Assessment (CSA). Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, and Carter & Carter Associates, 2017.
[xviii] Using Environmental Design to Prevent School Violence, https://www.cdc.gov/violenceprevention/youthviolence/cpted.html
[xix] Centers for Disease Control and Prevention. Crime Prevention Through Environmental Design (CPTED) School Assessment (CSA). Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, and Carter & Carter Associates, 2017.
[xx] High Risk Locations include, among others, stairwells, bathrooms, storage rooms, gym (when empty),sports equipment rooms, baseball dugouts, back seats of vehicles, woods around the building, unused, unlocked rooms, area behind vending machines,, unlit areas, unlit facility exterior areas.
[xxi] Key information interview, R. Leslie Nichols, MSSA, CPP,October 16, 2018 and October 8, 2019.
[xxii] Basile, K.C., DeGue, S., Jones, K., Freire, K., Dills, J., Smith, S.G., Raiford, J.L. (2016). STOP SV: A Technical Package to Prevent Sexual Violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
[xxiii] Kaufman K, 2015.
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[xxv] *Shifting Boundaries: Lessons on Relationships for Students in Middle School*, Nan D. Stein, Ed.D. with Kelly Mennemeier, Natalie Russ, and Bruce Taylor, Ph.D. December 2010.
[xxvi] Responsible Behavior with Younger Children Survey, Johns Hopkins Bloomberg School of Public Health

[xxvii] Charol Shakeshaft, Rebecca L. Smith, Steven Tucker Keener & Emma Shakeshaft (2019) A Standard of Care for the Prevention of Sexual Misconduct by School Employees, Journal of Child Sexual Abuse, 28:1, 105-124, DOI: 10.1080/10538712.2018.1477219

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APPENDIX Q

HIDDEN PREDATOR ACT (SB134 & HB263)

Will Maryland protect its children or protect its predators?

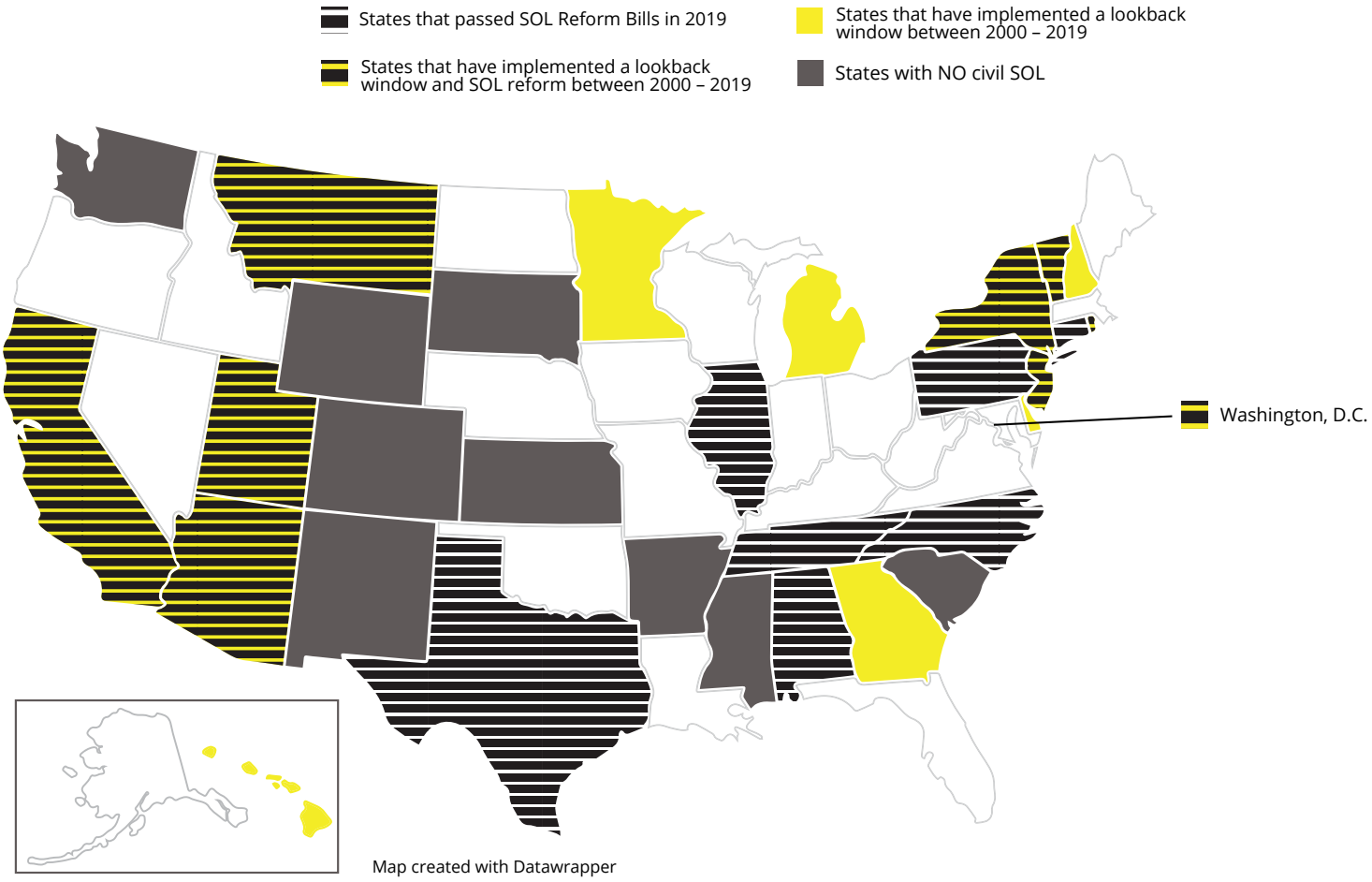
GOALS OF HIDDEN PREDATOR ACT (SB134 & HB263)

- Identify Hidden Predators
- Disclose Facts of Sex Abuse Epidemic to Public
- Arm Trusted Adults to Protect Children
- Shift Cost of Abuse from Victim to Those Who Caused It
- Justice for Victims Ready to Come Forward

WHAT WILL THE HIDDEN PREDATOR ACT (SB134 & HB263) DO?

- Eliminate the civil statute of limitations going forward.
- Create a lookback window for those victims who have been previously barred by the statute of limitations, allowing them to file suit for a period of two years.
- Removes the "statute of repose" making it clear to the courts, the public and survivors that the Maryland General Assembly did not intend to vest constitutionally protected property rights in child sexual predators nor the individuals and organizations that hid predators from discovery and prosecution.

Since 2018, 1/3 of states have passed laws extending the civil statute of limitations (SOL) and establishing a lookback window for child sexual abuse claims, enabling survivors the opportunity to have their claim considered in a court of law. This bill would apply to all individuals and organizations, **no one would be exempt from civil litigation.**



HIDDEN PREDATOR ACT (SB134 & HB263)

FACT: There is a national shift towards exposing Hidden Predators through civil SOL lookback windows.

In 2019, Washington D.C.:

- Extended the civil SOL where victim was under 35-40 with a 5 year discovery rule
- Opened 2 year revival window for victims abused as minors and adults
- **16** states + D.C. have passed "lookback windows" or revival laws and **9** states, including MD, have introduced these laws in 2020

In 2019, New Jersey:

- Extended the civil SOL for child sex abuse to age 55 or 7 years from discovery for claims against individuals, public and private institutions
- Removed claim presentment requirement for claims against public entities
- Opened 2 year revival window for victims abused as minors or adults against perpetrators and institutions

FACT: In other states lookback windows have exposed hidden predators.

In Delaware:

- During 2 year lookback window ('07-'09), **175** survivors filed claims
- Under follow-up window for healthcare providers, **1,000** claims made solely against Pediatrician Dr. Earl V. Bradley, the most active previously undisclosed predator to date

In Minnesota:

- **125+** predators identified, including the predator in the high-profile cold case of Jacob Wetterling
- During the 3 year lookback window ('13-'16), **1,006** claims were filed

In California:

- **300+** predators were identified
- During the 1 year look back window in '03, **1,150** survivors filed claims

Q: Is there a need for further Civil SOL reform?

A: Criminal and civil proceedings provide different solutions and both are needed for justice to be served. Criminal prosecutions are at the discretion of prosecutors and law enforcement with limited resources and are often not pursued. If pursued, the remedy is a criminal sentence for perpetrators. Civil suits empower victims to initiate a court case to shift the cost from the victim to those who caused the harm.

Q: How will the lookback window impact institutions that provide education and social services to low-income individuals and communities?

A: Many institutions receive a large percentage of their funding from government agencies as payment for services provided. This bill would have no effect on that funding or the ability to provide those social services. For example, nearly 77% of Catholic Charities revenue comes from governmental agencies. In rare circumstances, an organization may choose to seek legal relief under the bankruptcy code to reorganize their debt. This legal relief does not cause operations to close.

Q: In 2017, did the Maryland General Assembly intend to include a "statute of repose" in the legislation?

A: A "statute of repose" gives constitutionality protected property rights to a defendant. It is intended to be used in product liability cases to limit the length of time that the builder or inventor may be held responsible for problems or defects. It was never intended to protect wrongdoing by sexual predators and those that protect them from prosecution or discovery.

In 2017 There was no discussion or debate of the constitutional implications of the "statute of repose" in committee or on the floor of either chamber. Neither the Fiscal and Policy Note, nor the Revised Fiscal and Policy Note, make any notice of the pivotal constitutional implications to this law. Neither the constitutionality of a lookback window nor a "statute of repose" in child sexual abuse cases has been decided by the Maryland courts. Constitutionality should be determined by the courts.

The Hidden Predator Act (SB134 & HB263) removes the "statute of repose" language making it clear to the courts, the public, and survivors that the Maryland General Assembly did not intend to vest constitutionally protected property rights in child sexual predators nor the individuals and organizations that hid predators from discovery and prosecution.

Q: How will this bill help Maryland prosper?

A: The average age for adults to disclose childhood sexual abuse is 52. Research shows that children who experience an Adverse Childhood Experience (ACEs) can have poor long-term mental and physical health, educational, and employment outcomes at enormous cost to individuals and the state. The trauma from childhood sexual abuse may lead to PTSD, alcohol and opioid abuse, depression, suicide, and poor educational and employment outcomes. The lookback window provides survivors a window of time to access justice and shifts the costs of healing to those who caused the harm. It also provides protection for our children who may still be at risk from formerly unknown abusers and leads to improved institutional practices that keep children safe from sexual predators.

For additional information, please contact the State Council for Childhood Abuse and Neglect (SCCAN):
Claudia Remington, Executive Director | Claudia.Remington@maryland.gov

APPENDIX R

Questions in the 12-item Resilience Research Centre Adult Resilience Measure (RRC-ARM)

To what extent do the statements below describe you?

Response options: Not at all, a little, somewhat, quite a bit, a lot

1. I have people I can respect in my life
2. Getting and improving qualifications or skills is important to me
3. My family know a lot about me
4. I try to finish what I start
5. I can solve problems without harming myself or others (e.g. without using drugs or being violent)
6. I know where to get help in my community
7. I feel I belong in my community
8. My family stand by me during difficult times
9. My friends stand by me during difficult times
10. I am treated fairly in my community
11. I have opportunities to apply my abilities in life (like skills, a job, caring for others)
12. I enjoy my community's cultures and traditions

Questions included in the 12-item Child and Youth Resilience Measure (CYRM)

When you were growing up, during the first 18 years of life, to what extent would the following sentences have described you?

Response options: Not at all, a little, somewhat, quite a bit, a lot

1. I had people I looked up to
2. Getting an education was important to me
3. My parents/caregivers knew a lot about me
4. I tried to finish activities that I started
5. I was able to solve problems without harming myself or others (e.g. without using drugs or being violent)
6. I knew where to go in my community to get help
7. I felt I belonged in my school
8. My family would stand by me during difficult times
9. My friends would stand by me during difficult times
10. I was treated fairly in my community
11. I had opportunities to develop skills to help me succeed in life (like job skills and skills to care for others)
12. I enjoyed my community's cultures and traditions

APPENDIX S

Essentials for Childhood Survey on Awareness, Commitment, Norms

We would like to include you as a participant in the quarterly YouGov study on health and culture across the nation. If you agree to be in this study, we will ask you about your views and experiences with regard to quality of life issues. Participation is voluntary, and you may decline to answer any questions that you do not want to answer. The survey will take about 15 minutes to finish.

Below are some reasons people give to explain why some children struggle (i.e., disrupt the classroom, do poorly in school, become teen parents, get into drugs or involved in crime). For each one, please indicate how important do you think the reason is for why some children might struggle in the United States.

1. Children growing up living in poverty
2. Parents not working hard enough.
3. Families living in neighborhoods with a lot of other families that can't make ends meet
4. People not willing to support solutions that benefit all children, not just their own
5. Parents not thinking about the future of their children
6. Children born with bad personality traits that are passed from one generation to the next
7. Lack of public investment (e.g., in early care and education, schools, job opportunities) in low income neighborhoods and communities of color
8. Families living in unsafe neighborhoods (i.e., with easy access to drugs, guns, or gangs)
9. Children living in families with challenges like substance abuse, violence, mental health problems
10. Employers not adopting family-friendly practices (e.g., paying family and sick leave, flexible schedules to accommodate children's needs)
11. Parents being stressed about money
12. Children not working hard enough in school
13. Families living in neighborhoods with few resources or public services like community centers, libraries, or transportation
14. Children not having high quality (i.e., nurturing, stimulating, safe, and stable) early child care
15. Parents not knowing how to parent correctly
16. Children with learning challenges not getting the support they need
17. Limited political support for helping poor families get out of poverty
18. Children treated unfairly because of their color (e.g., in schools, by police, or the justice system)
19. Parents not having enough time for their children
20. Employers not paying parents enough to support a family
21. Children not thinking things carefully enough and end up making poor choices
22. Parents using harsh or aggressive discipline
23. Parents not supporting their children's learning through educational activities like reading to them or playing with them
24. Children going to poor quality schools
25. Parents not thinking things carefully enough and end up making poor choices.

RESPONSE OPTIONS:

extremely important
somewhat important
neither important or unimportant
somewhat unimportant
not at all important

Below are some things people have suggested communities could do to increase the opportunity for **all children** to succeed.

Please indicate how strongly you support or oppose the idea that communities should provide that all families….

26. Have easy access to affordable parenting classes
27. Have paid parental leave to care for a new child
28. Be able to buy enough nutritious food
29. Be able to live in safe and stable housing
30. Be able to leave their children in child care that is good for the child's development
31. Be able to send their children to high quality preschool
32. Be able to send their children to high quality schools in their neighborhood
33. Be able to get support to address their child's special learning challenges
34. Be able to send their children to schools that don't punish children by suspending or expelling them
35. Have easy access to after-school and summer care that provide meaningful opportunities for children
36. Have at least one adult (other than a parent or caregiver) who would provide a safe, stable, nurturing relationship for their children (e.g., a mentor, coach, or teacher)
37. Be able to live in a safe neighborhood where children aren't exposed to violence or illegal drugs
38. Be able to live in a neighborhood where few or no families have a hard time making ends meet
39. Be able to live in a city or county where their children are treated fairly in school, by police, or the justice system regardless of the color of their skin
40. Have a full-time job that provides sufficient income to cover basic needs for the employee and his/her child
41. Have a job that is "family-friendly" (e.g., provides flexible schedules, has on-site child care or provides subsides for child care, provides paid days to care for sick family members, paid leave to attend school events)
42. Have access to health care
43. Have access to mental health care or substance abuse treatment, if needed
44. Receive income support (cash, vouchers, or tax refund) to cover basic needs (e.g., housing, food, child care) if a bread winner loses his/her job or household income is below the income needed to cover basic needs

RESPONSE OPTIONS
- Strongly support
- Support
- Neither support or oppose
- Oppose
- Strongly oppose

45. Thinking about the ideas you **strongly** supported to increase the opportunity for **all children** to succeed, what action(s) have you personally taken in the past 12 months. (Check all that apply)

- I shared information about their importance with others
- I signed a petition or e-mailed a prewritten letter to decision-makers
- I asked friends or family to sign a petition or write to decision-makers
- I donated money to an organization supporting these ideas
- I made phone calls or went door to door to gather support for them
- I attended a meeting with business or community groups to urge they support them
- I attended a town hall meeting or public rally to support them

I met with an elected official or his/her staff to talk about them
I did none of the above

46. Sometimes we can feel passionate about issues in our community but not have enough time to take action. Again, thinking about the ideas you **strongly** supported to increase the opportunity for **all children** to succeed, how likely are you in the next 12 months to do the following ? (Check all that apply)
    I would share information about their importance with others
    I would sign a petition or e-mail a prewritten letter to decision-makers
    I would ask friends or family to sign a petition or write to decision-makers
    I would donate money to an organization supporting these ideas
    I would be willing to pay more taxes or higher prices at the register to support them
    I would make phone calls or go door to door to gather support for them
    I would attend a meeting with business or community groups to urge they support them
    I would attend a town hall meeting or public rally to support them
    I would meet with an elected official or his/her staff to talk about them
    I would do none of the above

In the next section, we would like to know about behaviors often used in caring for young children.

47. How many children live in your household? ____
48. This past year, was there a child under the age of 5 in your home or do you care for children under age 5 at least once a week?
    ☐ YES ☐ NO (If NO, skip to Q54).

In the past year, how often have you:

49. Let your child (or the child you cared for) know when you liked what he/she was doing?
    ☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

50. Responded to your crying infant (or infant you cared for) by trying to comfort them?
    ☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

    ☐ Not applicable because I did not care for an infant this past year

51. Played with or read a story to your child (or child you cared for) under the age of five?
    ☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

52. Spanked your child (or child you cared for) on the bottom?
    ☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

53. Yelled at or fought with another adult in front of your child (or child you cared for) or where the child could hear
    ☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

54. Asked or searched for help with parenting or caring for children when needed?
    ☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

55. Helped your child (or child you cared for) express themselves with words when they were angry or frustrated

☐ every time ☐ almost every time ☐ sometimes ☐ seldom ☐ never

56. Been a mentor (like a Big Brother or Big Sister) to an unrelated child?
☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

II. In this next section, we are interested in your perceptions of how the majority of parents behave with their children. Even if you are not sure, please give us your best guess.

Thinking about the **majority** of parents in [pipe inputstate]: how often do you think they…

57. Let their children know when they liked what they are doing
☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

54. Respond to their crying infant by trying to comfort them

☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

58. Play with or read a story to their child under the age of five
☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

59. Yell at or fight with another adult in front of their child or where their child could hear
☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

60. Spank their child on the bottom with their hand
☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

61. Help their child express themselves with words when they are angry or frustrated
☐ every time ☐ almost every time ☐ sometimes ☐ seldom ☐ never

62. Asked or searched for help with parenting when they needed it
☐ every day ☐ almost every day ☐ sometimes ☐ seldom ☐ never

63. How often do adults in your state mentor an unrelated child (like being a Big Brother or Big Sister)
☐ Every time it's needed ☐ Most of the times it's needed ☐ sometimes ☐ Rarely

III. In this final section we are interested in the opinions of those important to you. Thinking about those who you look up to and whose opinion you value, please indicate what you think they believe. Even if you are not sure about their opinion, please give us your best guess.

Thinking about those people whose opinions you trust and respect, how strongly do you believe they would agree or disagree with the following statements:

64. Letting children know when you like what they are doing is a good way to teach a child how to behave
☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

65. Always trying to comfort a crying infant will spoil the baby
☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

66. Playing with or reading a story to young children every day will help the child's brain develop
☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

67. Yelling at or fighting with another adult in front of your child or where the child could hear is bad for the child's health
    ☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

68. Spanking your child on the bottom is a necessary part of parenting
    ☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

69. Helping children express themselves with words when they are angry or frustrated is better than getting mad at them
    ☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

70. Asking or searching for help with parenting means there's something wrong with you because you should know how to parent your child
    ☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

71. Being a mentor (like a Big Brother or Big Sister) to an unrelated child is a good use of your time
    ☐ Strongly agree ☐ Agree ☐ Neither agree or disagree ☐ Disagree ☐ Strongly disagree

Citizens Review Board For Children

CRBC
Citizens Review Board for Children

MARYLAND

ANNUAL REPORT

FISCAL YEAR 2022

(July 1st 2021 - June 30th 2022)

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Introduction

Maryland's Citizens Review Board for Children (CRBC) is comprised of volunteer citizens and Department of Human Services (DHS) staff that provide child welfare expertise, guidance and support to the State and Local Boards.

CRBC is charged with examining the policies, practices and procedures of Maryland's child protective services, evaluating and making recommendations for systemic improvement in accordance with §5-539 and § 5-539.1 and the Federal Child Abuse and Treatment Act (CAPTA) (Section 106 (c)).

CRBC reviews cases of children and youth in Out-of-Home Placement, monitors child welfare programs and makes recommendations for system improvements. Although CRBC is housed within the DHS organizational structure, it is an independent entity overseen by its State Board.

There is a Memorandum of Agreement (MOA) between the Department of Human Services (DHS), the Social Services Administration (SSA) and CRBC that guides the work parameters by which CRBC and DHS function regarding CRBC review of cases.

The CRBC State Board reviews and coordinates the activities of the local review boards. The board also examines policy issues, procedures, legislation, resources and barriers relating to Out-of-Home Placement and the permanency of children. The State Board makes recommendations to the General Assembly around ways of improving Maryland's child welfare system.

Since January 2021, the local Boards have conducted virtual instead of in person case reviews of children in Out-of-Home Placement for all Local Department of Social Services (LDSS) and in every jurisdiction. Individual recommendations regarding permanency, placement, safety and well-being are sent to the Local Juvenile Courts, the LDSS and interested parties involved with the child's care.

This CRBC Fiscal Year 2022 (FY2022) Annual Report contains CRBC's findings from our case reviews, advocacy efforts, CPS panel activities and recommendations for systemic improvements.

On behalf of the State Board of the Maryland Citizens Review Board for Children (CRBC), it's staff and citizen volunteer board members, I present our FY2022 Annual Report.

Sincerely,
Nettie Anderson-Burrs
State Board Chair

Executive Summary

The COVID-19 Pandemic began during the third quarter of fiscal year 2020. As a result, children, youth and families were exposed to additional stressors. The state of emergency, mandatory telework and stay at home orders in addition to day care and school closures, unemployment, housing and food insecurities likely added trauma for the most vulnerable children in Maryland. In CRBC'S FY2021 Annual Report CRBC indicated that as a result of additional challenges and stressors it was even more imperative to ensure support, provide trauma informed services and a capable child welfare workforce that is supported with the necessary resources to ensure appropriate oversight of Maryland's most vulnerable children and families' needs.

Demographic changes due to retirements and child welfare staff turnover precipitated by the pandemic and likely continuously impacted by competitive processes such as compensation, advancement opportunities and employment flexibility, in addition to hiring delays impacts the quality of services and ultimately safety, well-being, permanency.

In many jurisdictions child welfare staff vacancies increased significantly. Local Departments of Social Services (LDSS) faced in some cases unprecedented challenges with social worker and supervisory vacancies, leading to increased caseload, increased workload. This resulted in some interruption in continuity of delivery of care and services from gaps created by staff shortages. LDSS simultaneously faced challenges with increasingly more complex cases requiring intensive behavioral and mental health support, intervention, services and placements that are scarce and for some jurisdictions not available. Expanding and investing in proven innovative strategies for workforce recruitment, development and retention is necessary to support the challenging and necessary work of Maryland's child welfare staff. A well-equipped and supported child welfare workforce requires and deserves the necessary resources including placements for children and youth in out of home placement. The ability to provide oversight of health, mental health and educational services at the local department level is imperative to ensure that decisions regarding health, mental health, education, services, placement, safety and permanency are made with consideration of relevant factors for Maryland's most vulnerable children, youth and families. Access to data and coordination of services at the state and local level beyond initial assessments is needed. Ensuring that children and youth have health, mental health and education needs met beyond initial assessments is crucial for child safety, well-being, permanency and improving outcomes. This requires shareability of information and documentation of health and education services and progress.

Older youth aging out of care while a decreasing segment of the out-of-home placement population in recent years due to the number of youths aging out, present unique challenges due to their age and especially in instances where there is substance use, complex behavioral, health or mental health issues. The need for adequate preparedness for older youth aging out of care necessitates addressing issues including lack of resources and youth engagement.

During fiscal year 2022, the Citizens Review Board for Children reviewed 660 cases of children and

youth in Out-of-Home Placements statewide. Reviews are conducted per a work plan developed in coordination with DHS and SSA with targeted review criteria based on Out-of-Home Placement permanency plans of any children/youths who has a sibling in care. This report includes Out-of-Home Placement review findings and CRBC activities including legislative advocacy and recommendations for system improvement for FY2022.

Health and Education Findings for statewide reviews include:

CRBC conducted virtual reviews of local department of social services cases statewide. Reviews included Google Meet interviews with local department staff and interested parties identified by the local department of social services such as parents, youth, caregivers, providers, CASA, therapists and other relevant parties to individual cases. At the time of the review local review boards requested information and documentation regarding education and health including preventive physical, dental and vision exams. Reviewers also considered medication reviews, treatment recommendations, health and mental health follow up appointments and referrals recommended by medical providers.

- The local boards found that for 284 (43%) of the 660 total cases reviewed, the health needs of the children/youth had been met.
- Approximately 286 (43%) of the children/youths were prescribed medication.
- Approximately 243 (37%) of the children/youths were prescribed psychotropic medication.
- The local boards found that there were completed medical records for 188 (28%) of the total cases reviewed.
- The local boards agreed that 404 (61%) of the children/youth were being appropriately prepared to meet educational goals.

Demographic findings for statewide reviews include:

- 411 (62%) of the children/youth were African American.
- 214 (32%) of the children/youth were Caucasian.
- 348 (53%) of the children/youth were Male.
- 312 (47%) of the children/youth were Female.

CRBC conducted 213 Reunification reviews. Findings include:

- 64 cases (30%) had a plan of reunification for 3 or more years.
- The local boards agreed with the placement plan for 113 (53%) of the cases reviewed.
- The local boards found that the local departments made efforts to involve the family in case planning for 154 (72%) of the cases reviewed.
- The local boards found that service agreements were signed for 49 (23%) of the eligible cases reviewed.
- The local boards agreed that the signed service agreements were appropriate to meet the needs of 47 of the 49 the children/youths.

CRBC conducted 80 Adoption reviews. Findings include:

- 16 (20%) of the 80 cases had a plan of adoption for 3 or more years.
- The local boards agreed with the placement plan for 77 (96%) of the cases reviewed.

- The local boards identified the following barriers preventing the adoption process or preventing progress in the child's case:

  - Pre-Adoptive resources not identified.
  - Child in pre-adoptive home, but adoption not finalized.
  - Efforts not made to move towards finalization.
  - Child does not consent.
  - Appeal by birth parents.
  - Other court related barrier.

CRBC conducted 265 Another Planned Permanent Living Arrangement (APPLA) reviews.

APPLA is the least desired permanency plan and should only be considered when all other permanency options have been thoroughly explored and ruled out. APPLA is often synonymous with long term foster care. Many youths with a permanency planning goal of APPLA remain in care until their case is closed when they age out of the foster care system. Findings include:

- 49 (18%) of the 265 cases had a plan of APPLA for 3 or more years.
- The local boards agreed with the permanency plan of APPLA for 264 (99%) of the 265 cases statewide. 256 of the cases reviewed with a permanency plan of APPLA were youth between the ages of 17-20.
- A permanent connection is an identified person that a youth can rely on for assistance with support, advice and guidance as they deal with the day-to-day life circumstances that adulthood can bring about on a regular basis. The local boards agreed that for 227 (86%) of the 265 cases of youth with a permanency planning goal of APPLA that a permanent connection had been identified, and the local boards agreed that the identified permanent connections were appropriate for 218 (96%) of the 227 cases.

Barriers to Permanency/Issues

The local boards identified the following barriers to permanency/issues:

- No service agreement with parents
- No current safety or risk assessment
- Lack of concurrent planning
- Lack of follow-up (general)
- Youth placed outside of home jurisdiction
- Youth has not been assessed for mental health concerns
- Issues related to substance abuse
- Other service resource barrier
- Other physical health barrier
- Youth refuses mental health treatment including therapy
- Other placement barrier
- Other child/youth related barrier
- Non-compliance with service agreement

- Child has behavior problems in the home
- Youth non-compliant with medication
- Youth engages in risky behavior

Ready By 21 (Transitioning Youth)

Age of Youth (14 years and older all permanency plans = 438 cases)

- 144 (33%) of the 438 youths reviewed were between 14-16 years old.
- 166 (38%) of the 438 youths reviewed were between 17-19 years old.
- 137 (31%) of the 438 youths reviewed were 20 years old.

Independent Living skills (438 cases)

- The local boards agreed that 210 (48%) of the eligible youths were receiving appropriate services to prepare for independent living.

Employment (438 cases)

- The local boards found that 157 (36%) of the 438 eligible youths were employed or participating in paid or unpaid work experience.
- The local boards agreed that 207 (47%) of the 438 eligible youths were being appropriately prepared to meet employment goals.

Housing (137 cases)

Transitioning Youth (20 and over with a permanency plan of APPLA or exiting care to independence within a year of the date of review).

- The local boards found that 86 (63%) of the 137 youths had a housing plan specified.
- The local boards agreed that 88 (64%) of the 137 youths were being appropriately prepared for transitioning out of care.

Concurrent Planning

Concurrent planning is an approach that seeks to eliminate delays in attaining permanent families for children in foster care. In concurrent planning, an alternative permanency plan or goal is pursued at the same time rather than being pursued after reunification has been ruled out. The Adoption and Safe Families Act (ASFA) of 1997 provided for legal sanctioning of concurrent planning in states by requiring that agencies make reasonable efforts to find permanent families for children in foster care should reunification fail and stating that efforts could be made concurrently with reunification attempts.

At least 21 states have linked concurrent planning to positive results including reduced time to permanency and establishing appropriate permanency goals, enhanced reunification or adoption efforts by engaging parents and reduced time to adoption finalization over the course of two

review cycles of the Federal Child and Family Services Review (Child Welfare Information Gateway, Issue Brief 2012, Children's Bureau/ACYF). DHS/SSA Policy Directive#13-2, dated October 12, 2012 was developed as a result of Maryland reviewing case planning policy including best practices and concurrent planning as part of Maryland's performance improvement plan.

CRBC supports concurrent planning when used in accordance with state policy to achieve goals of promoting safety, well-being, and permanency for children in out of home placement, reducing the number of placements in foster care and maintaining continuity of relationships with family, friends and community resources for children in out-of-home care.

According to SSA Policy Directive #13-2 a concurrent plan is required when the plan is reunification with parent or legal guardian, placement with a relative for adoption or custody and guardianship, and guardianship or adoption by a non-relative (prior to termination of parental rights).

The local boards found the following in statewide reviews:

- A total of 99 (25%) of the 395 eligible cases (660 total – 265 APPLA cases) had a concurrent permanency plan identified by the Local Juvenile Courts.
- The Local Departments (LDSS) were implementing the concurrent permanency plans identified by the Local Juvenile Courts for 86 (87%) of the 99 cases.
- The local boards found that for 133 (34%) of the 395 eligible cases the Local Departments (LDSS) were engaged in concurrent planning.

CRBC Recommendations to the Department of Human Services

1. Review and develop policies and practices to ensure that they are trauma informed policies.
2. Ensure consistency in the availability and delivery of services to children and youth involved with child welfare statewide by identifying resource needs and gaps to address lack of access.
3. Develop a system to track and monitor health including mental health of children and youth in out-of-home placement at the state and LDSS level to include documentation of health and education services and progress.
4. Identify gaps and areas needing improvement in the child welfare workforce. Increase efforts to improve workforce development in order to attain and maintain a highly experienced and skilled workforce to include transfer of knowledge. Develop and implement measures to retain child welfare staff by considering case and workloads, staff development and training, quality of supervision, competitive compensation, opportunities for advancement and filling vacancies expeditiously.
5. Coordination of services across Public Agencies such as Primary Care, Behavioral Health, Medicaid, Juvenile Criminal Systems, Education, and Public Assistance in an effort to improve

preventive health, mental health and education needs being met, and improving outcomes for children and youth in Out-of-Home Placement.

6. Ensure adequate in state resources to provide services to children and youth with intensive needs. Children with serious behavioral, emotional, and medical needs that require additional structure not provided in family or other group settings in state, should receive appropriate services and level of support for their own safety and the safety of others and to help improve outcomes.

7. Increase concurrent planning to increase the likelihood of establishing the appropriate permanency plan or goal and achieve permanency without undue delay.

8. Explore other permanency options at least every 6 months for children and youth with a permanency plan of APPLA.

9. Continue to focus on increasing the number of relative/kin placement and permanency resources.

10. Explore adoption counseling for children and youth that have not consented to adoption.

11. Transitional planning should begin for youth at 14 to include housing, education, employment, and mentoring. Plans should be developed by the youth with the assistance of the Department of Social Services worker and others identified by the youth for support. Engagement of the youth and individuals identified by the youth is important. The plan should build on the youth's strengths and support their needs. While it is important to understand and meet legislative requirements for youth transitional plans, it is crucial that child welfare professionals working with youth view transitional planning as a process that unfolds over time and through close youth engagement and not a checklist of items to accomplish.[1]

12. Ensure that youth 14 and older begin to prepare for self-sufficiency by providing resources and opportunities for consistent independent living skills for youth statewide.

13. Ensure that youth are engaged in opportunities to use independent living skills obtained prior to transitioning out of care.

14. Identify and increase housing resources and funding to address the lack of affordable housing options available for aging out youth.

15. Ensure that a specific housing plan is identified for older youth transitioning out of care at least 6 months prior to the anticipated date of discharge or before youth's 21st birthday.

16. Increase opportunities for community partnerships to connect, to use life/independent skills, to gain employment experience and to improve affordable housing options for older youth exiting care.

[1]Child Welfare Information Gateway https://www.childwelfare.gov

Acknowledgements

CRBC would like to acknowledge the commitment, dedication, passion, and service of all stakeholders advocating on behalf of Maryland's most vulnerable children to improve outcomes during FY2022 including:

- ★ CRBC Governor Appointed members for their tireless efforts on behalf of Maryland's most vulnerable children and youth. CRBC volunteers have been dedicated and committed to the mission, vision and goals of CRBC, successfully transitioning from conducting in person to 385 virtual case reviews and interviews, providing individual case advocacy.
- ★ The Department of Human Services (DHS)
- ★ The Social Services Administration (SSA)
- ★ The Local Departments of Social Services (LDSS), Baltimore County & Montgomery County (DHHS)
- ★ The State Council on Child Abuse and Neglect (SCCAN)
- ★ The State Child Fatality Review Team (SCFRT)
- ★ The Coalition to Protect Maryland's Children (CPMC)
- ★ Maryland CASA Association
- ★ The Local Juvenile Courts of Maryland
- ★ All Community Partners who strive to improve outcomes for children and youth involved with child welfare

SSA Response to the CRBC FY2021 Annual Report

(Reprinted for inclusion in Annual Report)

Larry Hogan, Governor | Boyd K. Rutherford, Lt. Governor | Lourdes R. Padilla, Secretary

April 26, 2022

Nettie Anderson-Burrs, Chairperson
Citizens Review Board for Children
1100 Eastern Avenue
Baltimore, Maryland 21221

Dear Ms. Anderson-Burrs and Review Board Members:

The Department of Human Services, Social Services Administration (DHS/SSA) extends its appreciation for the work of the Citizens Review Board for Children (CRBC). The CRBC annual report provides information that is essential for DHS/SSA to improve its services to Maryland's families, children, and youth who are involved with the child welfare system. The constructive feedback contained in the report, as well as the information received during meetings with CRBC leadership, contribute a great deal to our Continuous Quality Improvement (CQI) efforts.

DHS/SSA recognizes the need for consistent availability of critical services to meet the complex and individual needs of the families, children, and youth we serve. Across Maryland, we continue to strengthen partnerships with key service providers, stakeholders, sister agencies, and community partners to better coordinate services, communicate the needs of children and families, and raise awareness regarding needed services. The Department has implemented a phased roll-out to expand its capacity to serve families, children, and youth with prevention focused evidence-based practices (EBPs) across Maryland in 18 jurisdictions. Families First Prevention Services Act made it possible to expand offering Healthy Families America, Parent Child Interaction Therapy, Multisystemic Therapy, and Functional Family Therapy in Maryland in order to build upon the success we have already seen serving families with these EBPs in some jurisdictions.

In addition, DHS/SSA recognizes the importance of developing consistent and trauma-responsive services for Maryland's children, youth, families, and vulnerable adults. Maryland implemented its Integrated Practice Model (IPM) in 2020 and has continued to provide coaching to supervisory teams across the State in order to support consistent service delivery. The IPM espouses principles of practice to ensure our services are family-centered, individualized and strengths-based, trauma-responsive, outcomes driven, community-focused, and culturally and linguistically responsive. The IPM also highlights the need for a safe, engaged, and well-prepared professional workforce and aligns with CRBC's recommendations.

Of particular note, the CRBC report recommends that the Department develop a system to track and monitor health including mental health of children and youth in out-of-home placement. Under the leadership of the DHS Child Welfare Medical Director, the Department entered into an agreement

with the Chesapeake Regional Information System for our Patients (CRISP). This agreement allows the DHS Child Welfare Medical Director to access CRISP data in order to identify the health and wellness needs of children in the Department's care.

DHS/SSA has also partnered with the Governor's Office for Crime Prevention Youth and Victim Services and the Maryland Department of Health (MDH) to engage our private placement providers in discussions regarding access to higher levels of care. Through coordination with MDH, Maryland continues to offer Voluntary Placement Agreements to those families whose youth are eligible for a higher level of care reducing the number of youths in the State's care and custody.
In support of creating lasting permanency for children and youth in care, DHS/SSA has also entered into two contracts - Family Connections Program and Child Maltreatment Prevention Services striving to increase kinship placements and permanency resources. Additionally, DHA/SSA has developed contracts to provide adoption counseling and pre- and post-adoption support services to children, youth, and families. In regards to adoption counseling for youth who did not consent to adoption, DHS/SSA plans to explore the services offered to youth and what, if any, additional pre-adoption supports are needed. The Department remains committed to working diligently to address barriers to permanency for Maryland's children.

The CRBC recommendations around older youth transition planning, including planning for housing and other independent living skills are currently being explored by our Placement and Permanency Implementation Team. This team continues to provide support and guidance on SSA's broader goals of ensuring children, youth and vulnerable adults are:

- Safe and free from maltreatment
- Living with safe, supportive, and stable families and in least restrictive environments where they can grow and thrive
- Able to achieve timely and lasting permanency; and
- Connected with professionals, family members, and other supportive resources to enable them to sustain success upon exiting our child welfare system.

Through our Implementation Teamwork, DHS/SSA has updated the Youth Transition Plan (YTP) and process. This includes the integration of youth voice and allows space for growth and change over time. Transitional planning should begin for youth at age 14 to include housing, education, employment, and mentoring. Our goal is that all child welfare professionals who work with youth will view transitional planning as a process that unfolds over time and requires close youth involvement and ongoing engagement.

As such, the YTP is a youth driven document that is designed to be utilized statewide by all transition-age youth. To ensure services meet the needs of Maryland's youth in care, the YTP process includes an instructional video specifically tailored to our older youth. The YTP is also available online via Maryland's MyLife website. In addition, to address the housing needs of youth emerging from foster care, DHS/SSA maintains its partnership with the U.S. Department of Housing and Urban Development (HUD) to support maintenance of the Family Unification Program (FUP). DHS/SSA has also collaborated with the Maryland Developmental Disabilities Administration (DDA) to locate sustainable housing for youth who have disabilities.

The CRBC's careful assessment of our practices is very much appreciated. We are committed to continuing to identify and strategically implement best practices to effectively serve children, youth,

families, and vulnerable adults across Maryland. We look forward to our ongoing partnership with the CRBC in this regard.

Sincerely,

Denise Conway, LCSW-C
Executive Director
Social Services Administration
Maryland Department of Human Services

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CRBC Program Description

The Citizen Review Board for Children is rooted in a number of core values, which relate to society's responsibility to children and the unique developmental needs of children. We have a strong value of believing that children need permanence within a family, and that their significant emotional attachments should be maintained. We know children develop through a series of nurturing interactions with their parents, siblings and other family members, as well as culture and environment. Therefore, a child's identity or sense of selfhood grows from these relationships.

In addition, we believe children grow and are best protected in the context of a family. If parents or kin are not able to provide care and protection for their children, then children should be placed temporarily in a family setting, which will maintain the child's significant emotional bonds and promote the child's cultural ties.

The CRBC review process upholds the moral responsibility of the State and citizenry to ensure a safe passage to healthy adulthood for our children, and to respect the importance of family and culture.

As case reviewers, CRBC values independence and objectivity, and we are committed to reporting accurately what we observe to make recommendations with no other interest in mind but what is best for children. In addition, CRBC provides an opportunity to identify barriers that can be eradicated and can improve the lives of children and their families: and improve the services of the child welfare system (CRBC, 2013).

The Citizens Review Board for Children consists of Governor appointed volunteers from state and local boards. Currently, there are 35 local review boards representing all 24 jurisdictions (23 counties and Baltimore City). Volunteer members serving on local boards, review cases of children in Out-of-Home Placement. CRBC monitors child welfare programs and makes recommendations for system improvements.

The State Board reviews and coordinates the activities of the local review boards. The State Board also examines policy issues, procedures, legislation, resources, and barriers relating to Out-of-Home Placement and the permanency of children. The State Board makes recommendations to the General Assembly around ways of improving Maryland's child welfare system.

The Citizens Review Board for Children supports all efforts to provide permanency for children in foster care. The State Board provides oversight to Maryland's child protection agencies and trains volunteer citizen panels to aid in child protection efforts.

Mission Statement

To conduct case reviews of children in out-of-home care, make timely individual case and systemic child welfare recommendations; and advocate for legislative and systematic child welfare improvements to promote safety and permanency.

Vision Statement

We envision the protection of all children from abuse and neglect, only placing children in out-of-home care when necessary; and providing families with the help they need to stay intact; children will be safe in a permanent living arrangement.

Goals

Volunteer citizens review cases in order to gather information about how effectively the child welfare system discharges its responsibilities and to advocate, as necessary for each child reviewed in out-of-home care.

The Citizens Review Board for Children provides useful and timely information about the adequacy and effectiveness of efforts to promote child safety and well-being, to achieve or maintain permanency for children and about plans and efforts to improve services.

The Citizens Review Board for Children makes recommendations for improving case management and the child welfare system, and effectively communicates the recommendations to decision makers and the public.

Discrimination Statement

The Citizens Review Board for Children (CRBC) renounces any policy or practice of discrimination on the basis of race, gender, national origin, ethnicity, religion, disability, or sexual orientation that is or would be applicable to its citizen reviewers or staff or to the children, families, and employees involved in the child welfare system (CRBC, 2013).

Confidentiality

CRBC local board members are bound by strict confidentiality requirements. Under Maryland Human Services Code § 1-201 (2013), all records concerning out-of-home care are confidential and unauthorized disclosure is a criminal offense subject to a fine not exceeding $500 or imprisonment not exceeding 90 days, or both. Each local board member shall be presented with the statutory language on confidentiality, including the penalty for breach thereof, and sign a confidentiality statement prior to having access to any confidential information.

CRBC FY2022 Retention, Recruitment, Training and Activities

During FY2022, CRBC continued to utilize recruitment and retention strategies to ensure membership and facilitation of reviews in all 23 counties and Baltimore City. Many of CRBC members have been dedicated and committed to serving on behalf of Maryland's most vulnerable children and youth for numerous years. Ongoing recruitment is necessary to account for some expected reduction to avoid attrition. Passive recruitment efforts continued in order to support CRBC's mission, vision and goals.

In FY2022, 20 members were selected by a selection committee, recommended for appointment and appointed by the Governor to local out-of-home placement review boards in jurisdictions where they reside across the state. CRBC provided orientation and pre-service training for newly appointed members and in commemoration of National Child Abuse Prevention Month in April 2022 CRBC hosted training titled Cultural Learning Implications and Approaches for Respecting Who We Are. The focus of the training included participants appreciating the need for and importance of cultural awareness, for participants to gain knowledge and skills to effectively handle cultural variations, for participants to be able to bridge cross cultural communication barriers and to apply to the CRBC review process and advocacy. The training was facilitated by Dr. Edwin Green, Jr., ED. D, Executive Director of the 413 Center, Inc and CRBC Local Out of Home Placement Baltimore City Board Member.

CRBC Individual Case Reviews

As a result of the Pandemic, state of emergency and the Governor's mandatory telework order beginning on March 13, 2020 in the 3rd Quarter of FY2020, in person case reviews, in person recruitment and in person training was suspended. CRBC was successful in developing a process to transition from in person, on site reviews at local departments of social services to virtual reviews. Reviews were conducted virtually during FY2022.

Promoting Safety, Well-Being and Permanency

CRBC's priorities remained the safety and well-being of Maryland's most vulnerable children and youth. CRBC facilitated quarterly or as needed virtual meetings with local department of social services administrators in Baltimore County, Prince George's County and Baltimore City to discuss CRBC review findings, for individual and jurisdictional advocacy including to address lack of reasonable efforts findings by the juvenile court on several occasions in Prince George's County. CRBC members and LDSS child welfare Administrators and staff worked collaboratively to discuss and identify ways to address findings that needed attention and intervention. CRBC advocated for resources and support for children and youth, child welfare staff, caregivers and providers. CRBC participated in virtual meetings with members of the Department of Human Services, Social Services Administration, including Executive Directors Michelle Farr, and Denise Conway, in addition to members of the Child and Family Well-Being, Permanency, Placement and Education team representatives.

Virtual meetings with the Department of Human Services and Social Services Administration staff were held to discuss CRBC findings, concerns and for educational advocacy. Discussions included the lack of shared health and education information available at the LDSS (the potential impact on case management, planning, decision making, placement stability and permanency). Lack of documentation of preventive exams, updated medical records and concerns regarding educational services for children and youth with special education or special needs in out-of-home placement was discussed.

Education Advocacy Committee (EAC) Activities

Educational Advocacy

Education is a crucial component in well-being. It increases opportunities and choices in life due to the skills and confidence gained when appropriate educational services including emotional and mental health services are provided to support a child reaching their full potential.

Educational concerns consequent COVID that had arisen during the CRBC review process prompted the establishment of an Educational Advocacy Committee (EAC) in fiscal year 2021. The committee is a sub-committee of CRBC's State Board and its purpose is to support CRBC's efforts with advocacy around improvement in educational services for children in foster care. The committee makes recommendations to the State Board. The goal is that all of Maryland's children will have access to safe, equitable and sustainable education to support the well-being and success of all of Maryland's children.

This prompted plans for a deeper look of cases including those with Individual Education Plans (IEP) and those cases where a child may be in need of special education services but, as yet, have not been referred.

Also, consideration regarding if there was sufficient examination and review of these cases. Additional considerations include the following:

- The need for data on the number of children within foster care who qualify for special education services.
- The need for every foster child who has been identified as in need of special education to have a parent or person who can function as the parent in an IEP meeting
- Procedures within Department of Human Services (DHS) and Maryland State Department of Education (MSDE) regarding children in foster care
- Residential placement resources for a child who qualifies for special education
- Practices and policies of DHS regarding oversight of IEP development and implementation

The committee engaged in information gathering and a series of meetings with individuals with expertise in education and education advocacy during FY 2021 in addition to review of state and

federal policies and guidelines. In FY2022 the committee engaged in observation and surveying of selected local out of home placement reviews.

CRBC State Board will focus on providing training on education including state, federal and DHS policy, special education and educational advocacy to all of its members.

CRBC FY2022 Legislative Activities

CRBC has a Children's Legislative Activities Committee (CLAC) and was a voting member of the Coalition to Protect Maryland's Children (CPMC) in FY2022.

During the 2022 legislative session CLAC reviewed legislation and supported via CPMC with the goal met for 9. CRBC supported with testimony with the goal met for 3 and opposed 2 bills via CPMC with the goal met for both. CRBC opposed 1 bill with testimony with the goal met. Below are some of the bills that CRBC took a position on:

Supported

SB0820/HB1248-Child Abuse and Neglect-Investigations-Timeliness

SB656/HB0766-Children-Residential Treatment Centers-Education Funding

SB0003/HB0297-Facilities-Disabilities, Juveniles, Behavioral Health Care-Children and Community Relations Plans

S0020/HB0284-Criminal Procedure-Out of Court Statements-Child Victims

SB0017/HB0561-Child Custody-Cases Involving Child Abuse or Domestic Violence Training for Judges

SB0002/HB0032-Mental Health Law-Petitions for Emergency Evaluations

SB0012/HB0129-Behavioral Health Crisis Response Services and Public Safety Answering Points-Modifications

HB0496-Commission on the Establishment of a Family and Medical Leave Insurance Program

HB1169-Child Abuse and Neglect-Training of Health Care Professionals

HB0406-Children in Out of Home Placements-Placement in Medical Facilities

HB0118-Public Schools-Student Attendance-Excused Absences for Mental Health

HB0097-workgroup on Black, Latino, Asian American, Pacific Islander and Other Underrepresented Behavioral Health Professionals

Opposed

HB1155-Foster Parents, Kinship Parents, Pre-Adoptive Parents, and Caregivers Right to Intervene

SB0843/HB1335-Perinatal Care-Drug and Alcohol Testing and Screening-Consent

HB1320-Criminal Law-Sexual Crimes-Allowing Minor Who is a Previous Offender to Be in the Presence of Another Minor

CRBC Out-of-Home Placement Case Reviews

Targeted Review Criteria

The Department of Human Services (DHS), formerly the Department of Human Resources (DHR), Social Services Administration (SSA) and the Citizens Review Board for Children (CRBC) together have created a review work plan for targeted reviews of children in out-of-home-placement. This work plan contains targeted review criteria based on out-of-home-placement permanency plans.

Reunification:

- Already established plans of Reunification for children 10 years of age and older. CRBC will conduct a review for a child 10 years of age and older who has an established primary permanency plan of Reunification and has been in care 12 months or longer.

Adoption:

- Existing plans of Adoption. CRBC will conduct a review of a child that has had a plan of Adoption for over 12 months. The purpose of the review is to assess the appropriateness of the plan and identify barriers to achieve the plan.

- Newly changed plans of Adoption. CRBC will conduct a review of a child within 5 months after the establishment of Adoption as a primary permanency plan. The purpose is to ensure that there is adequate and appropriate movement by the local departments to promote and achieve the Adoption.

Another Planned Permanent Living Arrangement (APPLA):

- Already established plans of APPLA for youth 16 years of age and younger. CRBC will conduct a full review of a child 16 years of age and younger who has an established primary permanency plan of APPLA. The primary purpose of the review is to assess appropriateness of the plan and review documentation of the Federal APPLA requirements.

- Newly established plans of APPLA. CRBC will conduct a review of a child within 5 months after the establishment of APPLA as the primary permanency plan. Local Boards will review cases to ensure that local departments have made adequate and appropriate efforts to assess if a plan of APPLA was the most appropriate recourse for the child.

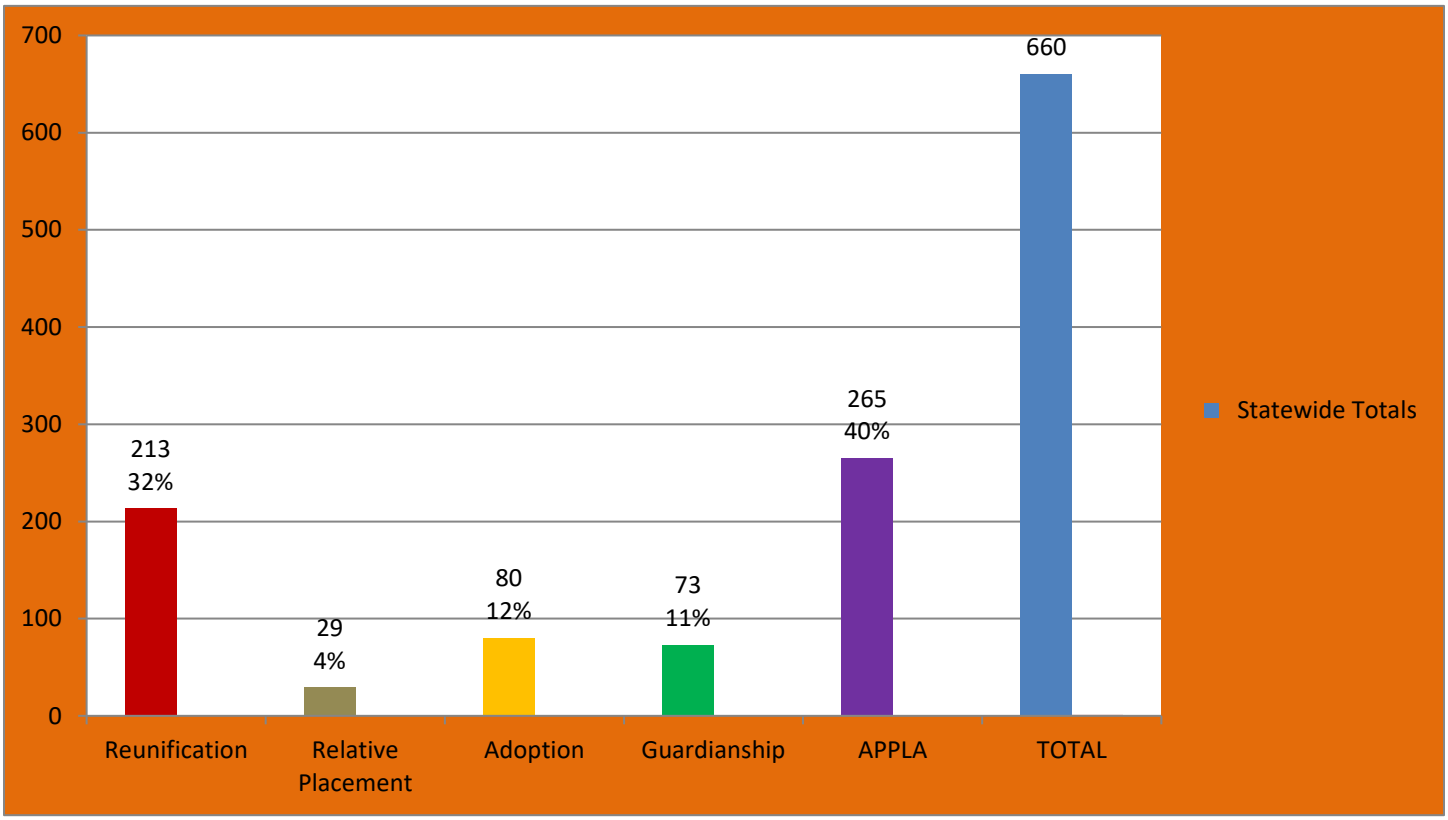
Older Youth Aging Out

- Older youth aging-out or remaining in the care of the State at age 17 and 20 years old. CRBC will conduct a review of youth that are 17 and 20 years of age. The primary purpose of the review is to assess if services were provided to prepare the youth to transition to successful adulthood.

Re-Review Cases:

- Assessment of progress made by LDSS. CRBC will conduct follow-up reviews during the fourth quarter of the current fiscal year of any cases wherein the local board identified barriers that may impede adequate progress. The purpose of the review is to assess the status of the child and any progress made by LDSS to determine if identified barriers have been removed.

CRBC FY2022 Case Review Findings by Permanency Plan



*(Note: Relative Placement is the combined total of Relative Placement for Adoption (2) and Relative Placement for Custody/Guardianship (29))

Gender Totals (660)

Male	Female
348 (53%)	312 (47%)

Male

Reunification	Relative Placement(*)	Adoption	Guardianship	APPLA
113 (53%)	18 (62%)	47 (59%)	42 (58%)	128 (48%)

Female

Reunification	Relative Placement(*)	Adoption	Guardianship	APPLA
100 (47%)	11 (38%)	33 (41%)	31 (42%)	137 (52%)

Ethnicity Overall (660)

African American	Caucasian	Asian	Native American	Other
411 (62%)	214 (32%)	8 (1%)	3 (>1%)	24 (4%)

Age Range by Permanency Plan

[RE] = Reunification
[RA] = Relative Placement for Adoption
[RG] = Relative Placement for Custody & Guardianship
[AD] = Non-Relative Adoption
[CG] = Non-Relative Custody & Guardianship
[AP] = Another Planned Permanent Living Arrangement (APPLA)

AGE RANGE	RE	RA	RG	AD	CG	AP	Totals
age 1 thru 5	23	1	5	22	3	0	54
age 6 thru 10	42	1	5	11	10	0	80
age 11 thru 13	45	0	4	13	17	0	79
age 14 thru 16	71	0	10	18	36	9	144
age 17 thru 19	26	0	3	5	6	126	166
age 20	6	0	0	0	1	130	137
Totals	213	2	27	80	73	265	660

CRBC FY2022 Case Reviews by Jurisdiction & Permanency Plans

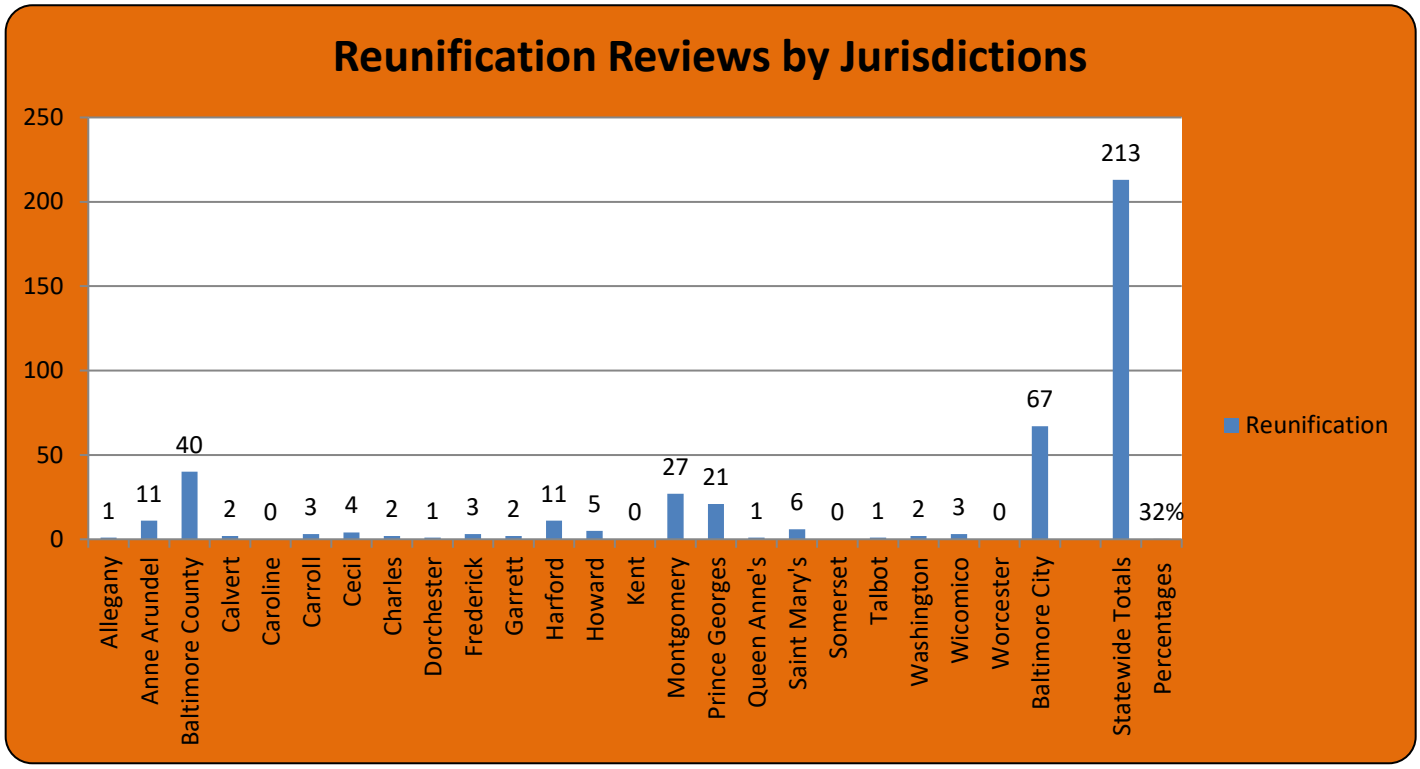
Jurn #	County	Reunification	Relative Placement	Adoption	Custody Guardianship	APPLA	TOTAL	Boards held
01	Allegany	1	0	2	0	2	5	2
02	Anne Arundel	11	1	0	4	10	26	7
03	Baltimore County	40	1	10	1	33	85	23
04	Calvert	2	1	0	0	5	8	2
05	Caroline	0	1	0	0	2	3	1
06	Carroll	3	0	0	1	3	7	2
07	Cecil	4	0	1	2	8	15	4
08	Charles	2	0	0	1	9	12	3
09	Dorchester	1	0	0	1	4	6	2
10	Frederick	3	0	5	2	7	17	5
11	Garrett	2	0	0	1	1	4	1
12	Harford	11	1	11	0	6	29	7
13	Howard	5	0	0	0	6	11	3
14	Kent	0	0	1	1	0	2	1
15	Montgomery	27	2	16	19	23	87	23
16	Prince Georges	21	4	6	3	40	74	20
17	Queen Anne	1	0	0	0	1	2	1
18	Saint Mary's	6	0	4	1	5	16	4
19	Somerset	0	2	1	2	1	4	1
20	Talbot	1	0	1	1	1	4	1
21	Washington	2	3	2	2	15	24	6
22	Wicomico	3	0	2	0	3	8	2
23	Worcester	0	0	2	0	4	6	2
49	Baltimore City	67	13	16	33	76	205	60
	Statewide Totals	213	29	80	73	265	660	183
	Percentages	32%	4%	12%	11%	40%	100%	

* Relative Placement is the combined total of Relative Placement for Adoption = 2 and Relative Placement for Custody/Guardianship = 27

CRBC conducted a total of 660 individual out-of-home case reviews (each case reviewed represents 1 child/youth) in all 24 Jurisdictions on 183 boards that held reviews during Fiscal Year 2022.

Reunification Case Reviews

The permanency plan of Reunification is generally the initial goal for every child that enters out- of-home placement and appropriate efforts should be made to ensure that the child/youth is receiving the services that are necessary to reunite with their family and have permanency. It is equally as important to make sure that reasonable efforts have been made with the identified parent or caregiver to promote reunification without undue delay.



Age Range	Statewide Totals	Reunification	Percentage
Age 1 thru 5	54	23	43%
Age 6 thru 10	80	42	53%
Age 11 thru 13	79	45	57%
Age 14 thru 16	144	71	49%
Age 17 thru 19	166	26	16%
Age 20	137	6	4%
Total	660	213	32%

Permanency

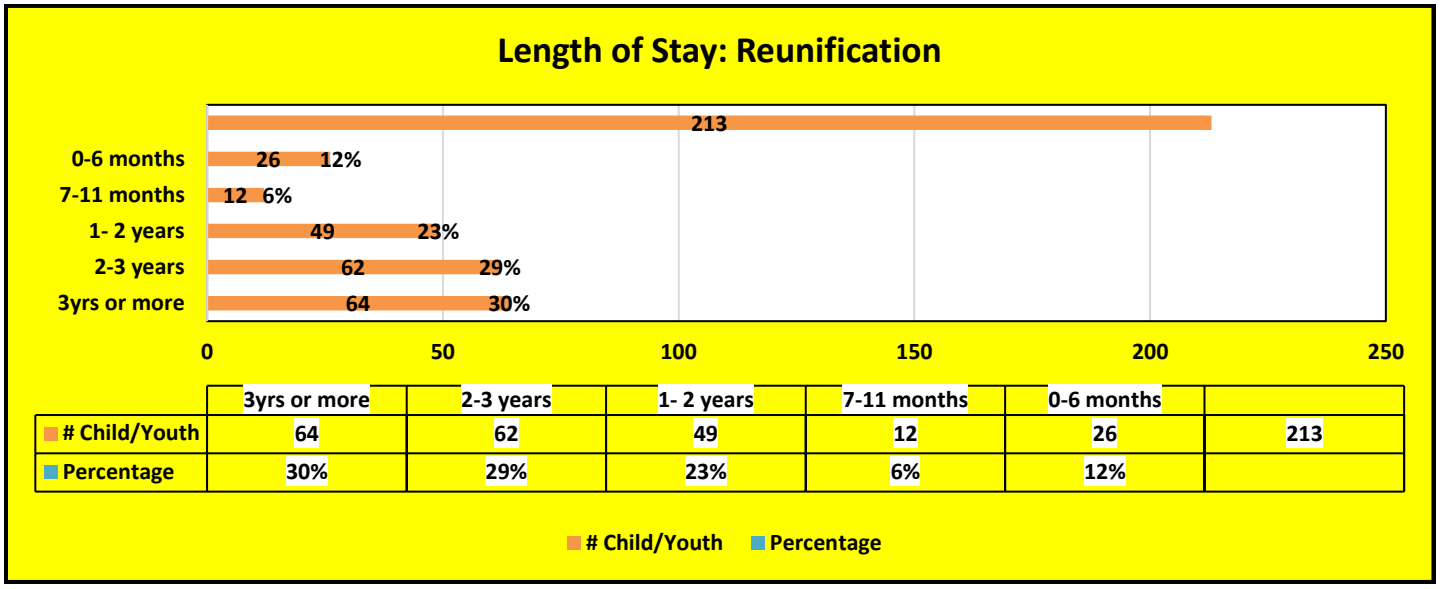
The local boards agreed with the permanency plan of reunification for 113 (53%) of the 213 cases reviewed.

The local Juvenile Courts identified concurrent permanency plans for 63 (30%) of the 213 cases reviewed.

The local departments (LDSS) were implementing the concurrent plans set by the local Juvenile Courts for 54 (86%) of the 63 cases.

Length of Stay for Children/Youths with a plan of Reunification

The local boards found that the lengths of stay for the 213 children/youths with a plan of Reunification were as follows:



Case Planning/Service Agreements

Family Involvement Meetings (prior to entry): The local departments held family involvement meetings prior to entry for 154 (72%) of the 213 cases reviewed.

Service Agreements: The local departments had signed service agreements for 49 (23%) of the 211 eligible cases. 2 cases were Post-TPR children under the age of 14. Efforts to involve the families in the service agreement process were made for 94 (45%) of the 211 cases.

The local boards agreed that the service agreements were appropriate for 47 (96%) of the 49 signed cases.

Placement/Living Arrangement (LA)

Number of Cases	Placement/Living Arrangement (LA)
27	Formal Kinship Care
18	Regular Foster Care
11	Restricted (Relative) Foster Care
10	Treatment Foster Care
65	Treatment Foster Care (Private)
13	Residential Group Home
20	Therapeutic Group Home
3	Independent Living Residential Program
6	Residential Treatment Center
2	Teen Mother Program
1	Non-Relative
5	Diagnostic Center
3	Other
1	Correctional Institution (LA)
4	Inpatient Psychiatric Care (LA)
4	Runaway (LA)
1	Secure Detention Facility (LA)
16	Trial Home Visit (LA)
3	Unapproved Kinship Home (LA)

In 96 (45%) of the 213 cases reviewed the children/youths were placed in their home jurisdiction in settings that were in close proximity to their communities which allowed for the continuity of services.

The local boards agreed with the department's placement plan for 180 (84%) of the 213 cases reviewed.

Placement Stability

The local boards found that in 95 (45%) of the 213 cases reviewed there were changes in placement within the 12 months prior to the review. 60 (63%) of the 95 cases had 1 placement change, 16 (17%) had 2 placement changes, 9 (9%) had 3 placement changes and 10 (11%) had 4 or more placement changes.

A family involvement meeting took place with the most recent placement changes for 65 (68%) of the 95 cases.

The following levels of care were found for the 95 most recent placement changes:

- 28 (29%) were in less restrictive placements
- 17 (18%) were in more restrictive placements
- 47 (49%) had the same level of care
- 3 (3%) runaway

The local boards found that the primary positive reasons for the 95 most recent placement changes were:

- Transition towards a permanency goal: 33 cases
- Placement with relatives: 6 cases
- Placement with siblings: 1 case

Provider specific issues for the most recent placement changes were:

- Allegation of provider abuse/neglect: 4 cases
- Provider home closed: 5 cases
- Provider request: 6 cases

Child/youth specific issues for the most recent placement changes were:

- Behavioral: 23 cases
- Threats of harm to self/others: 1 case
- Sexualized: 3 cases
- Runaway: 3 cases
- Hospitalization: 5 cases

While child/youth was in the placement from which they were removed, were placement specific services adequate to support the provider:

- Yes, for 77 cases

For the current placement, is there a match between the child/youth's needs and the provider's ability to meet those needs?

- Yes, for 87 cases

Health/Mental Health

- Developmental/Special Needs: The local departments reported that 86 (40%) of the 213 children/youths reviewed had developmental or special needs.

- Current Physical: 120 (56%) children/youths had a current physical exam.

- Current Vision: 75 (35%) children/youths had a current vision exam.

- Current Dental: 94 (44%) children/youths had a current dental exam.
- Follow-up Health Concerns: The local departments ensured that appropriate follow-ups occurred on all health concerns noted by a physician for 42 (55%) of 76 eligible children/youths.
- Completed Medical Records: The local departments reported that 58 (27%) children/youths had completed medical records in their case files.
- Prescription Medication: 102 (48%) children/youths were taking prescription medication.
- Prescription Medication Monitored: Prescription medication was being monitored regularly for 101 (99%) of the 102 children/youths.
- Refused Prescribed Medication: 18 (18%) of the 102 children/youths refused to take prescribed medication.
- Psychotropic Medication: 92 (43%) children/youths were taking psychotropic medication.
- Psychotropic Medication Monitored: Psychotropic medication was being monitored at least quarterly for 91 (99%) of the 92 children/youths.
- Mental Health Issues: 158 (74%) children/youths had mental health issues.
- Mental Health Diagnosis: 155 (98%) of the 158 children/youths had a mental health diagnosis.
- Mental Health Issues Addressed: Yes, for 130 (82%) of the 158 children/youths.
- Mental Health Issues/Transitioning/Services: 3 youths with mental health issues who were transitioning out of care, had an identified plan to receive services in the adult mental health system and 2 youths did not have a plan.
- Substance Abuse: 21 (10%) children/youths had a substance abuse problem.
- Substance Abuse Addressed: Yes for 3 (14%) of the 21 children/youths.
- Behavioral Issues: 113 (53%) children/youths had behavioral issues.
- Behavioral Issues Addressed: Yes, for 84 (74%) of the 113 children/youths.
- Standard Health Exams: 4 (2%) of the 213 children/youths refused to comply with standard health exams.

The local boards found that the health needs of 80 (38%) of the 213 children/youths had been met.

Education

190 (89%) of the 213 children/youths reviewed were enrolled in school or another educational/vocational program. 186 of the 190 were in Pre-K thru 12th grade, 3 were enrolled in a GED program and 1 was in college. 3 of the 23 children/youths not enrolled in school or another educational/vocational program had already graduated high school, 7 refused to attend school and 13 were under the age of 5.

109 (59%) of the 186 children/youths enrolled in school or another educational/vocational program had a 504 or IEP plan. 69 (63%) of the 109 had a copy of the 504/IEP plan in the child/youth's record.

A current progress report/report card was available for review for 80 (73%) of the 109 children/youths enrolled in school or another educational/vocational program.

The local boards agreed that 138 (73%) of the 190 children/youths enrolled in school or another educational/vocational program were being appropriately prepared to meet educational goals.

Ready by 21

- Employment (age 14 and older – 100 cases)

  13 (13%) of the 100 youths were employed or participating in paid or unpaid work experience. 2 youths were unable to participate due to being medically fragile, 21 due to mental health reasons and 2 were in a Correctional Facility.

  22 (22%) youths were referred to summer or year-round training and/or employment opportunities.

  The local boards agreed that 25 (25%) youths were being appropriately prepared to meet employment goals.

- Independent Living Services (age 14 and older – 100 cases)

  The local boards agreed that 25 (25%) of the 100 youths were receiving appropriate services to prepare for independent living. 2 youths were unable to receive appropriate services due to being medically fragile, 21 due to mental health reasons and 2 were in a Correctional Facility.

  18 youths had completed a Life Skills Assessment and 24 were receiving required independent living skills.

- Housing (Transitioning Youth – 6 cases)
  (Age 20 with a permanency plan of APPLA or planning to exit to independence within a year from the review)

  Housing had been specified for 1 of the 6 youths transitioning out of care.

Alternative housing options were provided for 1 youth.

The local boards agreed with the transitional housing plan for 1 youth.

The local boards agreed that 1 youth was being appropriately prepared to transition out of care.

Risk and Safety

The local boards agreed that safety and risk protocols were followed for 191 (90%) of the 213 children/youths.

CASA (Court Appointed Special Advocate)

The local boards found that for 57 (27%) of the 213 cases reviewed the children/youths had a court appointed special advocate.

Child Visits with Parents, Relatives and Siblings

Child Visits	With Parents	With Relatives
Yes	131	59
No	82	154

Frequency of Visits	With Parents	With Relatives
Daily	4	8
Once a week	44	14
More than once a week	17	3
Once a month	11	7
More than once a month	31	11
Quarterly	2	1
Yes, but undocumented	22	15

Supervision of Visits	With Parents	With Relatives
Supervised	40	9
Unsupervised	91	50

Who Supervises Visits	With Parents	With Relatives
LDSS Agency Representative	22	7
Other Agency Representative		
Biological Family Member	7	1
Foster Parent	8	1
Other	3	

Where do Visits Occur?	With Parents	With Relatives
Parent/Relative Home	47	46
LDSS/Visitation Center	17	
Public Area	29	7
Child's/Youth's Placement	35	6
Other	3	

Overnight Stays	With Parents	With Relatives
Yes	37	27
No	94	32

Siblings/Visits

The local boards found that 132 (62%) of the 213 children/youths had siblings in care. 59 of the 132 children/youths had 1 sibling in care, 32 had 2 siblings in care, 20 had 3 siblings in care, 14 had 4 siblings in care and 6 had 5 siblings in care. Efforts were made to place siblings who did not reside together for 106 children/youths. 81 children/youths with siblings in care had visits with their siblings who did not reside with them and 62 had visits with their siblings who were not in care.

Barriers to Permanency/Issues

The local boards identified the following barriers to permanency/issues:

- No service agreement with parents.
- No service agreement with youth.
- Missing or lack of documentation.
- Annual physicals not current.
- Board does not agree with current permanency plan.
- Dentals not current.
- Vision not current.
- No current IEP.
- Other child/youth related barrier.
- Other agency related barrier.
- Other independence barrier.
- Other education barrier.
- Youth has not been assessed for mental health concerns.
- Poor coordination within DSS.
- Worker did not submit referral for needed resource/service.
- Lack of concurrent planning.
- Youth not enrolled in school.
- Child has behavior problems in the home.
- Youth not attending school or in GED program.
- Other physical health barrier.
- No follow up on medical referrals.
- Other placement barrier.

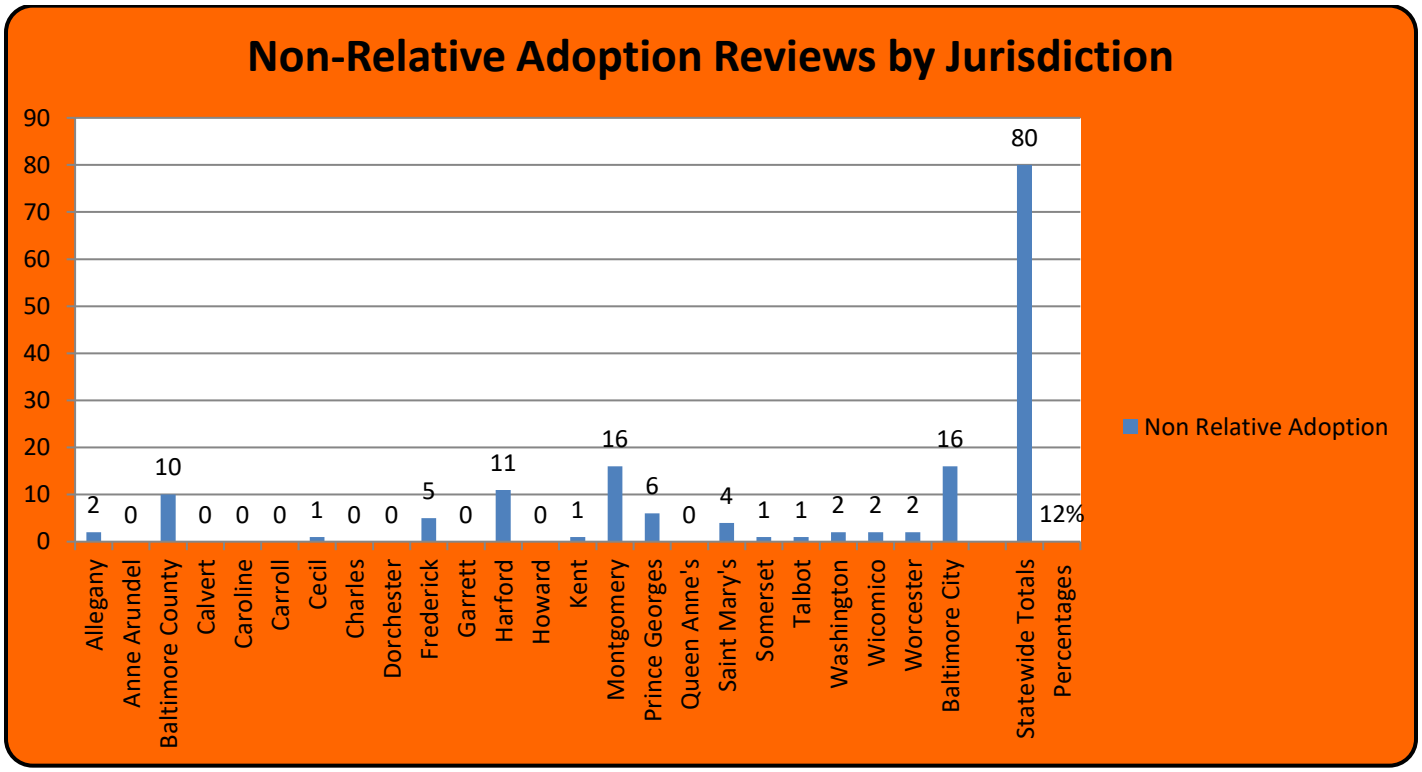
- Transitional housing has not been identified.
- Inadequate preparation for independence (general).
- Youth engages in risky behavior.
- No current Safe-C/G.
- Other court related barrier.
- Youth refuses mental health treatment including therapy.
- Youth non-compliant with medication.
- Youth placed outside of home jurisdiction.
- Youth not employed and transitioning out of care.

Summary

Based on the findings of the review the local boards determined that the local Department of Social Services made adequate progress towards a permanent placement (COMAR – 07.01.06.05 (F)) for 139 (65%) of the 213 children reviewed.

Non-Relative Adoption Case Reviews

When parental rights are terminated (TPR) Adoption becomes the preferred permanency plan. There are a number of factors to consider when a plan of adoption has been established, ranging from the termination of parental rights to what post adoption services are made available to the adoptive families. Reasonable efforts should be made to identify adoptive resources and provide appropriate services identified to remove barriers to adoption and achieve permanency for the child/youth in a timely manner.



Age Range	Statewide Totals	Adoption	Percentage
Age 1 thru 5	54	22	41%
Age 6 thru 10	80	22	28%
Age 11 thru 13	79	13	16%
Age 14 thru 16	144	18	13%
Age 17 thru 19	166	5	3%
Age 20	137	0	N/A
Total	660	80	12%

Permanency

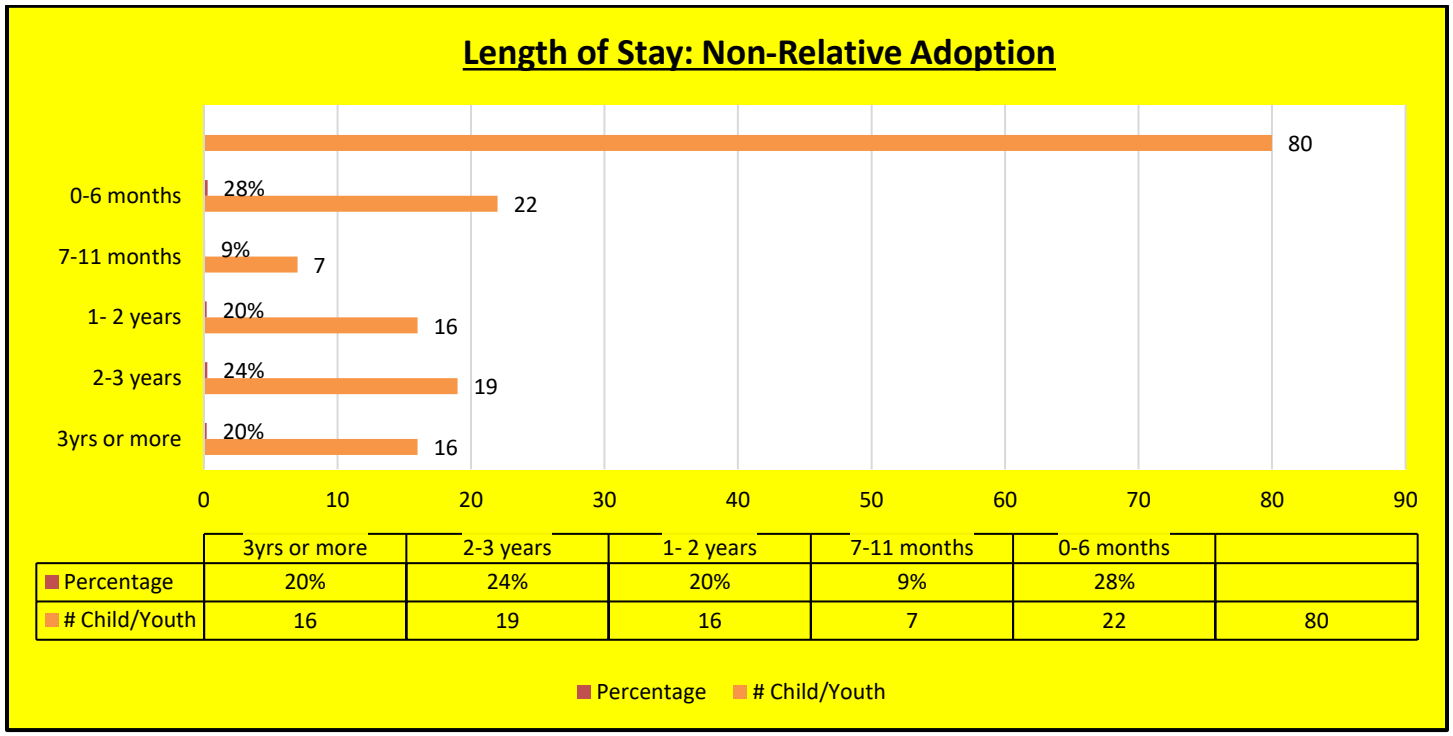
The local boards agreed with the permanency plan of Non-Relative Adoption for 70 (88%) of the 80 cases reviewed.

The local Juvenile Courts identified concurrent permanency plans for 13 (16%) of the cases reviewed.

The local departments were implementing the concurrent permanency plans set by the local Juvenile Courts for the 13 cases.

Lengths of Stay for Children/Youths with a plan of Adoption

The local boards found that the lengths of stay for the 80 children/youths with a plan of Non-Relative Adoption were as follows:



	3yrs or more	2-3 years	1- 2 years	7-11 months	0-6 months	
Percentage	20%	24%	20%	9%	28%	
# Child/Youth	16	19	16	7	22	80

Case Planning/Service Agreements

Family Involvement Meetings (prior to entry): The local departments held family involvement meetings prior to entry for 55 (69%) of the 80 cases reviewed.

Service Agreements: The local departments had signed service agreements for 8 (17%) of the 47 eligible cases. 33 cases were Post-TPR children under the age of 14. Efforts to involve the families in the service agreement process were made for 16 (34%) of the 47 cases.

The local boards agreed that the service agreements were appropriate for the 8 signed cases.

Placement/Living Arrangement (LA)

Number of Cases	Placement/Living Arrangement (LA)
2	Formal Kinship Care
24	Pre-Finalized Adoptive Home
17	Regular Foster Care
3	Treatment Foster Care
17	Treatment Foster Care (Private)
3	Residential Group Home
5	Therapeutic Group Home
4	Residential Treatment Center
2	Other
1	Inpatient Medical Care Facility (LA)
1	Runaway (LA)
1	Secure Detention Facility (LA)

In 44 (55%) of the 80 cases reviewed the children/youths were placed in their home jurisdiction in settings that were in close proximity to their communities which allowed for the continuity of services.

The local boards agreed with the department's placement plan for 77 (96%) of the 80 cases reviewed.

Placement Stability

The local boards found that in 25 (31%) of the 80 cases reviewed there was a change in placement within the 12 months prior to the review. 12 (48%) of the 25 cases had 1 placement change, 5 (20%) had 2 placement changes, 5 (20%) had 3 placement changes, and 3 (12%) had 4 or more placement changes.

A family involvement meeting took place with the most recent placement changes for 15 (60%) of the 25 cases.

The following levels of care were found for the 25 most recent placement changes:

- 4 (16%) were in less restrictive placements
- 7 (28%) were in more restrictive placements
- 13 (52%) had the same level of care
- 1 (4%) runaway

The local boards found that the primary positive reasons for the 25 most recent placement changes were:

- Transition towards a permanency goal: 9 cases

Provider specific issues for the most recent placement changes were:

- Provider home closed: 1 case
- Provider request: 1 case
- Allegation of provider abuse/neglect: 3 cases
- Founded incident of provider abuse/neglect: 1 case

Child/youth specific issues for the most recent placement changes were:

- Behavioral: 4 cases
- Threats of harm to self or others: 1 case
- Sexualized: 1 case
- Delinquent behavior: 2 cases
- Runaway: 1 case

While child/youth was in the placement from which they were removed, were placement specific services adequate to support the provider:

- Yes, for 16 cases

For the current placement, is there a match between the child/youth's needs and the provider's ability to meet those needs?

- Yes, for 22 cases

Health/Mental Health

- Developmental/Special Needs: The local departments reported that 37 (46%) of the 80 children/youths reviewed had developmental or special needs.

- Current Physical: 57 (71%) children/youths had a current physical exam.

- Current Vision: 35 (44%) children/youths had a current vision exam.

- Current Dental: 45 (56%) children/youths had a current dental exam.

- Follow-up Health Concerns: The local departments ensured that appropriate follow-ups occurred on all health concerns noted by a physician for 23 (68%) of 34 eligible children/youths.

- Completed Medical Records: The local departments reported that 27 (33%) children/youths had completed medical records in their case files.

- Prescription Medication: 41 (51%) children/youths were taking prescription medication.

- Prescription Medication Monitored: Prescription medication was being monitored regularly for the 41 (51%) children/youths.

- Refused Prescribed Medication: 2 (5%) of the 41 children/youths refused to take prescribed medication.
- Psychotropic Medication: 33 (41%) children/youths were taking psychotropic medication.
- Psychotropic Medication Monitored: Psychotropic medication was being monitored at least quarterly for 32 (40%) children/youths.
- Mental Health Issues: 52 (65%) children/youths had mental health issues.
- Mental Health Diagnosis: 49 (61%) children/youths had mental health diagnosis.
- Mental Health Issues Addressed: Yes, for 41 (83%) of the 49 children/youths.
- Mental Health Issues/Transitioning/Services: Not applicable. None of the youths with mental health issues were transitioning out of care.
- Substance Abuse: 4 (5%) children/youths had a substance abuse problem.
- Substance Abuse Addressed: Yes, for the 4 children/youths.
- Behavioral Issues: 43 (54%) children/youths had behavioral issues.
- Behavioral Issues Addressed: Yes, for 38 (88%) of the 43 children/youths.
- Standard Health Exams: 2 (2%) of the 80 children/youths refused to comply with standard health exams.
- The local boards found that the health needs of 48 (60%) of the 80 children/youths had been met.

Education

65 (81%) of the 80 children/youths reviewed were enrolled in school or another educational/vocational program. 64 of the 65 children/youths were in Pre-K thru 12th grade and 1 child/youth was enrolled in a GED program. 3 of the 15 children/youths not enrolled in school or another educational/vocational program refused to attend school and 12 were under the age of 5.

43 (66%) of the 65 children/youths enrolled in school or another educational/vocational program had a 504 or IEP plan. 30 (70%) of the 43 cases had a copy of the 504/IEP plan in the child/youth's record.

A current progress report/report card was available for review for 29 (45%) of the 64 children/youths enrolled in school or another educational/vocational program.

The local boards agreed that 54 (83%) of the 65 children/youths enrolled in school or another educational/vocational program were being appropriately prepared to meet educational goals.

Ready by 21

- Employment (age 14 and older – 23 cases)

  4 (17%) of the 23 youths were employed or participating in paid or unpaid work experience.

  2 youths were unable to participate due to being medically fragile, 3 due to mental health reasons and 1 was in a Correctional Facility.

  3 (13%) of the 23 youths were referred to summer or year-round training and/or employment opportunities.

  The local boards agreed that 4 (17%) youths were being appropriately prepared to meet employment goals.

- Independent Living Services (age 14 and older – 23 cases)

  2 youths were unable to receive appropriate services due to being medically fragile, 3 due to mental health reasons and 1 was in a Correctional Facility.

  4 youths had completed a Life Skills Assessment and 5 were receiving required independent living skills.

  The local boards agreed that 5 (22%) of the 23 youths were receiving appropriate services to prepare for independent living.

- Housing (Transitioning Youth – None)
  (Age 20 with a permanency plan of APPLA or planning to exit to independence within a year from the review)

  Not applicable.

Child's Consent to Adoption

The age of consent for adoption in the State of Maryland is ten. Children 10 and older must consent to be adopted. The local boards found that 20 (25%) of the 80 children/youths consented to adoption and 34 (43%) children/youths were under the age of consent.

Consent to Adoption for Cases Reviewed with Adoption Plans

Child's Consent to Adoption	Cases
Yes	20
Yes, with conditions	1
Child did not want to be Adopted	6

N/A under age of consent	34
No, Medically Fragile, unable to consent	3
No, Mental Health Reasons, unable to consent	2
Unknown	14

Pre-Adoptive Placement, Recruitment, Services and Resources

Pre-Adoptive Placements (45 cases)

45 (56%) of the 80 children/youths with a plan of adoption were placed in pre-adoptive homes. The family structure was comprised of a married couple for 29 (64%) of the 45 cases, an unmarried couple for 3 (7%) and a single female for 13 (29%) cases. The relationship to the pre-adoptive children/youths was a relative foster parent for 1 case, non-relative foster parents for 41 cases and fictive kin foster parents for 3 cases.

Lengths of time in the pre-adoptive placements were as follows:

- 1 case(s) from 1 to 3 months
- 8 case(s) from 4 to 6 months
- 7 case(s) from 12 to 15 months
- 7 case(s) from 16 to 20 months
- 22 case(s) 21 months or more

An adoptive home study was completed and approved for 32 (71%) of the 45 cases.

The local boards agreed that appropriate services and supports were in place for the pre-adoptive families to meet the identified needs of the children/youths for all 45 (100%) cases.

The local boards found that the pre-adoptive placements were appropriate for all 45 (100%) cases.

Adoptive Recruitment (35 cases)

The local boards found that the local department had documented efforts to find an adoptive resource for 18 (51%) of the 35 children/youths not placed in pre-adoptive homes. The adoptive recruitment resources included Adopt Us Kids, Adoption Together, Wednesdays Child, Wednesday's Wonderful Kids and Local Channel 4 news.

The local boards agreed that the adoptive recruitment efforts were appropriate for the 18 (51%) children/youths.

Post-Adoptive Services and Resources (80 cases)

Post-adoptive services were needed for all 45 (100%) children/youths placed in pre-adoptive homes. The services that were needed were Medical for 41 cases, Mental Health services for 22 cases, Educational services for 21 cases, Respite Services for 5 cases and DDA services for 4 cases.

Post-adoptive subsidies were needed for 24 (53%) of the 45 children/youths.

The local boards agreed that the post-adoptive services and resources were appropriate for 53 (66%) of the 80 children/youths.

Risk and Safety

The local boards agreed that safety and risk protocols were followed for 71 (89%) of the 80 children/youths.

CASA (Court Appointed Special Advocate)

The local boards found that for 33 (41%) of the 80 cases reviewed the children/youths had a court appointed special advocate.

Child Visits with Parents, Relatives and Siblings

Child Visits	With Parents	With Relatives
Yes	20	12
No	60	68

Frequency of Visits	With Parents	With Relatives
Daily		
Once a week	4	
More than once a week		2
Once a month	9	3
More than once a month	5	1
Quarterly		
Yes, but undocumented	2	6

Supervision of Visits	With Parents	With Relatives
Supervised	12	4
Unsupervised	8	8

Who Supervises Visits	With Parents	With Relatives
LDSS Agency Representative	10	1
Other Agency Representative		
Biological Family Member		
Foster Parent	1	3
Other	1	

Where do Visits Occur?	With Parents	With Relatives
Parent/Relative Home	4	5
LDSS/Visitation Center	10	
Public Area	3	1
Child's/Youth's Placement	3	5
Other		1

Overnight Stays	With Parents	With Relatives
Yes	5	6
No	15	6

Siblings/Visits

The local board found that 51 (64%) of the 80 children/youths had siblings in care. 23 of the 51 children/youths had 1 sibling in care, 16 had 2 siblings in care, 1 had 3 siblings in care, 8 had 4 siblings in care and 3 had 5 siblings in care. Efforts were made to place siblings who did not reside together for 35 (69%) of the 51 children/youths. 32 (40%) of the 51 children/youths with siblings in care had visits with their siblings who did not reside with them. 11 children/youths had visits with their siblings who were not in care.

Barriers to Permanency/Issues

The local boards identified the following barriers to permanency/issues:

- No service agreement with youth.
- Missing or lack of documentation.
- Child has behavior problems in the home.
- TPR not granted.
- Child in pre-adoptive home but adoption not finalized.
- Disrupted finalized adoption.
- Annual physicals not current.
- Dentals not current.
- Vision not current.
- Board does not agree with current permanency plan.
- Other independence barrier.
- Pre-Adoptive resources not identified.
- Other education barrier.
- Lack of concurrent planning.
- Youth placed outside of home jurisdiction.
- No current Safe-C/G.
- Postponement or continuation of hearings.
- Appeal by birth parents.

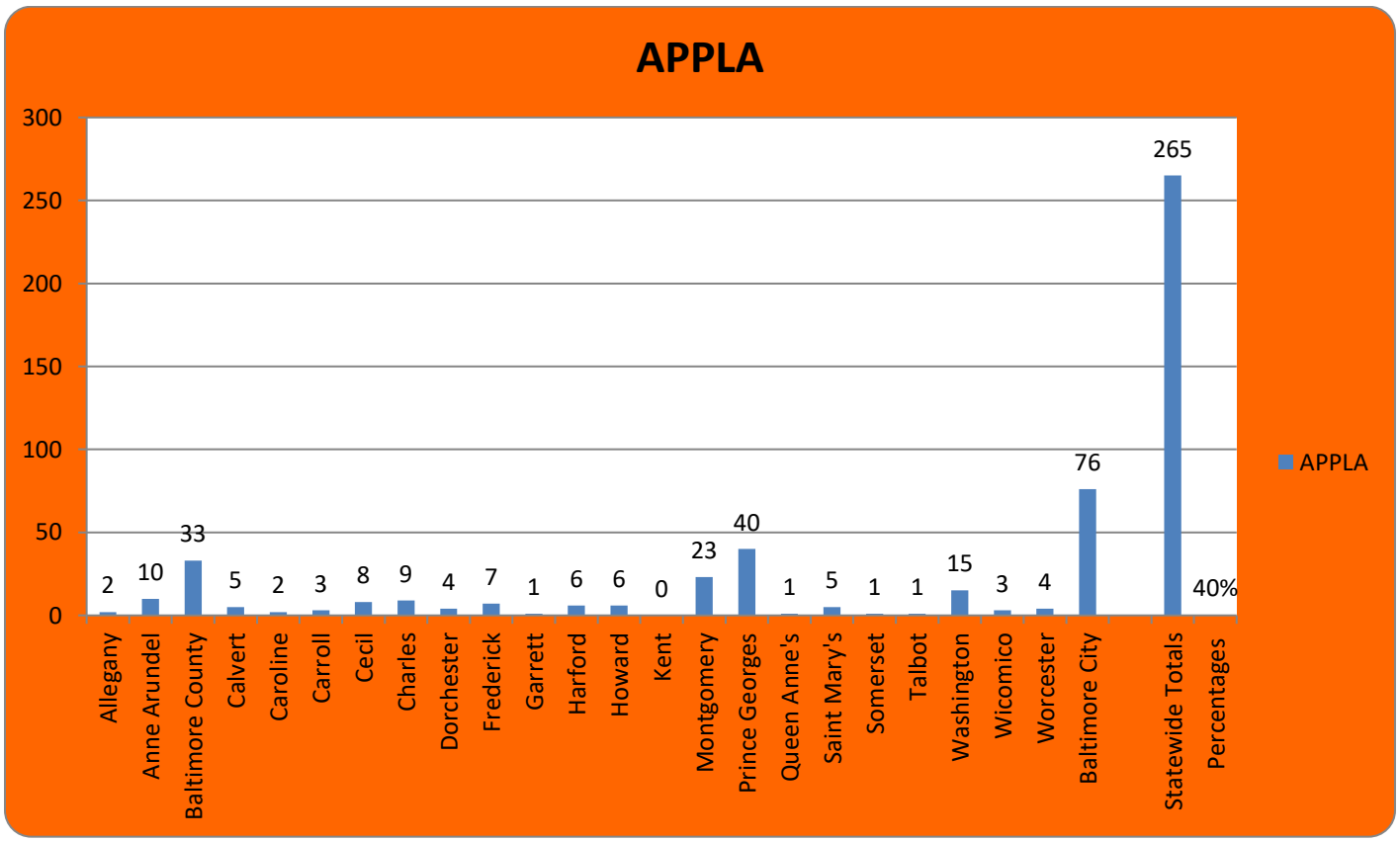
Summary

Based on the findings of the review the local boards determined that the local Department of Social Services made adequate progress towards a permanent placement (COMAR – 07.01.06.05 (F)) for 65 (81%) of the 80 children reviewed.

APPLA Reviews
(Another Planned Permanent Living Arrangement)

APPLA is the least desired permanency plan. All efforts should be made to rule out all other permanency plans including reunification with birth family, relative placement for custody and guardianship or adoption, adoption to a non-relative and guardianship to a non-relative before a child/youth's permanency plan is designated as APPLA.

Out of the total number of 660 cases reviewed, 265 (40%) of the cases had a plan of APPLA. Baltimore City had the most cases at 76 (29%), Prince George's County 40 cases (15%), Baltimore County 33 cases (13%), Montgomery County 23 cases (9%), Washington County 15 cases (6%), Anne Arundel County 10 cases (4%), Charles County 9 cases (3%) and Cecil County 8 cases (3%). All other counties had two percent or less. Many of the cases reviewed were cases of older youth, between 17 and 20 years of age who are expected to remain in care until they age out on their 21st birthday.



Age Range	Statewide Totals	APPLA	Percentage
Age 1 thru 5	54	0	N/A
Age 6 thru 10	80	0	N/A
Age 11 thru 13	79	0	N/A
Age 14 thru 16	144	9	6%
Age 17 thru 19	166	126	76%
Age 20	137	130	95%
Total	660	265	40%

Permanency

The local boards agreed with the permanency plan of APPLA for 264 (99%) of the 265 cases reviewed.

Category of APPLA plan

The local boards found the following categories for the APPLA plans were:

- Emancipation/Independence: 221 (85%) cases
- Transition to an Adult Supportive Living Arrangement: 39 (15%) cases

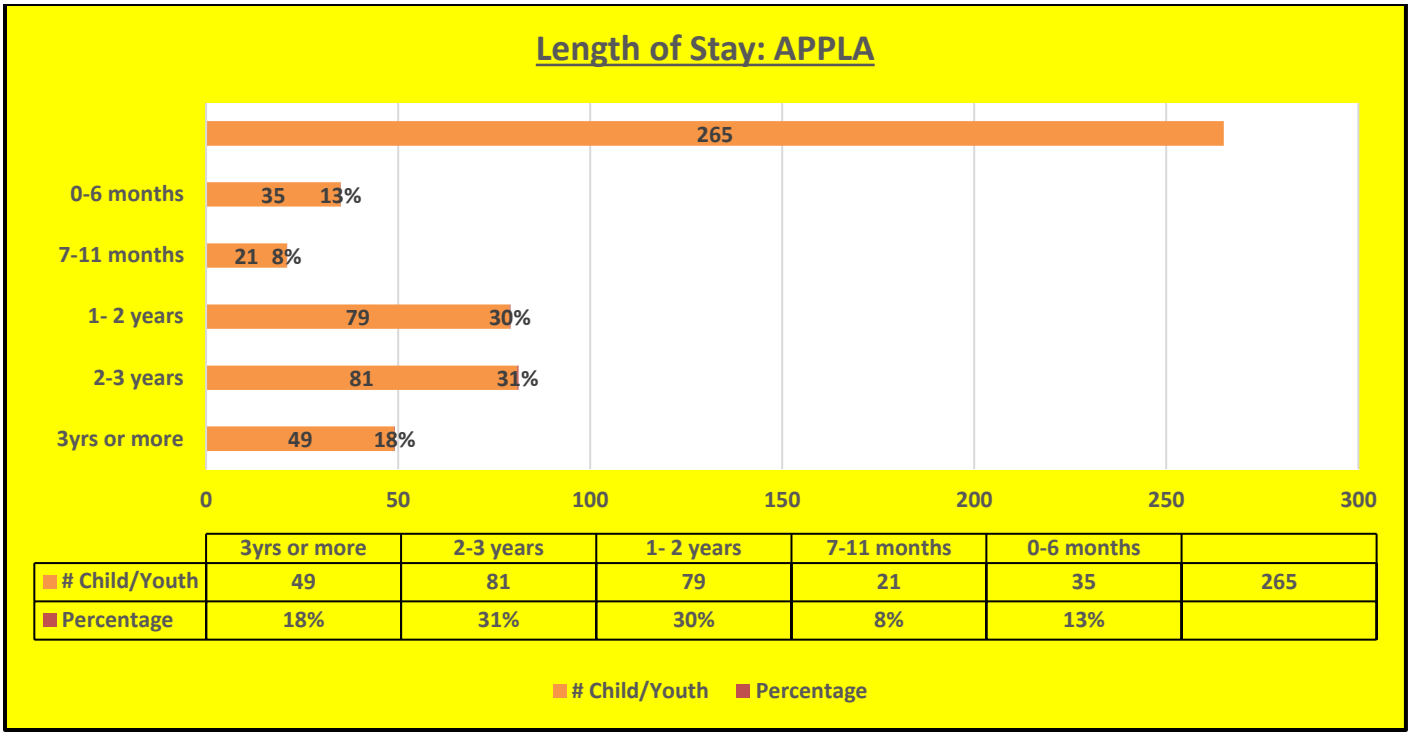
Permanent Connections (265 cases)

A permanent connection is an identified person that a youth can rely on for assistance with support, advice and guidance as they deal with the day-to-day life circumstances that adulthood can bring about on a regular basis.

The local boards found that for 227 (86%) of the 265 cases reviewed, a permanent connection had been identified for the children/youths by the local departments and that the identified permanent connections were appropriate for 218 (96%) of the 227 cases.

Length of stay Child/Youth had a plan of APPLA

The local boards found that the lengths of stay of the 265 children/youths with a plan of APPLA were as follows:



Case Planning/Service Agreements

Family Involvement Meetings (prior to entry): The local boards found that the local departments held family involvement meetings prior to entry for 173 (65%) of the 265 cases reviewed.

Service Agreements: The local departments had signed service agreements for 126 (48%) of the 265 cases. Efforts to involve the families in the service agreement process were made for 159 (60%) cases.

The local boards found that the service agreements were appropriate for 120 (95%) of the 126 signed cases.

Placement/Living Arrangement (LA)

Number of Cases	Placement/Living Arrangement (LA)
3	Formal Kinship Care
9	Regular Foster Care
1	Restricted (Relative) Foster Care
2	Treatment Foster Care
60	Treatment Foster Care (Private)
1	Alternative Living Units
19	Residential Group Home
14	Teen Mother Program
18	Therapeutic Group Home

51	Independent Living Residential Program
2	Residential Treatment Center
7	Relative
7	Non-Relative
24	Own Dwelling
2	Diagnostic Center
1	Psychiatric Respite
7	Other
	Living Arrangement (LA)
5	College (LA)*
3	Correctional Institution (LA)
1	Own Home/Apartment (LA)
1	Inpatient Psychiatric Care (LA)*
2	Inpatient Medical Care (LA)*
9	Runaway (LA)
3	Secure Detention Facility (LA)
1	Military (LA)
1	Unapproved Kinship Home (LA)
9	Unapproved Living Arrangement (LA)
2	Other

(*These cases have both a living arrangement and a placement) Living arrangements are usually temporary and not paid placements.

In 126 (48%) of the 265 cases reviewed the children/youths were placed in their home jurisdiction in settings that were in close proximity to their communities which allowed for the continuity of services.

The local boards agreed with the department's placement plan for 230 (87%) of the 265 cases reviewed.

Placement Stability

The local boards found that for 111 (42%) cases reviewed there was a change in the placement in the last 12 months prior to being reviewed. 66 (60%) of the 111 cases had 1 placement change, 30 (27%) had 2 placement changes, 8 (7%) had 3 placement changes and 7 (6%) had 4 or more placement changes.

A family involvement meeting took place with the most recent placement changes for 50 (45%) of the 111 cases.

- 46 (41%) were in less restrictive placements
- 8 (7%) were in more restrictive placements
- 46 (41%) had the same level of care
- 8 (7%) youth on runaway

The primary positive reason for the most recent placement changes were:

- Transition towards a permanency goal: 48 cases
- Placement with siblings: 1 case

Provider specific issues for the most recent placement changes included:

- Provider home closed: 1 case
- Provider request: 1 case

Child/youth specific issues for the most recent placement changes were:

- Behavioral: 28 cases
- Sexualized: 2 cases
- Delinquent behavior: 1 case
- Runaway: 12 cases
- Hospitalization: 2 cases

While child/youth was in the placement from which they were removed, were placement specific services adequate to support the provider:

- Yes, for 89 cases

For the current placement, is there a match between the child/youth's needs and the provider's ability to meet those needs?

- Yes, for 91 cases

Health/Mental Health

- Developmental/Special Needs: The local departments reported that 66 (25%) of the 265 children/youths reviewed had developmental or special needs.

- Current Physical: 143 (54%) children/youths had a current physical exam.

- Current Vision: 114 (43%) children/youths had a current vision exam.

- Current Dental: 115 (43%) children/youths had a current dental exam.

- Follow-up Health Concerns: The local departments ensured that appropriate follow-ups occurred on all health concerns noted by a physician for 54 (57%) of 95 eligible children/youths.

- Completed Medical Records: The local departments reported that 74 (28%) of the children/youths had completed medical records in their case files.

- Prescription Medication: 89 (33%) children/youths were taking prescription medication.

- Prescription Medication Monitored: Prescription medication was being monitored regularly for 87 (98%) of the 89 children/youths.
- Refused Prescribed Medication: 66 (74%) of the 89 children/youths refused to take prescribed medication.
- Psychotropic Medication: 77 (29%) children/youths were taking psychotropic medication.
- Psychotropic Medication Monitored: Psychotropic medication was being monitored at least quarterly for 75 (97%) of the 77 children/youths.
- Mental Health Issues: 214 (81%) children/youths had mental health issues.
- Mental Health Diagnosis: 210 (79%) children/youths had mental health diagnosis.
- Mental Health Issues Addressed: Yes, for 124 (58%) of the 214 children/youths.
- Mental Health Issues/Transitioning/Services: 23 (11%) of the 214 youths with mental health issues who were transitioning out of care, had an identified plan to receive services in the adult mental health system and 37 (17%) did not have an identified plan.
- Substance Abuse: 73 (28%) children/youths had a substance abuse problem.
- Substance Abuse Addressed: Yes for 22 (30%) of the 73 children/youths.
- Behavioral Issues: 127 (48%) children/youths had behavioral issues.
- Behavioral Issues Addressed: Yes, for 68 (54%) of the 127 children/youths.
- Standard Health Exams: 42 (16%) of the 265 children/youths refused to comply with standard health exams.
- The local boards found that the health needs of 108 (41%) of the 265 children/youths had been met.

Education

118 (31%) of the 265 children/youths reviewed were enrolled in school or another educational/vocational program. 81 (69%) of the 49 were in Pre-K through 12th grade, 7 (6%) were enrolled in a GED program, 24 (20%) were in college and 6 (5%) were in trade school. 102 (69%) of the 147 children/youths not enrolled in school or another educational/vocational program had already graduated high school and 45 (31%) refused to attend school.

54 (67%) of the 81 children/youths enrolled in Pre-K through 12th grade had a 504 or IEP plan. 36 (44%) of the 81 children/youths had a copy of the 504/IEP plan in the child/youth's record.

A current progress report/report card was available for review for 36 (44%) of the 81 children/youths enrolled in school or another educational/vocational program.

The local boards agreed that 220 (83%) of the 265 children/youths enrolled in school or another educational/vocational program and/or had graduated high school/GED or were being appropriately prepared to meet educational goals.

Ready by 21

- Employment (age 14 and older – 262 cases)

  129 (49%) of the 262 youths were employed or participating in paid or unpaid work experience.

  7 youths were unable to participate due to being medically fragile and 12 youths due to mental health reasons.

  1 youth was unable to participate due to being in a Juvenile Justice Facility and 3 youths due to being in a Correctional Institution.

  73 youths (28%) were referred to summer or year-round training and/or employment opportunities.

  The local boards agreed that 159 youths (61%) were being appropriately prepared to meet employment goals.

- Independent Living Services (age 14 and older – 262 cases)

  7 youths were unable to receive appropriate services due to being medically fragile and 12 youths due to mental health reasons.

  1 youth was unable to receive appropriate services due to being in a Juvenile Justice Facility and 3 youths due to being in a Correctional Institution.

  146 youths (56%) had completed a Life Skills Assessment for successful transition to adulthood.

  151 youths (58%) were receiving required independent living skills.

  The local boards agreed that 157 youths (60%) were receiving appropriate services to prepare for independent living.

- Housing (Transitioning Youth – 130 cases)
  (Age 20 with a permanency plan of APPLA or planning to exit to independence within a year from the review)

Housing had been specified for 85 (65%) of the 130 youths transitioning out of care.

Alternative housing options were provided for 98 youths.

The local boards agreed with the transitional housing plan for 98 youths.

The local boards agreed that 98 (75%) of the 130 youths were being appropriately prepared to transition out of care.

Risk and Safety

The local boards agreed that safety and risk protocols were followed for 243 (92%) of the 265 children/youths.

CASA (Court Appointed Special Advocate)

The local boards found that in 66 (25%) of the 265 cases reviewed the children/youths had a court appointed special advocate.

Child Visits with Parents, Relatives and Siblings

Child Visits	With Parents	With Relatives
Yes	106	82
No	159	183

Frequency of Visits	With Parents	With Relatives
Daily		
Once a week	11	8
More than once a week	7	2
Once a month	19	10
More than once a month	23	10
Quarterly	6	1
Yes, but undocumented	40	51

Supervision of Visits	With Parents	With Relatives
Supervised	4	4
Unsupervised	102	78

Who Supervises Visits	With Parents	With Relatives
LDSS Agency Representative	2	1
Other Agency Representative	2	2

Biological Family Member		
Foster Parent		
Other		1

Where do Visits Occur?	With Parents	With Relatives
Parent/Relative Home	66	66
LDSS/Visitation Center	1	1
Public Area	18	6
Child's/Youth's Placement	20	8
Other	1	1

Overnight Stays	With Parents	With Relatives
Yes	45	55
No	61	27

Siblings/Visits

The local boards found that 57 (22%) of the 265 children/youths had siblings in care. 47 of the 57 children/youths had 1 sibling in care, 5 had 2 siblings in care, 4 had 3 siblings in care and 1 had 5 siblings in care. Efforts were made to place siblings who did not reside together for 35 (61%) of the 57 children/youths. 35 (61%) of the 57 children/youths with siblings in care had visits with their siblings who did not reside with them. 115 children/youths had visits with their siblings who were not in care.

Barriers to Permanency/Issues

The local boards identified the following barriers to permanency/issues:

- No service agreement with parents.
- No service agreement with youth.
- Youth placed outside of home jurisdiction.
- Missing or lack of documentation.
- Child has behavior problems in the home.
- Issues related to substance abuse.
- Not following up on referrals.
- Youth not enrolled in school.
- Youth not attending school or in GED program.
- Youth not receiving adequate services.
- No current IEP.
- Board does not agree with current permanency plan.
- Annual physicals not current.
- Dentals not current.
- Vision not current.
- No follow up on medical referrals.
- Transitional housing has not been identified.
- Inadequate preparation for independence (general).
- Youth not employed and transitioning out of care.

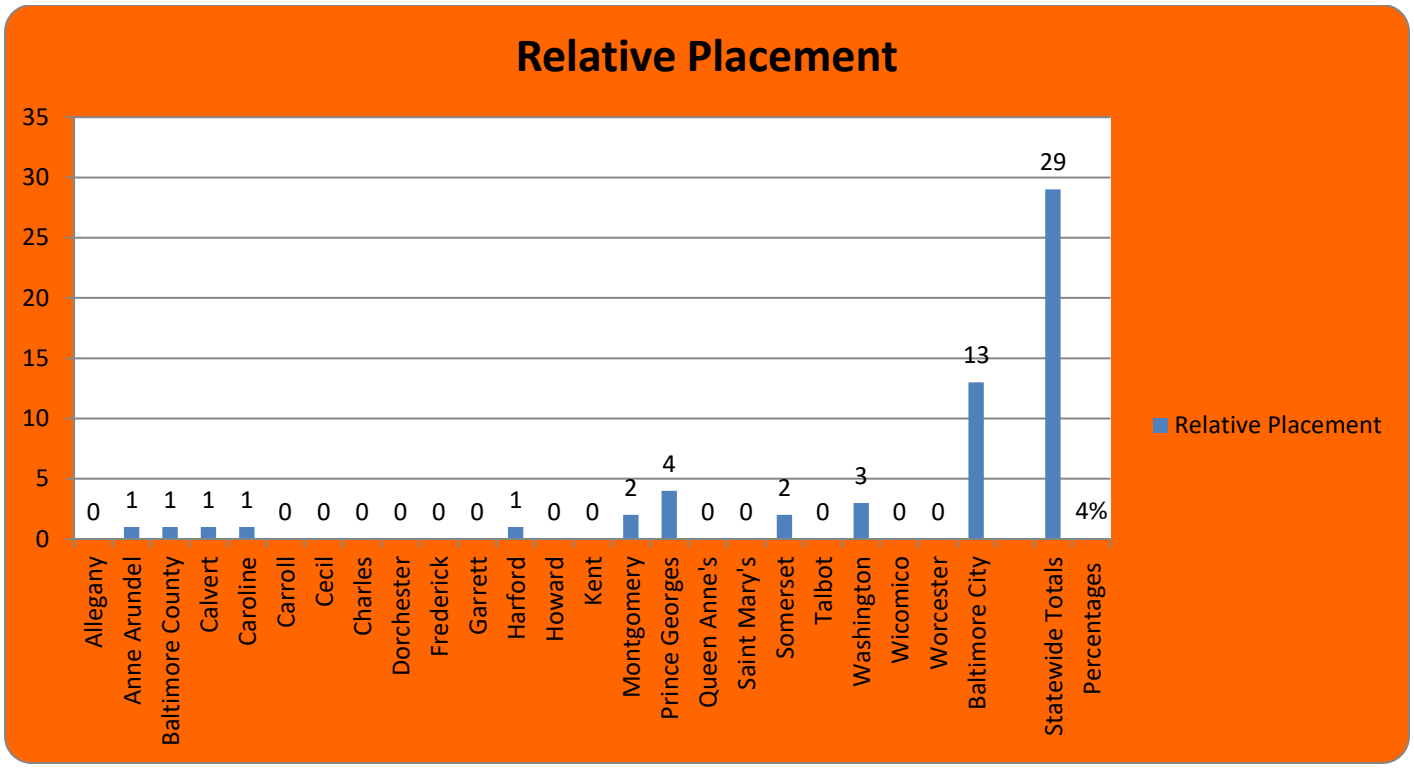
- Other education barrier.
- Other independence barrier.
- Other placement barrier.
- Youth refuses mental health treatment including therapy.
- Youth non-compliant with medication.
- No current Safe C/G.
- Youth engages in risky behavior.
- Other mental health barrier.
- Other legal barrier.
- Other child/youth related barrier.

Summary

Based on the findings of the review the local boards determined that the local Department of Social Services made adequate progress towards a permanent placement (COMAR – 07.01.06.05 (F)) for 208 (76%) of the 265 children reviewed.

Relative Placement Case Reviews

It is the responsibility of the local departments to seek out opportunities for placement with a blood relative or explore other permanency resources including fictive kin when reunification is not possible.



Category of Relative Placement

- Relative Placement for Adoption: 2 cases
- Relative Placement for Custody/Guardianship: 27 cases

Age Range	Totals	Relative Placement	Percentage
Age 1 thru 5	54	6	11%
Age 6 thru 10	80	6	8%
Age 11 thru 13	79	4	5%
Age 14 thru 16	144	10	7%
Age 17 thru 19	166	3	2%
Age 20	137	0	N/A
Total	660	29	4%

Permanency

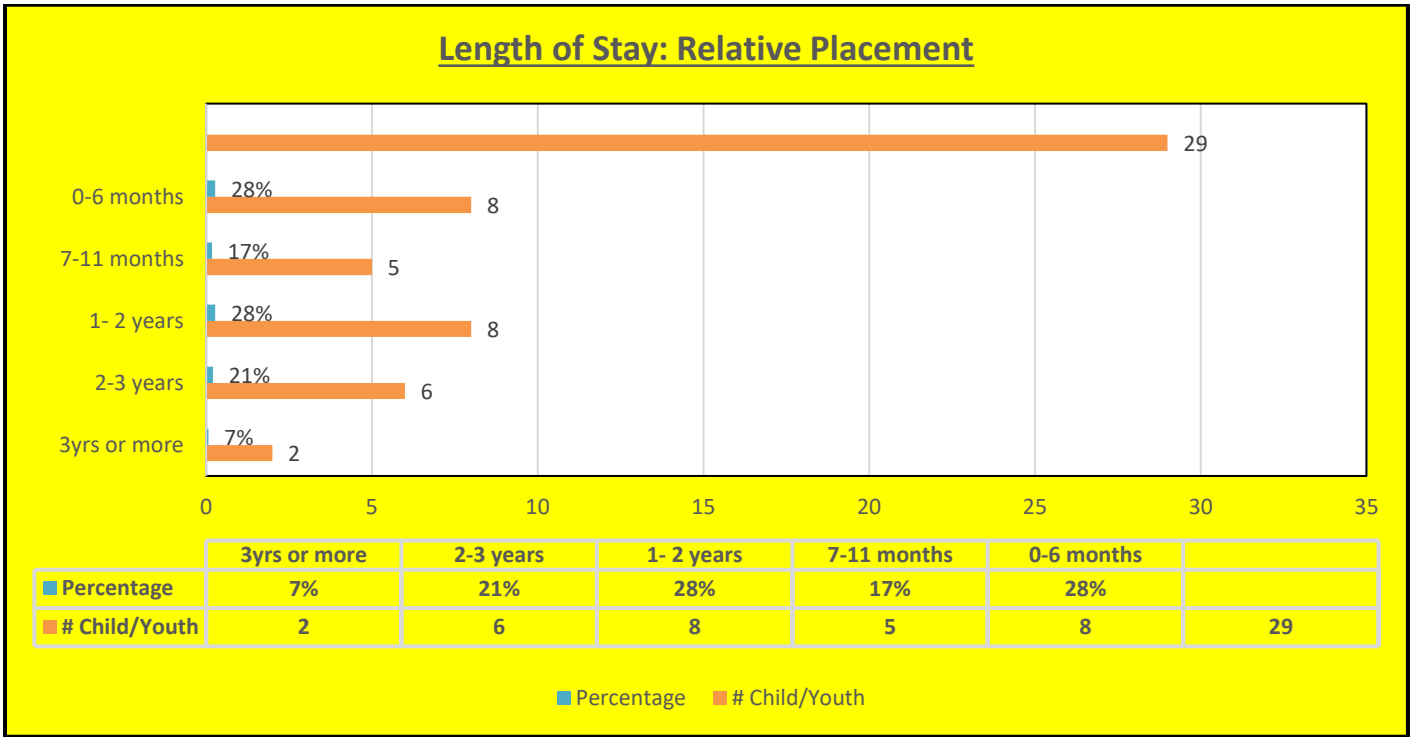
The local boards agreed with the permanency plan of relative placement for 22 (76%) of the 29 cases reviewed.

The local Juvenile Courts identified concurrent permanency plans for 4 (14%) of the 29 cases reviewed.

The local departments were implementing the concurrent plans set by the local Juvenile Courts for the 4 cases.

Lengths of Stay for Children/Youth with a plan of Relative Placement

The local boards found that the lengths of stay of the 29 children/youths with a plan of Relative Placement for Adoption and/or Custody/Guardianship were as follows:



	3yrs or more	2-3 years	1- 2 years	7-11 months	0-6 months	
Percentage	7%	21%	28%	17%	28%	
# Child/Youth	2	6	8	5	8	29

Case Planning/Service Agreements

Family Involvement Meetings (prior to entry): The local boards found that the local departments held family involvement meetings prior to entry for 21 (72%) of the 29 cases reviewed.

Service Agreements: The local departments had signed service agreements for 3 (13%) of the 23 eligible cases. 6 cases were Post-TPR children/youths under the age of 14. Efforts to involve the families in the service agreement process were made for 9 (39%) of the 23 eligible cases reviewed.

The local boards agreed that the service agreements were appropriate for the 3 signed cases.

Placement/Living Arrangement (LA)

Number of Cases	Placement/Living Arrangement (LA)
4	Formal Kinship Care
2	Pre-Finalized Adoptive Home
3	Regular Foster Care
5	Restricted (Relative) Foster Care
9	Treatment Foster Care (Private)
2	Residential Group Home
2	Residential Treatment Center
1	Psychiatric Respite
1	Runaway (LA)

The local boards found that in 16 (55%) of the 29 cases reviewed the children/youths were placed in settings that were in close proximity to their communities which allowed for the continuity of services.

The local boards agreed with the placement plan for 26 (88%) of the 29 cases reviewed.

Placement Stability

The Local boards found that for 4 (14%) of the 29 cases reviewed there was a change in placement within the 12 months prior to the review. 1 (25%) of the 4 cases had 1 placement change, 2 (50%) had 2 placement changes and 1 (25%) had 4 or more placement changes.

A family involvement meeting took place with the most recent placement changes for 3 of the 4 cases.

The following levels of care were found for the 4 most recent placement changes:

- 4 cases (100%) had the same level of care

Child/youth specific issues for the most recent placement changes were:

- Behavioral: 3 cases

While child/youth was in the placement from which they were removed, were placement specific services adequate to support the provider:

- Yes, for all 4 cases

For the current placement, is there a match between the child/youth's needs and the provider's ability to meet those needs?

- Yes, for all 4 cases

Health/Mental Health

- Developmental/Special Needs: The local departments reported that 3 (10%) of the 29 children/youths reviewed had developmental or special needs.
- Current Physical: 17 (59%) children/youths had a current physical exam.
- Current Vision: 11 (38%) children/youths had a current vision exam.
- Current Dental: 14 (48%) children/youths had a current dental exam.
- Follow-up Health Concerns: The local departments ensured that appropriate follow-ups occurred on all health concerns noted by a physician for 2 (28%) of the 7 eligible children/youths.
- Completed Medical Records: The local departments reported that 11 (38%) of the children/youths had completed medical records in their case files.
- Prescription Medication: 12 (41%) children/youths were taking prescription medication.
- Prescription Medication Monitored: Prescription medication was being monitored regularly for all 12 children/youths.
- Refused Prescribed Medication: 5 (42%) of the 12 children/youths refused to take prescribed medication.
- Psychotropic Medication: 6 (21%) children/youths were taking psychotropic medication.
- Psychotropic Medication Monitored: Psychotropic medication was being monitored at least quarterly for all 6 children/youths.
- Mental Health Issues: 21 (72%) children/youths had mental health issues.
- Mental Health Diagnosis: 21 (72%) children/youths had a mental health diagnosis.
- Mental Health Issues Addressed: Yes, for 12 (57%) of the 21 children/youths.
- Mental Health Issues/Transitioning/Services: Not applicable. None of the children/youths with mental health issues were transitioning out of care.

- Substance Abuse: 2 (7%) children/youths had a substance abuse problem.
- Substance Abuse Addressed: Yes, for 1 of the 2 children/youths.
- Behavioral Issues: 18 (62%) children/youths had behavioral issues.
- Behavioral Issues Addressed: Yes, for 14 (78%) of the 18 children/youths.
- Standard Health Exams: 1 (3%) of the 29 children/youths refused to comply with standard health exams.
- The local boards found that the health needs of 12 (41%) of the 10 children/youths had been met.

Education

24 (83%) of the 29 children/youths reviewed were enrolled in school or another educational/vocational program. All 24 (100%) were in Pre-K through 12th grade. 1 of the 5 (20%) children/youths not enrolled in school or another educational/vocational program had already graduated high school, 1 (20%) child/youth refused to attend school and 3 (60%) were under the age of 5.

6 (25%) of the 24 children/youths enrolled in Pre-K through 12th grade had a 504 or IEP plan. 3 of the 6 children/youths had a copy of the 504/IEP plan in the child/youth's record.

A current progress report/report card was available for review for 9 (38%) of the 24 children/youths enrolled in school or another educational/vocational program.

The local boards agreed that 19 (76%) of the 25 children/youths enrolled in school or another educational/vocational program and/or had graduated high school/GED or were being appropriately prepared to meet educational goals.

Ready by 21

- Employment (age 14 and older – 12 cases)

  4 (33%) of the 12 youths were employed or participating in paid or unpaid work experience.

  3 youths (25%) were referred to summer or year-round training and/or employment opportunities.

  The local boards agreed that 7 youths (58%) were being appropriately prepared to meet employment goals.

- Independent Living Services (age 14 and older – 12 cases)

  The local boards agreed that 7 (58%) of the 12 youths were receiving appropriate services to prepare for independent living and 6 youths had completed a Life Skills Assessment.

- Housing (Transitioning Youth – None)
  (Age 20 and/or planning to discharge within a year from the review)

  Not Applicable.

Risk and Safety

The local boards agreed that safety and risk protocols were followed for 26 (90%) of the 29 children/youths.

CASA (Court Appointed Special Advocate)

The local boards found that for 8 (28%) of the 29 cases reviewed the children/youths had a court appointed special advocate.

Child Visits with Parents, Relatives and Siblings

Child Visits	With Parents	With Relatives
Yes	9	9
No	20	20

Frequency of Visits	With Parents	With Relatives
Daily		
Once a week		2
More than once a week	1	
Once a month	3	2
More than once a month	4	
Quarterly		3
Yes, but undocumented	1	2

Supervision of Visits	With Parents	With Relatives
Supervised	6	1
Unsupervised	3	8

Who Supervises Visits	With Parents	With Relatives
LDSS Agency Representative	4	
Other Agency Representative		
Biological Family Member		

Foster Parent		
Other	2	1

Where do Visits Occur?	With Parents	With Relatives
Parent/Relative Home		4
LDSS Visitation Center		
Public Area	4	1
Child's/Youth's Placement	4	4
Other	1	

Overnight Stays	With Parents	With Relatives
Yes	1	5
No	8	4

Siblings/Visits

The local boards found that 15 (52%) of the 29 children/youths had siblings in care. 5 of the 15 children/youths had 1 sibling in care, 5 had 2 siblings in care and 5 had 3 siblings in care. Efforts were made to place siblings who did not reside together for 8 (53%) of the 15 children/youths. 10 (67%) of the 15 children/youths with siblings in care had visits with their siblings who did not reside with them. 12 children/youths had visits with their siblings who were not in care.

Barriers/Issues

The local boards identified the following barriers to permanency/issues:

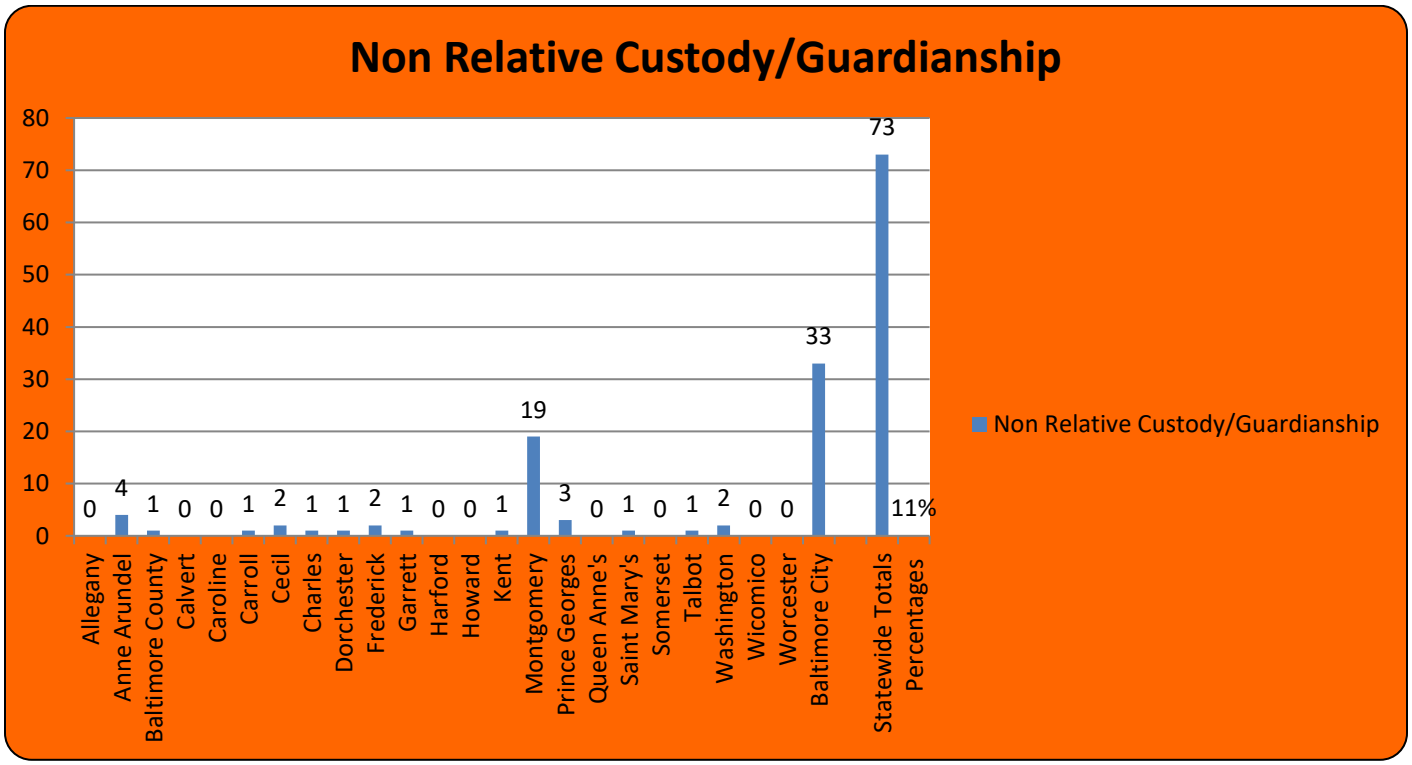
- Youth placed outside of home jurisdiction.
- Lack of concurrent planning.
- No service agreement with youth.
- Missing or lack of documentation.
- Annual physicals not current.
- Dentals not current.
- Vision not current.
- Child has behavior problems in the home.
- Not following up on referrals.
- Other child/youth related barrier.
- No follow up on medical referrals.

Summary

Based on the findings of the review the local boards determined that the local Department of Social Services made adequate progress towards a permanent placement (COMAR – 07.01.06.05 (F)) for 20 (69%) of the 29 children reviewed.

Non-Relative Custody/Guardianship Reviews

Custody and guardianship is another option that local departments can explore for permanency, and that is made available to a caregiver that would like to provide a permanent home for a child/youth, without having the rights of the parents terminated. This plan allows the child/youth to have a connection with their external family members.



Age Range	Statewide Totals	Custody/Guardian	Percentage
Age 1 thru 5	54	3	6%
Age 6 thru 10	80	10	13%
Age 11 thru 13	79	17	22%
Age 14 thru 16	144	36	25%
Age 17 thru 19	166	6	4%
Age 20	137	1	<1%
Total	660	73	11%

Permanency

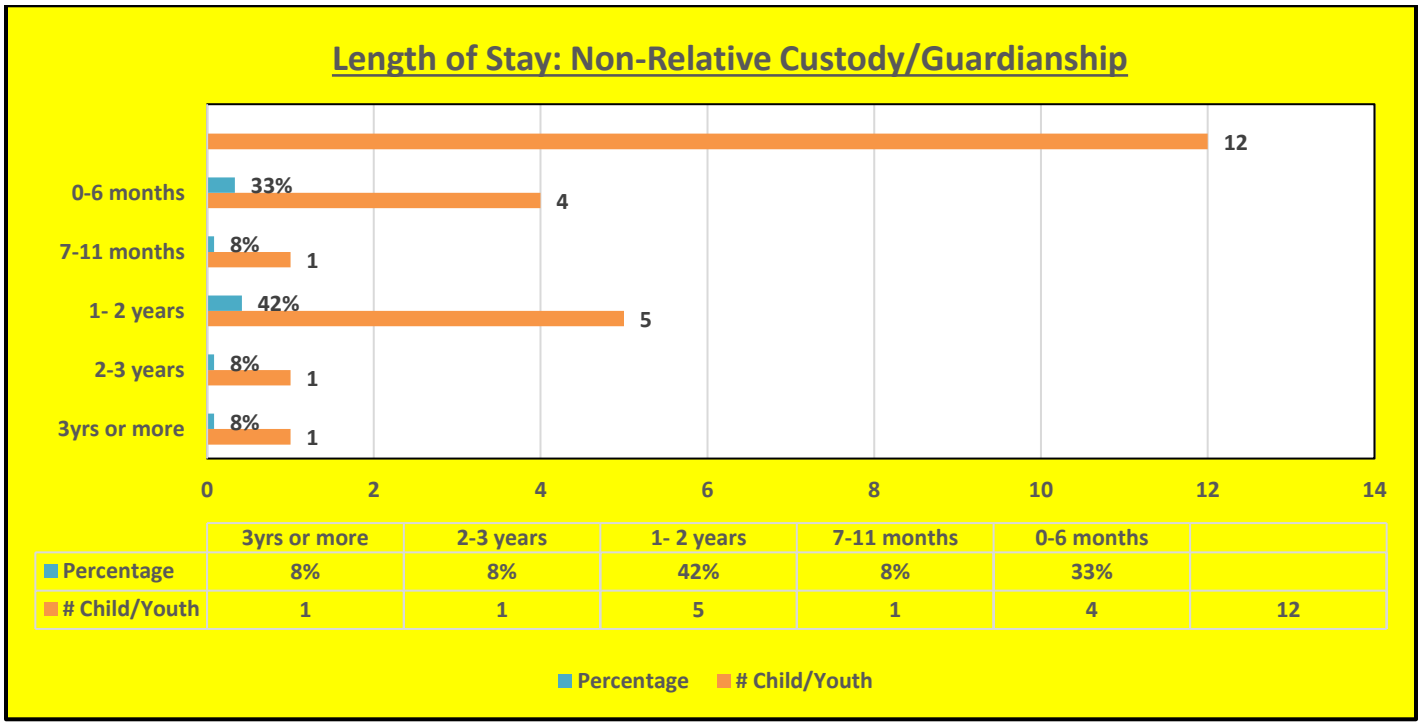
The local boards agreed with the permanency plan of Non-Relative Custody/Guardianship for 71 (97%) of the 73 cases reviewed.

The local Juvenile Courts identified a concurrent permanency plan for 18 (25%) of the 73 cases reviewed.

The local departments were implementing the concurrent permanency plans set by the local Juvenile Courts for 14 (77%) of the 18 cases.

Lengths of Stay for Children/Youths with a plan of Non-Relative Custody/Guardianship

The local boards found that the lengths of stay of the 73 children/youths with a plan of Non-Relative Custody/Guardianship were as follows:



	3yrs or more	2-3 years	1- 2 years	7-11 months	0-6 months	
Percentage	8%	8%	42%	8%	33%	
# Child/Youth	1	1	5	1	4	12

Case Planning

Family Involvement Meetings (prior to entry): The local boards found that the local departments held family involvement meetings prior to entry for 43 (59%) of the 73 cases reviewed.

Service Agreements: The local departments had signed service agreement for 16 (24%) of the 66 eligible cases. 7 cases were Post-TPR children/youths under the age of 14. Efforts to involve the families in the service agreement process were made for 33 (50%) of the 66 eligible cases reviewed.

The local boards found that the service agreements were appropriate for the 16 signed cases.

Placement/Living Arrangement (LA)

Number of Cases	Placement/Living Arrangement (LA)
3	Formal Kinship Care
7	Regular Foster Care
1	Restricted (Relative) Foster Care
2	Treatment Foster Care
37	Treatment Foster Care (Private)
1	Residential Group Home
12	Therapeutic Group Home
2	Residential Treatment Center
1	Diagnostic Center
4	Other
2	Runaway (LA)
1	Secure Detention Facility (LA)

The local boards found that for 37 (51%) of the 73 cases reviewed the children/youths were placed in settings that were in close proximity to their communities which allowed for the continuity of services.

The local boards agreed with the placement plan for 68 (93%) of the 73 cases reviewed.

Placement Stability

The Local boards found that for 28 (38%) of the 73 cases reviewed there was a change in placement within the 12 months prior to the review. 14 (50%) of the 28 cases had 1 placement change, 11 (39%) had 2 changes, 2 (7%) had 3 changes and 1 (4%) had 4 or more placement changes.

A family involvement meeting took place with the most recent placement changes for 13 (46%) of the 28 cases.

The following levels of care were found for the 28 most recent placement changes:

- 8 (29%) were in less restrictive placements
- 7 (25%) were in more restrictive placements
- 12 (43%) had the same level of care
- 1 (4%) child/youth on runaway

The primary positive reasons for the most recent placement changes were:

- Transition towards a permanency goal: 8 cases
- Placement with relatives: 1 case

Provider specific issues for the most recent placement changes were:

- Incompatible match: 2 cases
- Allegation of provider abuse/neglect: 1 case

Child/youth specific issues for the most recent placement changes were:

- Behavioral: 8 cases
- Threats of harm to self or others: 2 cases
- Sexualized: 1 case
- Delinquent behavior: 1 case
- Runaway: 2 cases

While child/youth was in the placement from which they were removed, were placement specific services adequate to support the provider:

- Yes, for 21 cases

For the current placement, is there a match between the child/youth's needs and the provider's ability to meet those needs?

- Yes, for 24 cases

Health/Mental Health

- Developmental/Special Needs: The local departments reported that 34 (47%) of the 73 children/youths reviewed had developmental or special needs.

- Current Physical: 43 (59%) children/youths had a current physical exam.

- Current Vision: 30 (41%) children/youths had a current vision exam.

- Current Dental: 32 (44%) children/youths had a current dental exam.

- Follow-up Health Concerns: The local departments ensured that appropriate follow-ups occurred on all health concerns noted by a physician for 15 (45%) of 33 eligible children/youths.

- Completed Medical Records: The local departments reported that 18 (25%) children/youths had completed medical records in their case files.

- Prescription Medication: 42 (58%) children/youths were taking prescription medication.

- Prescription Medication Monitored: Prescription medication was being monitored regularly for 40 (95%) of the 42 children/youths.
- Refused Prescribed Medication: 6 (14%) of the 42 children/youths refused to take prescribed medication.
- Psychotropic Medication: 35 (48%) children/youths were taking psychotropic medication.
- Psychotropic Medication Monitored: Psychotropic medication was being monitored at least quarterly for 33 (94%) of the 35 children/youths.
- Mental Health Issues: 59 (81%) children/youths had mental health issues.
- Mental Health Diagnosis: 61 (84%) children/youths had a mental health diagnosis.
- Mental Health Issues Addressed: Yes, for 45 (76%) of the 59 children/youths.
- Mental Health Issues/Transitioning/Services: 1 youth with mental health issues who was transitioning out of care had an identified plan to receive services in the adult mental health system and 1 youth did not have a plan.
- Substance Abuse: 6 (8%) children/youths had a substance abuse problem.
- Substance Abuse Addressed: Yes for 1 (16%) of the 6 children/youths.
- Behavioral Issues: 45 (62%) children/youths had behavioral issues.
- Behavioral Issues Addressed: Yes, for 40 (89%) of the 45 children/youths.
- Standard Health Exams: 4 (6%) of the 73 children/youths refused to comply with standard health exams.
- The local boards found that the health needs of 36 (49%) of the 73 children/youths had been met.

Education

67 (75%) of the 73 children/youths reviewed were enrolled in school or another educational/vocational program. 66 (90%) were in Pre-K through 12th grade and 1 youth was enrolled in a GED program. 1 of the 6 youths not enrolled in school or another educational/vocational program had already graduated high school/GED program, 3 youths refused to attend school and 2 children were under the age of 5.

37 (55%) of the 67 children/youths enrolled in school or another educational/vocational program had a 504 or IEP plan. 26 (70%) of the 37 had a copy of the 504/IEP plan in the child/youth's record.

A current progress report/report card was available for review for 32 (48%) of the 67 children/youths enrolled in school or another educational/vocational program.

The local boards agreed that 58 (85%) of the 67 children/youths enrolled in school or another educational/vocational program were being appropriately prepared to meet educational goals.

Ready by 21

- Employment (age 14 and older – 41 cases)

  7 (17%) of the 41 youths were employed or participating in paid or unpaid work experience.

  1 youth was unable to participate due to being medically fragile, 3 youths due to mental health reasons and 2 youths were in a Juvenile Justice Center.

  11 (27%) of the 41 youths were referred to summer or year-round training and/or employment opportunities.

  The local boards agreed that 14 (34%) of the 41 youths were being appropriately prepared to meet employment goals.

- Independent Living Services (age 14 and older – 41 cases)

  1 youth was unable to receive appropriate services due to being medically fragile, 3 youths due to mental health reasons and 2 youths were in a Juvenile Justice Center.

  13 (32%) of the 41 youths had completed a Life Skills Assessment.

  The local boards agreed that 16 (25%) of the 41 youths were receiving appropriate services to prepare for independent living.

- Housing (Transitioning Youth – 1 case)
  (Age 20 and/or planning to discharge within a year from the review)

  Housing had been specified for the youth transitioning out of care.

  Alternative housing options were provided for the youth.

  The local boards agreed with the transitional housing plan for the youth.

  The local boards agreed that 1 youth was being appropriately prepared to transition out of care.

Risk and Safety

The local boards agreed that safety and risk protocols were followed for 68 (93%) of the 73 children/youths.

CASA (Court Appointed Special Advocate)

The local boards found that for 8 (11%) of the 73 cases reviewed the children/youths had a court appointed special advocate.

Child Visits with Parents, Relatives and Siblings

Child Visits	With Parents	With Relatives
Yes	12	16
No	61	57

Frequency of Visits	With Parents	With Relatives
Daily		
Once a week	4	1
More than once a week		
Once a month	5	9
More than once a month	2	2
Quarterly	1	1
Yes, but undocumented		3

Supervision of Visits	With Parents	With Relatives
Supervised	9	6
Unsupervised	3	10

Who Supervises Visits	With Parents	With Relatives
LDSS Agency Representative	5	1
Other Agency Representative	1	2
Biological Family Member	1	2
Foster Parent	2	1
Other		

Where do Visits Occur?	With Parents	With Relatives
Parent/Relative Home	1	8
LDSS/Visitation Center	3	1
Public Area	2	1
Child's/Youth's Placement	3	4
Other	3	2

Overnight Stays	With Parents	With Relatives

Yes	8	7
No	4	9

Siblings/Visits

The local boards found that 50 (69%) of the 73 children/youths had siblings in care. 25 (50%) of the 50 children/youths had 1 sibling in care, 12 had 2 siblings in care, 10 had 3 siblings in care, 1 had 4 siblings in care and 2 had 5 siblings in care. Efforts were made to place siblings who did not reside together for 39 (78%) of the 50 children/youths. 42 (84%) of the 50 children/youths with siblings in care had visits with their siblings who did not reside with them. 21 (29%) of the 73 children/youths had visits with their siblings who were not in care.

Barriers/Issues

The local boards identified the following barriers to permanency/issues:

- Lack of concurrent planning.
- No service agreement with youth.
- No current IEP.
- Annual physicals not current.
- Dentals not current.
- Vision not current.
- Youth placed outside of home jurisdiction.
- Board does not agree with current permanency plan.
- Inadequate preparation for independence.
- Other independence barrier.
- Other education barrier.

Summary

Based on the findings of the review the local boards determined that the local Department of Social Services made adequate progress towards a permanent placement (COMAR – 07.01.06.05 (F)) for 68 (93%) of the 73 children reviewed

Montgomery County Citizens Review Panel

December 22, 2022

The Montgomery County Citizens Review Panel has continued to meet monthly throughout FY2022. The Panel has consisted of between 6 – 8 active members and the Panel continues to work with the County to recruit additional Panel members.

Current Panel Members:

Stacey McNeely (Chair)
Laura Coyle
Laura Brown
Ronald Whalen
Kay Farley
Shaoli Katana

Agenda items that the Panel has focused on:

- Recruitment and Retention of Resource (Foster) Parents
- LGBTQ Foster Youth: Services available to youth and young adults
- Recruitment and Retention of Resource Homes:
  - The Panel began an assessment of this SSA policy issue by reviewing two prior CWS Resource Home surveys and established its own survey, asking Child Welfare staff to complete.
  - The Panel reviewed the staff's responses and developed a summary.
  - The Panel will be discussing the summary in an effort to identify areas for follow up and further review.

Increase Panel focus:

- This includes working with the State Citizens Review Board for Children (CRBC) for background and resource materials to new Panel members, invitations to new Panel members to CRBC's pre-service training sessions, and invitations to all Panel members to all CRBC's in-service training sessions.
- The Panel is also increasing awareness of potential opportunities to collaborate with other County panels, boards and commissions in areas of overlapping interest.

CRBC FY2022 Review Metrics

Total # of Children - Scheduled on the Preliminary:	1565
Total # of Children - Closed (adopted, reunified, exited care), Non-Submission:	565
Total # of Children - Rescheduled (DSS caseworker requests, board overload):	277
Total # of Children - Eligible for Review:	723
Total # of Children - Reviewed at the Board:	660
Total # of Children - Not Reviewed at the Board (worker no shows, closed):	63
Percentage of Children Reviewed for the Period:	91%
Percentage of Children Not Reviewed for the Period:	9%
Recommendation Reports to DSS - Number Sent:	660
Recommendation Reports to DSS - Number Sent on Time:	583
Recommendation Reports to DSS - Percentage Sent on Time:	88%
Recommendation Reports from DSS - Number of Responses Received:[1]	233
Recommendation Reports from DSS - Percentage of DSS Responses:	36%
Recommendation Reports from DSS - Number Received on Time:	195
Recommendation Reports from DSS - Percentage Received on Time	84%
Number of Boards Held	183
Recommendation Reports - Number of DSS Agreement:	228
Recommendation Reports - Percentage of DSS Agreement:	98%
Recommendation Reports - Number of DSS Disagreement:	5
Recommendation Reports - Percentage of DSS Disagreement:	2%
Recommendation Reports - Number of Blank/Unanswered:[2]	0
Recommendation Reports - Percentage of Blank/Unanswered:	0%
Percentage of REUNIFICATION Children Reviewed for the Period:	32%
Percentage of RELATIVE PLACEMENT - Adoption Children Reviewed:	<1%
Percentage of RELATIVE PLACEMENT - C & G Children Reviewed:	4%
Percentage of ADOPTION Children Reviewed for the Period:	12%
Percentage of CUSTODY/GUARDIANSHIP Children Reviewed for the Period:	11%
Percentage of APPLA Children Reviewed for the Period:	40%

[1] The Local Department of Social Services is required by COMAR 07.01.06.06 (H) to respond to the local out-of-home placement review board's recommendations within 10 days of receipt of the report.

[2] The number of recommendation report responses received from the Local Department of Social Services that did not indicate acceptance or non-acceptance of the local board's recommendation.

CRBC FY2022 State Board

Nettie Anderson-Burrs (Chair)
Circuit 4: Representing Allegany, Garrett, and Washington Counties

Delores Alexander (Vice Chair)
Circuit 3: Representing Baltimore and Harford Counties

Dr. Theresa Stafford
Circuit 1: Representing Dorchester, Somerset, Wicomico, and Worchester Counties

Reginald Groce Sr.
Circuit 2: Representing Caroline, Cecil, Kent, Queen Anne's, and Talbot Counties

Dr. Kathy Boyer-Schick
Circuit 5: Representing Anne Arundel, Carroll, and Howard Counties

Sandra "Kay" Farley
Circuit 6: Representing Frederick and Montgomery Counties

Davina Richardson
Circuit 7: Representing Calvert, Charles, Prince George's, and St. Mary's Counties

Beatrice Lee
Circuit 8: Representing Baltimore City

Rita Jones
Circuit 8: Representing Baltimore City

Benia Richardson
Circuit 8: Representing Baltimore City

Denise E. Wheeler
CRBC Administrator

CRBC FY2022 Members

Ms. Carmen Jackson	Mrs. Nechelle Kopernacki	Ms. Melissa Burch
Ms. Shirley Struck	Mrs. Velma Walton	Ms. Iris Pierce
Mrs. Mary Ann Bleeke	Mrs. Roberta Berry	Mrs. Davina Richardson
Ms. Heidi Busch	Mr. Robert Foster Jr.	Mrs. Linda Love McCormick
Mr. David Ferris	Mrs. Denise Joseph	Mr. Kashmere Mims
Mrs. Catherine Gonzalez	Ms. Gail Radcliff	Ms Marilyn Moses
Ms Elaine Reed	Mrs. Kamilah Way	Ms Jessalyn Schwartz
Mrs. Linda Robeson	Mrs. Katrena Batson Bailey	Ms. Mildred Stewart
Ms. Delores Alexander	Mrs. Shirley Greene	Ms. Stephanie Vaughn Bovell
Mrs. Jennifer Gill	Mrs. Barbara Hubbard	Ms. Celinda Carr
Ms. Melissa Parkins-Tabron	Mrs. Portia Johnson-Ennels	Dr. Jessica Denny
Ms. Laura Steele	Dr. Norby Lee	Mrs. Terry Perkins-Black
Ms. Rosina Watkins	Dr. Theresa Stafford	Ms. Elli Straus
Ms. Juanita Bellamy	Mrs. Vatice Walker	Dr. Corinne Vinpool
Ms. Beverly Corporal	Ms. Helen Johnson	Mrs. Patricia Duncan
Ms Pashia Covington	Ms. Lise Robinson	Ms. Theresa Thomas
Mrs. Ernestine Jackson-Dunston	Ms. Katie Sillex	Mr. Kirkland Hall Sr.
Mr. David Marshall	Mrs. Sharde Twyman	Ms. Deonna Henson
Ms. Tamara Vaughn McDuffie	Mrs. Nancy Wiley	Ms. Vanessa Ward
Mrs. Charlotte Williams	Mrs. Debra Stephens	Dr. Sharon Washington
Mr. Wesley Hordge	Ms. Manolya Bayar	Ms. Stephanie Chester
Ms. Gail McCloud	Mrs. Pamela Dorsey	Mrs. Brenda Gaines-Blake
Mrs. Gwendolyn Statham	Mrs. Virginia Heidenreich	Mrs. Phyllis Hubbard
Mrs. Jean West	Ms. Maureen North	Mrs. Mary Taylor-Acree
Ms. Cherryllynn Williams	Mr. Quintin Seadler	Ms. Nettie Anderson-Burrs
Ms. Tambra Chisolm	Mr. John Kelly	Mrs Jean Harries
Mrs Anita Fishbein	Mr. Donald Pressler	Ms. Joanne Morgan
Mr. Edwin Green Jr.	Mrs. Patricia Soffen	Ms. Judith Niedzielski
Mrs. Eunice Johnson	Mr. Kyle Kirby Esq.	Mrs. Karen Nugent
Ms. Gabrielle Shirley	Ms. Deborah Wiener	Mrs. Yvonne Armwood
Ms. Nicole Cooksey	Us. Alison Obrien	Ms. Doretha Henry
Ms. Denise Lienesch	Ms. Alicia Prager Stern	Mr. Robert Horsey
Ms. Janet Fountain	Ms. LaVerne Stringfield	Ms. Karen Milbourne-Haggins
Mr. Reginald Groce Sr.	Ms. Florence Webber	Ms. Jeronna Truitt-Smith
Mrs. Wanda Morlock	Ms. Sandra Farley	Mrs. Helen Lockwood
Dr. William Dash	Mrs. Susan Fensterheim	Mrs. Terry Smith
Ms. Courtney Edwards	Mrs. Janis Tabor	Mrs. Valerie Turner
Ms. Adelaide Lagnese	Ms. Sandra Dee Hoffman	Mrs. Tara Armstrong
Ms. Kimberly Odam	Ms. Cheryl Keeney	Ms. Otanya Brown
Ms. Carmen Shanholtz	Mrs. Claire McLaughlin	Ms. Joyce Carter
Ms. Dianne Fox	Mr. David Schardt	Dr. Thomas Dorsett
	Mr. Erwin Brown Jr.	

Ms. Joann Henson	Ms. Lisa Jordan	Mrs. Helene Goldberg
Mr. Reed Hutner	Mr Dennis Lee	Ms. Suzanne Parejo
Ms . Stephanie Lansey	Mr. James Myers	Ms. Benia Richardson
Ms. Charmika Burton	Mr. Tyler Alcorn	Dr. Patricia Whitmore-Kendall
Ms. Jackie Donowitz	Ms. Katrina Brooks	
Mr. Leon Henry	Ms. Rosemarie Mensuphu-Bey	Ms. Barbara Crosby
Mrs. Jennifer Joyner		Ms. Terri Howard
Ms. Beatrice Lee	Ms. Ella Pope	Ms. Britonya Jackson
Mrs. Rasheeda Peppers	Mr. Gregory Riddick	Ms. Ginnie McKnight
Ms. Elizabeth Williams	Ms. Valerie Sampson	Ms. Deanna Miles-Brown
Ms. Sharon Buie	Mrs. Roslyn Chester	Mr. Cortly Witherspoon
Mrs. Rita Jones	Dr. Walter Gill	

New Members appointed by the Governor in Fiscal Year 2022.

Mr. Gregory Riddick	Ms. Tamara Vaughn McDuffie	Ms. Kristin Morris
Ms. Marilyn Moses	Ms. Stephanie Vaugn Bovell	Ms. Paula Fleet
Ms. Jeronna Truitt-Smith	Ms. Kashmere Mims	Ms. Martika Futrell
Ms. Karen Milbourne-Haggins	Ms. Janis Tabor	Mr. Joshua Payne
Ms. Alicia Prager Stern	Mr. David Marshall	Ms. Joelen Stone Frank
Mr. Dennis Lee	Ms. Tambra Chisolm	Ms. Hailey Peters
Mr. Tyler Alcorn	Mr. David Ferris	

CRBC FY2022 Staff Members

Denise E. Wheeler
Administrator

Crystal Young, MSW
Assistant Administrator

Jerome Findlay
Information Technology Officer

Hope Smith
IT Functional Analyst

Michele Foster, MSW
Child Welfare Specialist

Marlo Palmer-Dixon, M.P.A
Child Welfare Specialist

Nikia Greene
Child Welfare Specialist

Sandy Colea, CVA
Volunteer Activities Coordinator Supervisor

Lakira Whitaker,
Volunteer Activities Coordinator II

Agnes Smith
Executive Assistant

Cindy Hunter-Gray
Lead Secretary

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COMAR 07.02.11.01. Purpose of Out-of-Home Placement Program. Title 07 Department of Human Services (formerly Dept. of Human Resources).

COMAR 07.02.11.03. Out of Home Placement: Definitions. Title 07 Department of Human Services (formerly Dept. of Human Resources).

COMAR 07.02.11.08. Out of Home Placement: Medical Care. Title 07 Department of Human Services (formerly Dept. of Human Resources).

COMAR 07.02.12.04. Post Adoption Services. Title 07 Department of Human Services (formerly Dept. of Human Resources),

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MARYLAND DEPARTMENT OF HUMAN SERVICES

Larry Hogan, Governor | Boyd K. Rutherford, Lt. Governor | Lourdes R. Padilla, Secretary

April 22, 2022

Dr. Wendy Lane, Chair
State Council on Child Abuse and Neglect
Department of Epidemiology and Public Health
University of Maryland School of Medicine
Baltimore, MD 21201

Dear Dr. Lane and Council Members:

The Department of Human Services, Social Service Administration (DHS/SSA) appreciates the work and advocacy of the State Council on Child Abuse and Neglect (SCCAN) as evidenced in a very thorough report on behalf of Maryland's children and families. The report title, "The Power of Community " connotes the essence of systems change that we are collectively moving toward to transform Maryland's child welfare system. It is the partnership and advocacy of not only SCCAN and DHS/SSA, but all community stakeholders (providers, court partners, advocates, and mandated reporters) as well as the families, children, and youth who have been involved in our system that will keep moving us toward a more trauma-responsive, family-centered, outcomes driven, community focused, and individualized strengths-based system. DHS/SSA remains committed to serving and supporting Maryland's children, youth, and families so that they are:

1. Safe and free from maltreatment;
2. Living with safe, supportive, and stable families where they can grow and thrive;
3. Healthy and resilient with lasting family connections;
4. Able to access a full array of high-quality services and supports that are designed to meet their needs; and
5. Partnered with safe, engaged, and well-prepared professionals that effectively collaborate with individuals and families to achieve positive and lasting results.

The following highlights of Maryland DHS/SSA's work over the last year is aligned with many of the recommendations SCCAN has outlined in its report:

Improving Data Collection

Maryland continued to work toward improving its data collection capabilities in 2021 by refining, improving, and expanding the new Child, Juvenile, and Adult Management System (CJAMS). Consequently, Maryland is now able to utilize more data for policy and practice decision-making than it has in years past. Enhancements and system builds continue to improve CJAMS' functionality. For example, in the latter part of 2021 and early 2022 our efforts concentrated on the Adoption Foster Care Analysis Reporting System (AFCARS 2.0) updates for an October 2022 implementation date. CJAMS will include identifiers, such as whereabout unknown, psychological or medical neglect, domestic violence, sex trafficking, and longitudinal placement information. We are also continuing the work to build specific data collection mechanisms to capture race equity information in order to ensure systemic biases are addressed in our system.

Family First Implementation

Maryland's Family First Prevention Services workgroup has continued to work toward connecting families to evidence-based prevention services. The State has implemented a phased roll-out to expand its capacity to serve families, children, and youth with prevention focused evidence-based practices (EBPs) across Maryland in 18 jurisdictions. Families First Prevention Services Act made it possible to expand offering Healthy Families America, Parent Child Interaction Therapy, Multisystemic Therapy, and Functional Family Therapy in Maryland in order to build upon the success we have already seen serving families with these EBPs in some jurisdictions. Efforts were made to train staff and court partners to promote expansion of delivering these services. Maryland is also piloting a peer support Kinship Navigation model to link families with resources and peer support in order to promote kinship connections with families to prevent further system involvement.

Addressing Adverse Childhood Experiences (ACEs), Trauma, Resiliency, and Brain Science

Implementation of an Integrated Practice Model (IPM) in Maryland

For many years, Maryland has incorporated foundations of trauma, resiliency, and current brain science research in its training of the child welfare workforce. Maryland has implemented an Integrated Practice Model (IPM) across the State throughout 2021 in order to promote consistent practice that encompasses a customized approach to serving families. Workers and supervisors have been trained in strategies and skills of authentic partnership and engagement, teaming, and collaborative assessment and planning. These foundational trainings were designed to assist workers in navigating trauma, minimizing and preventing further trauma and ACEs and honoring the resiliency and strengths of individuals and families. The IPM focuses on using strengths and a family's natural support to build resilience and protective factors. Supervisors also participated in learning collaboratives in order to implement the IPM. Individual supervisory teams in each jurisdiction began participating in "coaching intensives" over the past year to build consistent practice. The IPM is also based on the tenets of Safety Culture, a safety science approach that promotes psychological safety in order to navigate the secondary trauma needs of the workforce.

Collaborative Assessment

Maryland's use of a collaborative assessment process with families features communimetric assessment tools including the CANS (for youth in foster care) and CANS-F (for families engaged in family preservation services) to identify ACEs as well as individual strengths, resilience and protective factors that can be built upon in service planning. These specific tools are designed to build collaborative service plans that maximize use of strengths and protective factors in an effort to mitigate trauma and further ACEs.

Safety Culture and Maryland's New Child Maltreatment Fatality Review Implementation

Maryland has embarked on a new Child Maltreatment Fatality Review process based on the Safety Culture model. This process is based on safety science principles which acknowledge the high-risk nature of the child welfare system's activities and determination to achieve consistently safe operations. The model promotes collaboration across disciplines, a culture of organizational learning in order to consistently improve and uses data to inform adopted organizational culture practices to promote safety. Maryland piloted this model in four jurisdictions in 2021 and plans to expand Statewide in 2022.

Systems Collaboration and Community Partnerships

DHS/SSA continues to partner and collaborate with community providers and other agencies to improve service delivery in a trauma-responsive manner. DHS continues to partner with the Maryland Department of Health to implement the Sobriety Treatment and Recovery Team (START) Program throughout the State. This program incorporates peer mentors with lived experience who work collaboratively with child welfare staff to support parents with substance use disorders to prevent further system involvement and promote reunification when children require placement outside the home to keep them safe. Maryland's Integrated Practice Model Implementation Team also created a specific Court Outreach Workgroup in order to identify ways to promote cross-systems education and communication among our court partners to better understand DHS practices and policies and work toward a collective trauma informed and trauma responsive means of working with the children, youth, and families in our system. We continue to work closely with the Department of Juvenile Services to implement use of qualified residential treatment providers who specifically use evidence-based trauma informed services as part of Family First Prevention Services Act.

Maryland has been committed for many years to family centered service delivery. We believe that families are the experts on themselves and that they should be empowered to make decisions that impact their families in partnership with DHS. Maryland has also continued its partnership with the Maryland Coalition of Families, which helps to support and ensure family voice in DHS/SSA's implementation structure. In 2021, DHS hired two staff members who have lived experience to represent the family voice in our policy development and practice decisions.

Race Equity

Maryland has engaged in an intentional focus on race equity in its child welfare system. We are actively examining data specific to racial disparities of children and families served in child welfare. We are also examining the roots of institutional racism in our system and are actively working to identify strategies to address disparities and ensure racial equity moving forward by dismantling policies and structures that have historically perpetuated disparities.

As we continue these efforts to transform our child welfare system, DHS/SSA invites SCCAN members to partner with us in our implementation teams to work collectively on improving the lives of children, youth, and families around the State.

Sincerely,

Denise Conway, LCSW-C
Executive Director
Social Services Administration
Maryland Department of Human Services

MARYLAND DEPARTMENT OF HUMAN SERVICES

Wes Moore, Governor | Aruna Miller, Lt. Governor | Rafael López, Secretary

May 19, 2023

Ms. Nettie Anderson-Burrs, Chair
Citizens Review Board for Children
1100 Eastern Avenue
Baltimore, MD 21221

Dear Ms. Anderson-Burrs and Review Board Members:

The Department of Human Services Social Services Administration (DHS/SSA) would like to thank the Citizens Review Board for Children for the valuable service you provide to support the safety, permanency and well-being of Maryland's children and youth in care. Your oversight and feedback are an important catalyst for continuous quality improvement in Maryland's child welfare system.

As indicated in the 2022 report, Maryland's emergence from the pandemic has illuminated a crisis in staffing and placement resources for our youth in care. After receiving no responses to a Request for Proposals for respite and diagnostic services for youth in the Spring of 2022, the State began planning for different options in procuring placement resources to meet the complex needs of youth in care. DHS/SSA built upon the partnerships with the Developmental Disabilities Administration, Maryland Department of Health and the Department of Juvenile Services to better manage the lack of placement options, streamline resources and help customize placements and service needs for youth. We have established an interagency workgroup that meets weekly to leverage resources and services for youth in need of placements. In the meantime, SSA has conducted a statewide community partnerships and services survey to identify further gaps in services and use results to strategically plan with our sister agencies and local departments of social services to meet these needs moving forward. Top priority needs included mental health/psychiatric services for youth, substance abuse services for youth, and housing needs. We will be using this information to guide decisions about service array needs and expanding evidence based practices to both prevent youth coming into care and grow services and partnerships to support youth in care.

In accordance with Families First Prevention and Services Act, Maryland launched an application process for providers to become Qualified Residential Treatment Centers across the state in 2022. To receive a designation, the provider must meet specific criteria including having a trauma-informed treatment program, having sufficient nursing and medical staff, providing aftercare services to youth and their families, and be an accredited program. Maryland now has 6 congregate care providers that meet this designation.

DHS/SSA has increased salaries for workers and supervisors in child welfare and developed a targeted recruitment plan to fill vacancies in these positions. While there are still shortages in staffing, we are gradually seeing some of those vacancies fill. Maryland continues to explore ways to partner with the University system to incentivize students to pursue careers in social work, while seeing a drop in enrollment in these academic programs across the state and nation. In addition, we continue to offer a

program made possible through federal reimbursement which pays tuition for social worker students who intern in child welfare and then become employees for Maryland's child welfare system.

A critical principle of Maryland's Integrated Practice Model (IPM) is operationalizing trauma-responsive practice. Trauma-responsive practice is a key principle of the model. As we continue to implement and sustain the IPM, we have structured all policy and guidance documents with a section that anchors the policy or practice to the IPM principles, core practices and values. All pre-service and in-service training across the state have been redesigned to use the IPM as a foundation upon which trauma-responsive practice is taught and reinforced throughout the child welfare workforce as well.

Adequately preparing youth to transition out of foster care is crucial to their success and well-being. In 2022, we released a new youth transition planning policy to guide our workforce in the practice of developing youth-driven goals and plans that cover all life skill domains. We hosted a first annual statewide Emerging Adult conference aimed at developing life skills and providing youth with tools and ideas for developing their transition plan goals. We continue to offer technical assistance to local departments to improve youth transition planning skills and understanding the key tenets of the new policy.

Improving the medical record collection and documentation of youth in care is very important to DHS/SSA. We track and monitor this information on a weekly basis, provide technical assistance, and are working with MD Think to improve the capability of CJAMS to collect relevant information about medical history, medications, medical follow up needs, and informed consent. Training for staff and resource parents on psychotropic medications and medical record management have also been implemented to assist in improving these processes and providing them with critical information.

Maryland is committed to improving permanency outcomes of our youth. An initiative in partnership with the Foster Care Court Improvement Project is currently underway to provide specific data to each jurisdiction around their permanency outcomes and customized technical assistance to meet identified needs. Concurrent planning has also been identified by local departments of social services and DHS/SSA as an important and sometimes under-utilized tool for expediting permanency. Refresher training for the workforce is being planned for late spring 2023 to support effective use of this practice to improve permanency for youth in care. Maryland also continues to contract for pre and post adoption services for children and youth and explore any other necessary support that may be needed for adopted children and families.

We value the continuous feedback that the Citizens Review Board for Children provides about our youth in care. Making sure our children live in safe, permanent homes that support their well-being is truly a community responsibility and we are grateful for the commitment of CRBC board members. We look forward to continued partnership and opportunities to innovate new possibilities together to support youth involved in Maryland's child welfare system.

Sincerely,

Stephen Liggett-Creel, Acting Executive Director
Maryland Department of Human Services
Social Services Administration

Maryland Department of Human Services
Combined Training Matrix for January 2022 - December 2022

Training Category	Course	Length of Training	Provider/Venue	Audience	Cost Allocation	Duration Category
January 2022 – April 2022						
Child Welfare Workforce	**Engaging Emerging Adults in Career Exploration** Finding a job let alone thinking about career options can be overwhelming or challenging for youth. This workshop will explore the steps child welfare workers can take to engage youth in this exploration process. Additionally, youth leaders will share their experiences on strategies that worked for them to gain employment or explore interests and skills they needed to develop to attain career goals. Title IV-E – Independent Living	3 hours	Department of Human Services/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $603.75	Long-Term
Child Welfare Workforce	**Every Conversation Matters** Engaging teens in a conversation about adoption and permanency planning can be a sensitive topic for discussion. "Every Conversation Matters" will emphasize how the importance of authentic youth engagement depends on building authentic relationships, which can begin with a single conversation. This workshop will provide child welfare professionals with tips to incorporate youth engagement in daily practice to support permanency planning. Title IV-E Permanency Planning	2 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training $402.50	Long-Term
Child Welfare Workforce	**2021 Review of Drugs in Our Society: Prevention and Beyond** This workshop is designed to help child welfare professionals increase their knowledge on current drug trends in Maryland including new drug paraphernalia and the impact of COVID-19 on	3 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate	Long-Term

Training Category	Course	Length of Training	Provider/Venue	Audience	Cost Allocation	Duration Category
	substance use disorders. Substance abuse prevention strategies including Family First will be discussed as well as the connection between drug use and mental health issues. Current data will be shared, and resources will be available to help caseworkers access intervention services for youth or caregivers in need. Title IV-E – General Substance Abuse				Estimated Cost to Provide Training: $605.75	
April 2022 – June 2022						
Training Category	**Course**	**Duration**	**Provider/Venue**	**Audience**	**Cost Allocation**	
Child Welfare Workforce	**Intimate Partner Violence: Ethics and Boundaries** This training will explain ethics and their importance when working with survivors of intimate partner violence. You will learn how to assess boundaries and make ethical considerations for working with survivors. The training also provides an opportunity to assess situations to determine the ethical considerations and how to maintain boundaries. Title IV-E – General Domestic Violence	3 hours	Department of Human Services/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $605.75	Long-Term
Child Welfare Workforce	**Intimate Partner Violence: Privilege and Oppression** This training defines systems of oppression and examines various forms of privilege and power. You will discuss the importance of intersectionality and a culturally-sensitive approach for working with members of marginalized communities who are domestic violence survivors. The training explores an anti-oppression framework, and the role staff play with allyship and advocacy for services from IPV providers. Title IV-E- General Domestic Violence	2 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $201.25	Long-Term

Training Category	Course	Length of Training	Provider/Venue	Audience	Cost Allocation	Duration Category
Child Welfare Workforce	**2021 Review of Drugs in Our Society: Prevention and Beyond** This workshop is designed to help child welfare professionals increase their knowledge on current drug trends in Maryland including new drug paraphernalia and the impact of COVID-19 on substance use disorders. Substance abuse prevention strategies including Family First will be discussed as well as the connection between drug use and mental health issues. Current data will be shared, and resources will be available to help caseworkers access intervention services for youth or caregivers in need. Title IV-E – General Substance Abuse	3 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $605.75	Long-Term
July 2022 – September 2022						
Training Activity	**Course**	**Duration**	**Provider/Venue**	**Audience**	**Cost Allocation**	
Child Welfare Workforce	**Gender Matters: The Intersection of Trauma and Addiction** According to the National Institute of Drug Abuse, men are more likely than women to abuse illicit drugs. Substance abuse treatment and interventions has historically been based on the needs of substance abusing men, but women are just as likely to become substance users. In fact, women are more susceptible to cravings and relapse than their male counterparts. Women respond to drug and alcohol use differently and present with unique treatment challenges. Research has indicated that substance-using females present with a host of problems that contribute to their addiction. The most prominent is a complex history of trauma. In this workshop the presenter will explore gender differences and addiction, trauma, co-occurring disorders, addiction vocabulary, and gender specific treatment, including Women's Integrated Treatment (WIT) mode and a child welfare's role in supporting women impacted by this intersectionality.	4 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $805.00	Long-Term

Training Category	Course	Length of Training	Provider/Venue	Audience	Cost Allocation	Duration Category
	Title IV-E – General Substance Abuse					
Child Welfare Workforce	**Understanding Systems of Oppression & Power in Child Welfare** This workshop is designed for child welfare professionals and is focused on supporting the workforce in cultivating an anti-racist mindset, promoting equity and dismantling structural racism and oppression within their units and agencies. Content is focused on increasing individual knowledge and capacity, moving from personal reckonings through institutional frameworks, and concrete action steps needed to understand systems of oppression and power in child welfare. Administrators and supervisors are strongly encouraged to attend. Title IV-E Activities: Cultural competency related to children and families	3 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $605.75	Long-Term
Child Welfare Workforce	**Moving from the Pandemic to an Endemic: Update on the Impact to Children and Families and Child Welfare Workers** For the past 2 years the nation has been impacted physically, socially and emotionally from COVID – 19. Recent conversations have switched from COVID- 19 being a pandemic to an endemic. Join representatives from Johns Hopkins Health System to discuss the current conditions of COVID in Maryland, the overall impact (mentally) on children and families and explore what social workers need to do to remain safe and healthy as they are providing direct service to families. Finally, the conversation will also discuss secondary traumatic stress and how to best support child welfare workers. Title IV-E Activities: Mental Health to Support Children and Families	1 hour	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training $201.25	Long-Term

Training Category	Course	Length of Training	Provider/Venue	Audience	Cost Allocation	Duration Category
	Secondary Traumatic Stress					
All Resource Parent Training utilize a trauma informed and cultural competency framework and are designed to support child growth and social, emotional, physical, and intellectual development, build communication skills to support relational competence, and increase the ability of Resource and Adoptive Parents to promote safety, provide support and assistance to children in their care are claimed at 75% FFP after applying Title IV-E penetration rate.						
Resource Parent*	**Analyzing & Treating the Onion Effect of Generational Trauma** How do we help clients or patients from repeating the cycle of trauma and stopping generational trauma from thriving? Often individuals with generational trauma are so immersed in their trauma narratives that base lines shift, and trauma is perceived as the norm. This webinar will analyze the complexities of treating the onion effect of generational trauma. Exploring the various layers that have to be exposed, addressed, and repacked. Trauma is a universal concept that every human being endures at some point in their lives. Often individuals sustain multiple traumas, and some become so pervasive and acute that they can develop into Big "T" traumas that can last for generations. This workshop will focus on the theory and concept of what trauma is and how individuals can grow and thrive despite their trauma narratives. And as a result, reduce or eliminate generational traumas. This is an interactive workshop where case vignettes will be presented, and participants will work in a group setting to maximize the learning and application of concepts presented.	Between 2-6 hours	Child Welfare Academy Virtual Training	Resource Parent, Adoptive Parents, Kinship Parents In-service	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $1,207.75	Long-Term
Resource Parent*	**Building and Promoting Resilience:** All of us face adversity and setbacks in life; it's inevitable. A growing body of research and clinical evidence shows us how we can become more resilient, better able to cope with life's challenges. In this training session you will learn about skills and mindsets that are known to increase our ability to adaptively and effectively cope with and grow from life's challenges. Learning Objectives: After completing this training, you will be better able	Between 2-6 hours	Child Welfare Academy Virtual Training	Resource Parent, Adoptive Parents, Kinship Parents In-service	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training:	Long-Term

Training Category	Course	Length of Training	Provider/Venue	Audience	Cost Allocation	Duration Category
	to (1) define and describe resilience at the individual, group, and community level; (2) discuss and understand why resilience is important, and (3) identify, discuss, and be prepared to use evidence-based best practices to increase resilience at these levels.				$1,207.75	
Resource Parent	**Continuing Bonds and Attachment in Grief:** In the late 1990s grief theory and research saw a significant paradigm shift, moving away from the early "grief work", stage-based models. Continuing Bonds theory emerged during this era, normalizing the ongoing relationships that individuals often maintain with deceased loved ones. In the years since the emergence of this theory, researchers and clinicians have examined the relationship between attachment theory and continuing bonds. Though continuing bonds theory is one of the most widely accepted and applied models among grief therapists and counselors, many clinicians who do not specialize in grief and the general public have limited knowledge of continuing bonds theory and its applications. A person's existing attachment style can have an impact on their grief, and grief can also have a significant impact on a person's attachment style. This session will provide a strong foundation in continuing bonds theory and attachment theory as it relates to grief and loss, as well as tools and activities to support continuing bonds.	Between 2-6 hours	Child Welfare Academy Virtual Training	Resource Parent, Adoptive Parents, Kinship Parents In-service	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $1,207.75	Long-Term
Resource Parent*	**Creating Safer Spaces for LGBTQ+ Youth:** Pansexual? AFAB? Non-binary? GSA? LGBTQQIA+? Do you want to learn about the range of sexual diversity terms and definitions? Want to learn about creating safer spaces for your LGBTQIA+ youth Join us for this interactive training to support in creating safer spaces for LBGTQ+ youth, understand state laws when it comes to being a resource parent for LBGTQIA+ youth, examine	Between 2-6 hours	Child Welfare Academy Virtual Training	Resource Parent, Adoptive Parents, Kinship Parents In-service	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $1,207.75	Long-Term

Training Category	Course	Length of Training	Provider/Venue	Audience	Cost Allocation	Duration Category
	our bias and blind spots, and the role you can play in being a trusted adult.					
Resource Parent	**Introduction to Restorative Justice:** Restorative justice (RJ) is a model and philosophy that is gaining popularity across a number of domains: schools, community organization, and the juvenile and criminal justice systems. RJ is both very old and relatively new, and it has applications and implications for human development and community and family relations that often go unrecognized. Learning Objectives: After completing this training, you will be better able to (1) define and discuss RJ and its main tenets; (2) appreciate its many applications to reducing harm and hurt across family, community, and institutional domains; and (3) use some of RJ basic tools and techniques to restore peace and calm.	Between 2-6 hours	Child Welfare Academy Virtual Training	Resource Parent, Adoptive Parents, Kinship Parents In-service	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $1, 207.75	Long-Term
Resource Parent*	**Promoting Openness in Foster Care:** This workshop explores the significance of first family relationships and the ways foster and adoptive families can support and nurture openness in a manner that is child centered. A broad approach to openness is explored, presenting openness as the spirit of parenting in which emotional space can be held for these relationships even in their physical absence. Parents will be encouraged to consider their own emotional responses to openness and will learn strategies for parenting with self-awareness and attention to self-care. We will discuss the significance of loss from the foster and adoptive child's perspective and explore meaningful ways to bear witness and nurture healing.	Between 2-6 hours	Child Welfare Academy Virtual Training	Resource Parent, Adoptive Parents, Kinship Parents In-service	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $1, 207.75	Long-Term
Resource Parent	**Sibling Separation and Healing Connections:** According to the Casey Organization, "approximately two-thirds of children in foster care have a sibling in care, and yet despite the benefits of joint sibling placements, it is estimated that more than	Between 2-6 hours	Child Welfare Academy Virtual Training	Resource Parent, Adoptive Parents,	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate	

Training Category	Course	Length of Training	Provider/Venue	Audience	Cost Allocation	Duration Category
(Previously offered for CW workforce)	70% of children with siblings are separated from one or more of their siblings." When children enter the foster care system, they are often afraid, anxious, and experiencing complex trauma and loss. These emotions are often further intensified when children are separated from everything they know including their siblings. Children will often look for and rely on the comfort and proximity of their siblings. Being placed with a sibling during a time of the unknown creates a small sense of normality. However, despite the benefits most siblings are often separated when they enter the foster care system. This webinar will explore how to help children process, grieve and thrive despite sibling separation so that they are able to have healing connections. This training will provide tools, caregiver recommendations and strategies to help siblings stay connected and heal during the separation process.			Kinship Parents In-service	Estimated Cost to Provide Training: $1,207.75	
***** Note: Based on the appropriateness of the content, some workshops currently planned for Resource Parents may be subsequently offered to child welfare workforce with any needed adaptions for the change in audience.						
October 2022 – December 2022						
Training Category	**Course**	**Duration**	**Provider/Venue**	**Audience**	**Cost Allocation**	
Child Welfare Workforce	**Effects of Cannabis Use During Pregnancy: Health Problems in Newborns** This lecture will present cannabis use in pregnancy and postpartum, neonatal outcomes of in utero cannabis exposure, and the use of newborn toxicology tests to understand and address symptoms related to in utero substance exposure and the impact on newborns. Title IV-E Activities: General substance abuse	90mins	DHS/SSA/ Virtual	Child Welfare staff and external stakeholders, community providers serving parents with substance use disorder or Substance	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $301.35	Long-Term

Training Category	Course	Length of Training	Provider/Venue	Audience	Cost Allocation	Duration Category
				Exposed Newborn (SEN)		
Child Welfare Workforce	**Effects of Nicotine & Vaping During Pregnancy** This webinar lecture will present research and discuss the effect of tobacco on mother and fetus, nicotine metabolism in pregnancy, changes to the lung during pregnancy, the effect of nicotine in vaping on the mother and fetus, and effect of nicotine on the brain and mechanism of addiction. How to treat clients for tobacco/nicotine use disorder in different populations including mental health, substance use disorders, and during pregnancy. Title IV-E Activities: General substance abuse	2hrs	DHS/SSA/ Virtual	Child Welfare staff and community providers	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $402.50	Long-Term
Child Welfare Workforce	**Examining and Combating Implicit Bias in Child Welfare** A significant body of research has documented the problem of systemic racial and ethnic disproportionality and disparity in the child welfare system. While there are many contributing factors, it is clear that personal biases may play a role in child welfare practices that are inequitable and potentially harmful. This workshop will help participants to recognize and critically examine their own biases and reflect on how they may impede authentic partnership and engagement and lead to differential outcomes for children, youth and families in child welfare. Specific strategies will be explored to mitigate the impact of implicit bias in the child welfare setting. Participants will learn what implicit bias is, the potential impact on racial disproportionality and disparity in the child welfare system, and ways to identify and mitigate the impact of their own biases in daily practice. Title IV-E Activity: Job performance enhancement	2 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 50% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training $402.50	Long-Term
Child Welfare Workforce	**Medical Cannabis and Mental Health**	2 hours	DHS/SSA/ Virtual	Child Welfare staff and	Title IV-E Training at 75% FFP after	Long-Term

Training Category	Course	Length of Training	Provider/Venue	Audience	Cost Allocation	Duration Category
	This live webinar will focus on Medical Cannabis and its use in Maryland. We will define medical cannabis and discuss different products available to consumers, identify different conditions that can be treated by Medical Cannabis, and explore the scientific evidence supporting the use of cannabis. We will explore the implications of Medical Cannabis for parents and families involved with the child welfare system. Speaker responds to attendee's questions related to Medical Cannabis as a method of treatment for mental health. Title IV-E Activity: General substance abuse and mental health			external stakeholders, community providers serving parents with substance use disorder or Substance Exposed Newborn (SEN)	applying Title IV-E penetration rate Estimated Cost to Provide Training: $402.50	
Child Welfare Workforce	**Parent Partnerships as a Tool to Build Trust and Support Reunification** This half-day workshop will facilitate the participants' understanding of their role in facilitating partnerships between resource parents and families or origin. This training will focus on the guiding principles and practices associated with the evidence-based outcomes achieved through building birth family and resource parent partnerships. Participants will identify strategies to address potential obstacles frequently identified with the partnership process and will develop personal/individual strategies to improve results that ultimately support reunification. Title IV-E Activities: Social work practice – Partnering Activities to strengthen and reunify the family	3 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $603.75	Long-Term
Child Welfare Workforce	**Toxicology Tests: Purpose in Treatment & Recovery** This webinar will focus on the purpose and effective use of toxicology testing to guide substance use and opioid use	2hrs	DHS/SSA Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate	Long-Term

Training Category	Course	Length of Training	Provider/Venue	Audience	Cost Allocation	Duration Category
	treatment and understand how toxicology results are used to address an individual's recovery needs. Title IV-E Activities: General substance abuse				Estimated Cost to Provide Training: $402.50	
Child Welfare Workforce	**Value of Peer Recovery Specialists: Improving Well-Being** This lecture will help participants understand the role of Peer Recovery Specialists and how to utilize Peer Recovery Services within the LDSS setting to support families with substance and opioid use disorders. Title IV-E Activities: General substance abuse	90mins	DHS/SSA/ Virtual	Child Welfare staff and external stakeholders, community providers serving parents with substance use disorder or Substance Exposed Newborn (SEN)	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $301.25	Long-Term
All Resource Parent Training utilize a trauma informed and cultural competency framework and are designed to support child growth and social, emotional, physical, and intellectual development, build communication skills to support relational competence, and increase the ability of Resource and Adoptive Parents to promote safety, provide support and assistance to children in their care are claimed at 75% FFP after applying Title IV-E penetration rate.						
Resource Parent*	**Anxiety from a Child's Perspective** What is anxiety like from a child's perspective? What are the sneaky causes of childhood anxiety that might be frequently overlooked? From the pandemic to school violence to bullying, our children are facing so much. Because parents are extremely busy these days, they may often overlook the subtle signs of anxiety in children. If anxiety is not treated, it can lead to life threatening situations including suicidal ideation and drug abuse. This workshop provides the keys to help parents be empowered in improving their child's mental health. Parents will be educated on the definition of anxiety, the various types of anxiety, and how	Between 2-6 hours	Child Welfare Academy Virtual Training	Resource Parent, Adoptive Parents, Kinship Parents In-service	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $1,207.75	Long-Term

Training Category	Course	Length of Training	Provider/Venue	Audience	Cost Allocation	Duration Category
	anxiety can be good in certain situations. This interactive workshop will help parents become empowered in creating a home that can help reduce anxiety and other mental health challenges in their children.					
Resource Parent	**Choosing Life…Choosing Hope:** Suicidal thoughts and attempts have risen dramatically since the pandemic. School closures, lock-downs, and other pandemic safety measures have inadvertently caused our children mental distress. This interactive workshop is for parents and children to participate in together. This workshop focuses on what is desired...life and hope. This workshop will discuss the specific stressors that children/teens are facing that can lead to suicidal ideation. This workshop does not just discuss surface issues, it gets to the core by examining the core beliefs and self-esteem of our young people. Through affirmations, improved coping skills and a survivor story, children and parents will leave the training feeling empowered about choosing life and having hope.	Between 2-6 hours	Child Welfare Academy Virtual Training	Resource Parent, Adoptive Parents, Kinship Parents In-service	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $1,207.75	Long-Term
Resource Parent*	**Working with African American Children and their Trauma: Where Does it Come From?** It is essential that persons that work with populations of color, particularly African-American/Black children are aware of some of the reasons for why they are hesitant to accept therapy, especially play as an effective way to heal their past hurts and trauma or those of their children.	Between 2-6 hours	Child Welfare Academy Virtual Training	Resource Parent, Adoptive Parents, Kinship Parents In-service	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate Estimated Cost to Provide Training: $1,207.75	Long-Term
* Note:						

Training Category	Course	Length of Training	Provider/Venue	Audience	Cost Allocation	Duration Category
Based on the appropriateness of the content, some workshops planned for Resource Parents may be subsequently offered to the child welfare workforce with any needed adaptations for the change in audience.						

Attachment C

Annual Reporting of Education and Training Vouchers Awarded

Name of State/ Tribe: Maryland

	Total ETVs Awarded	**Number of New ETVs**
Final Number: **2021-2022 School Year** (July 1, 2021 to June 30, 2022)	**145**	**53**
2022-2023 School Year* (July 1, 2022 to June 30, 2023)	**91**	**34**

Comments:
*The 2022-2023 school year data is as of May 24, 2023.

*in some cases this might be an estimated number since the APSR is due on June 30, the last day of the school year.