December 31, 2021

The Honorable Lawrence J. Hogan
Governor
100 State Circle
Annapolis, MD 21401-1991

RE: MSAR #6519 – Annual Social Services Administration Report
Completed pursuant to Human Services Article §4-205(f)

Dear Governor Hogan:

The Department of Human Services (DHS) is required to submit to the Governor, as well as the Department of Legislative Services, the annual Social Services Administration Report in accordance with the provisions of Human Services Article §4-205(f). In accordance with this reporting requirement, DHS is pleased to provide you with the enclosed report.

Please note the date of this report, June 2021, is the due date required by federal reporting standards.

If you should require additional information, please contact the Office of Government Affairs at 410-767-8966.

Sincerely,

Lourdes R Padilla

Lourdes R. Padilla
Secretary

cc: Sarah Albert, Mandate Reports Specialist, Department of Legislative Services (5 copies)

Maryland Department of Human Services

2022 Annual Progress and Services Report

MARYLAND DEPARTMENT OF HUMAN SERVICES

Larry Hogan, Governor | Boyd K. Rutherford, Lt. Governor | Lourdes R. Padilla, Secretary

Contents

Appendices:

ACRONYMS

ACRONYM	*DEFINITION*
ACF	*Administration for Children and Families*
ADHD	*Attention-Deficit/Hyperactivity Disorder*
AFCARS	*Adoption and Foster Care Analysis Reporting System*
AFS	*Automated Fiscal Systems*
APD	*Advance Planning Documents*
APPLA	*Another Planned Permanent Living Arrangement*
APSR	*Annual Program Services Review*
AR	*Alternative Response*
ARC	*American Red Cross*
ASCRS	*Adoption Search, Contact and Reunion Services*
ASFA	*Adoption and Safe Family Act*
AWOL	*Away Without Leave*
CANS	*Child and Adolescent Needs and Strengths*
CA/N	*Child Abuse/Neglect*
CANS-F	*Child and Adolescent Needs and Strength-Family*
CAPTA	*Child Abuse Prevention and Treatment Act*
CASA	*Court Appointed Special Advocates*
CB	*Children's Bureau*
CBCAP	*Community-Based Child Abuse and Prevention*
CCIF	*Children's Cabinet Interagency Fund*
CCWIS	*Comprehensive Child Welfare Information System*
CCO	*Coordination Organization*
CFSR	*Child and Family Services Review*
CFP	*Casey Family Programs*
CFSP	*Child and Family Services Plan*
CIHS	*Consolidated In-Home Services*
CINA	*Children in Need Of Assistance*
CIP	*Continuous Improvement Plan*
CIS	*Client Information System*
CJAMS	*Maryland Child, Juvenile and Adult Management System*
CME	*Care Management Entities*
CQI	*Continuous Quality Improvement*
CRBC	*Citizens Review Board for Children*
CSA	*Core Service Agencies*
COOP	*Continuity of Operations Plan*
CPS	*Child Protective Services*
CSOM	*Children's Services Outcome Measurement System*
CSTVI	*The Child Sex Trafficking Victims Initiative*
CWA	*Child Welfare Academy*
CY	*Calendar Year*
DDA	*Developmental Disabilities Administration*
CSA	*Core Service Agencies*
DHS	*The Maryland Department of Human Services*
DJJ	*Department of Juvenile Justice*
DJS	*Department of Juvenile Services*

DOB	***Date of Birth***
EBP	***Evidence-Based Practice***
ECE	***Early Care and Education***
EFT	***Electronic Funds Transfers***
EHR	***Electronic Health Record***
EP	***Emergency Preparation***
ESOL	***English for Speakers of Other Languages***
EPSDT	***Early and Periodic Screening, Diagnosis, and Treatment Program***
ESF	***Emergency Support Function***
EDHS/SSA	***Every Student Succeeds Act***
FASD	***Fetal Alcohol Spectrum Disorder***
FAST	***Family Advocacy and Support Tool***
FC2S	***Foster Care to Success***
FEMA	***Federal Emergency Management Agency***
FBI-CJIS	***Federal Bureau of Investigation Reports***
FFT	***Functional Family Therapy***
FCCIP	***Foster Care Court Improvement Project***
FCP	***Family Centered Practice***
FEMA	***Federal Emergency Management Agency***
FFPSA	***Families First Prevention Services Act***
FIM	***Family Involvement Meetings***
FLOW Model	***Fluent, Lead, Own, Withstand Model***
FPL	***Federal Poverty Level***
FMIS	***Financial Management Information System***
FSC	***Family Support Center***
GAP	***Guardianship Assistance Program***
GAPMA	***Guardianship Assistance Program Medical Assistance***
GEAR	***Growth, Empowerment, Advancement, Recognition***
GED	***General Educational Development***
GOC	***Governor's Office for Children***
GOCCP	***Governor's Office of Crime Control and Prevention***
GROW Model	***Goal, Reality, Options, Will Model***
IAR	***Institute of Applied Research***
ICPC	***Interstate Compact on the Placement of Children***
ICAMA	***Interstate Compact on Adoption and Medical Assistance***
IDEA	***State Interagency Coordinating Council for the Individuals with Disabilities Education Act***
IEP	***Individualized Education Programs***
IR	***Investigative Response***
LDSS	***Local Department of Social Services***
LEA	***Lead Education Agency***
LGBTQ	***Lesbian, Gay, Bi-sexual, Transgender, Questioning***
MAF	***Mission Asset Fund***
MD THINK	***Maryland's Total Human Services Information Network***
MEMA	***Maryland Emergency Management Agency***
MEPP	***Maryland Emergency Preparedness Program***
MFIRA	***Maryland Family Initial Risk Assessment***
MD CHESSIE	***Maryland's Children Electronic Social Services Information Exchange***

MCO	***Managed Care Organizations***
MD-CJIS	***Maryland Criminal Justice Information System***
MDH	***Maryland Department of Health***
MDH/DDA	***Maryland Department of Health / Developmental Disabilities Administration***
MD THINK	***Maryland's Total Human Services Information Network***
MFN	***Maryland Family Network, Incorporated***
MHA	***Mental Health Access***
MHEC	***Maryland Higher Education Commission***
MOU	***Memorandum of Understanding***
MRPA	***Maryland Resource Parent Association***
MSDE	***Maryland State Department of Education***
MST	***Multi-Systemic Therapy***
MTFC	***Multi-Dimensional Treatment Foster Care***
NCANDS	***National Child Abuse and Neglect Data System***
NCHCW	***National Center on Housing and Child Welfare***
NCSACW	***National Center on Substance Abuse and Child Welfare***
NGO	***Non-Government Organizations***
NRCPRFC	***National Resource Center for Permanency and Family Connections***
NRCCWDT	***National Resource Center for Child Welfare Data and Technology***
NYTD	***The National Youth in Transition Database***
OAG	***Office of the Attorney General***
OEO	***Office of Emergency Operations***
OOH	***Out-of-Home***
OHP	***Out-of-Home Placement***
OISC	***Outcomes and Improvement Steering Committee***
OLM	***Office of Licensing and Monitoring***
OLS	***Office of Legislative Services***
OFA	***Orphan Foundation of America***
PAC	***Providers Advisory Council***
PCP	***Primary Care Physician***
PIP	***Program Improvement Plan***
PSSF	***Promoting Safe and Stable Families***
QA	***Quality Assurance***
RFP	***Request for Proposal***
RTC	***Residential Treatment Center***
SACWIS	***Statewide Automated Child Welfare Information System Assessment Reviews***
SAFE	***Structured Analysis Family Evaluation***
SAMHSA	***Substance Abuse and Mental Health Services Administration***
SARGE	***State Automated Child Welfare Information System Review Guide***
SCCAN	***State Council on Child Abuse and Neglect***
SCYFIS	***State Children, Youth and Family Information System***
SDM	***Structure Decision Making***
SED	***Serious Emotional Disturbance***
SEN	***Substance Exposed Newborn***
SFC-I	***Services to Families with Children-Intake***
SILA	***Semi Independent Living Arrangements***
SMO	***Shelter Management/Operations***

SROP	***State Response Operations Plan***
DHS/SSA	***Social Services Administration***
SSI	***Supplemental Security Income***
SSTS	***Social Services Time Study***
SUD	***Substance Use Disorder***
SYAB	***State Youth Advisory Board***
US DOJ, FBI, CJIS	***United States Department of Justice, Federal Bureau of Investigation, Criminal Justice Information System***
TANF	***Temporary Assistance to Needy Families***
TAY	***Transition Age Youth***
TFCBT	***Trauma-Focused Cognitive Behavioral Therapy***
TOL	***Transfer of Learning***
TPR	***Termination of Parental Rights***
UMB	***University of Maryland, Baltimore***
WIOA	***Workforce Innovation and Opportunity Act***

Collaboration

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. Throughout CY2020, teams within the Implementation structure reviewed their membership list and explored ways to expand membership. Most notably a number of teams extended invitations to court and legal partners and implemented other strategies to share information from meeting discussions with these partners when participation in meetings was prohibitive, e.g., the Continuous Quality Improvement (CQI) Network added legal representation to the group in the fall of 2020.

In June 2020, DHS/SSA established the Family First Implementation Team to engage stakeholders in Maryland's implementation of FFPSA. Membership of this group includes representatives from other state agencies (i.e., Department of Juvenile Services (DJS), Maryland Department of Health (MDH), other DHS administrations (i.e., Office of Licensing and Monitoring (OLM), Budget and Finance, Office of the Attorney General (OAG), Learning Office), LDSS, Technical Assistance (TA) partners, and families of origin. Lastly, DHS/SSA continued its partnership with Maryland Coalition of Families (MCF) to ensure family of origin participation within the Implementation Structure. While in previous years additional cohorts of families have been trained to join various teams, the impact of the COVID-19 pandemic limited DHS/SSA and MCF's ability to train additional cohorts in CY2020.

Feedback Loops

In addition to expanding membership, the DHS/SSA Implementation Structure continued to be the vehicle by which to use DHS/SSA CQI Cycle to hold key discussions around agency strengths, opportunities for improvement, and review of statewide indicators and modifications of plans. The DHS/CQI cycle continues to provide the framework to accurately and efficiently monitor statewide progress towards achieving improvements in child welfare services. Maryland's Headline Indicators and Child and Family Services Review (CFSR) results are shared at quarterly and six-month intervals respectively as part of the quarterly SSA Advisory Board meetings and the Outcomes Improvement Steering Committee. Individual Implementation Teams and Networks also utilize this data to monitor progress and make adjustments to strategies as needed. The Implementation Teams and Networks maintained their efforts to facilitate action-oriented meetings using the DHS/SSA CQI Cycle as a framework of reviewing current quantitative and qualitative data to identify strengths, needs, as well as monitor and adapt current strategic plans. Key accomplishments made by various teams during CY2020 included:

<u>Integrated Practice Implementation Team</u>

- Engaged individuals with lived experience in the child welfare system including a foster youth alumnus, parent with lived experience, resource parent, and informal kinship provider as co-trainers in the Integrated Practice Model (IPM) training.
- Completed focus groups with families with lived experience to gather information on their lived experiences to inform skills taught through the IPM training.
- Engaged workers and supervisors joined storyboard sessions to provide input on the IPM training.
- Administered FIM feedback surveys to obtain input from families, staff, community providers, and other family team members to identify strengths and inform needed improvements in the teaming process.
- Utilized the IPM training to obtain feedback from participants on CFSR results and outcomes which were filtered back through DHS/SSA's implementation structure.
- Engaged community stakeholders, resource parents, court partners, FTDM facilitators, supervisors, LDSS leadership, families with lived experience, and youth for further development of a revised teaming approach, including the development of policy.
- Worked with Dorchester County to address questions and concerns their community and court partners shared regarding the drop in Child in Need of Assistance petitions. DHS/SSA attended a series of community meetings to educate the community providers, court partners, and other stakeholders about the outcomes of youth in care, collaborating on addressing needs in their community, and using this experience to inform further outreach efforts with the courts around the State.

<u>CQI Network</u>

- Continued to share CFSR performance with stakeholders through Implementation Teams, Outcomes Improvement Steering Committee, Foster Care Court Improvement Program, and SSA Advisory meetings, and posted on the Maryland public website and the internal site. These discussions provided opportunities to identify trends across program and service areas and assess the progress of performance goals. During these discussions, stakeholders reflect on practice strengths and barriers to performance and specify contributing factors and root causes to further analyze and address in improvement planning conversations.
- Facilitated convenings with LDSS and their local partners, following their onsite CFSR review, to construct data-driven, comprehensive continuous improvement plans tailored to address areas of improvement identified during the on-site review process. In addition, each jurisdiction received targeted assistance and facilitation from the CQI Unit following their onsite review.
- Presented CFSR findings at the OAG Conference held in December 2020 in partnership with the Placement and Permanency Team and the Office of the Attorney General.
- Utilized CFSR data within the Implementation Teams and Foster Care Court Improvement Program (FCCIP) to develop strategies and examine current practice to include:
    - Developing an FCCIP ad hoc group designed to evaluate concurrent planning across Maryland.
    - Assisting the Integrated Practice Implementation Team in using CFSR findings within the IPM training.
    - Assisting the Protective Services and Preservation Services Implementation Team in developing a pilot process to review CPS/Family Preservation services and the

timeliness of face to face contact with children identified as victims of maltreatment.

Service Array Implementation Team

- Continued to review available data and the goals and objectives of the team, including CFSR performance of Item 2 and Item 12, evidence-based practice (EBP) utilization data for models being implemented in Maryland, and health and substance use disorder data to better understand trends and barriers associated with accessibility of services.
- Engaged team members in discussions focused on providing input, feedback and suggested strategies to address areas needing improvements through a review of work plans which consist of goals, objectives and interventions.
- Obtained input on how to advance the work including recommendations to review data through the lens of children and families and take deeper dives into the Child and Adolescent Needs and Strengths (CANS) data to better match service gaps with needs.

CPS/Family Preservation Services Implementation Team

- Assessed, reviewed, and monitored safety and risk outcomes in alignment with the requirements of the Family First Prevention Services Act.
- Participated in training and implementation of Integrated Practice Model (IPM) training to increase engagement and teaming within foster care and support efforts to regularly review and realign Service Plans for out of home care.
- Evaluated performance through the assessment of data from youth in foster care and those receiving in-home services.

Emerging Adults

- Conducted youth focus groups, stakeholder surveys, virtual check ins for youth and adult supporters, youth and state advisory board meetings that supported the work and paved the way for collaboration and authentic engagement and partnerships.
- Reviewed themes identified in the root cause analysis for permanency outcomes particularly for adoption, length of stay, re-entry, and placement type to better understand challenges for older youth in care.
- Reviewed and revised the youth transition plan, Ready by 21 benchmarks and used feedback from youth and stakeholders to enhance and incorporate any changes.

Workforce Development Network (WFD)

- Researched/reviewed pre-service models of various states to gather information on structure, curricula, deliverables and data outcomes.
- Reviewed survey data from Maryland local department supervisors and assistant directors to evaluate satisfaction and relevance of the existing pre-service series and recommendations for change.
- Reviewed SFY2015-SFY2018 DHS retention and attrition data to identify statewide turnover rates and trends as initial steps to develop a comprehensive state worker retention plan.

Quality Service Review Initiative (QSRI)

- Engaged the placement provider community to complete surveys, interviews and provide data regarding the services provided to youth and families, staffing needed to provide services and cost associated with providing placement services.
- Utilized data collected from the surveys and interviews to establish proposed rate methodology, create a new service intervention, and initiate the development of services for the service intervention to include staffing models and performance measures.

Permanency Workgroup

- Engaged workgroup members including private providers, the LDSS, Maryland Resource Parent Association members and resource parents in:
    - Reviewing policies around adoption/guardianship.
    - Developing an adoption/guardianship fact sheet and quarterly adoption incentive goals that were distributed to local jurisdictions.
    - Developing a request for additional data on the timeliness to TPR to develop a deeper understanding of strengths and barriers to youth moving towards permanence in a timely manner.

Resource Parent Engagement Workgroup

- Engaged resource parents and biological parents/families of origin in the development, dissemination, and analysis of resource parent surveys designed to capture information related to needs in building partnerships between resource parents and families of origin.
- Utilized survey information to develop new policy to address resource parent and family of origin partnerships.

Update to the Assessment of Current Performance in Improving Outcomes

Over the last several years Maryland has been transitioning to a new Comprehensive Child Welfare Information System (CCWIS) CJAMS from the older Statewide Automated Child Welfare Information System (SACWIS) MD CHESSIE. One jurisdiction made the transition during CY2019 and the remaining jurisdictions transitioned in phases during the first seven months of CY2020, with all jurisdictions being in CJAMS by the last week of July 2020. As a result of this shift, the logic used to extract data from MD CHESSIE data tables was no longer accurate. Additionally, while CJAMS has enough functionality for the transitions to occur, there were still many features that continued to be developed/enhanced/modified for the next several months following the statewide implementation. As a result, the logic developed early on to extract the data also had to be changed/modified or totally reworked based on the changes to the CJAMS application. It was also necessary to ensure that the migrated data from MD CHESSIE and the new CJAMS data were both included in the data extractions where necessary. This has frequently required reworking of the logic and identification of the appropriate data tables to ensure that the data was comprehensive and accurate. These efforts to ensure complete and accurate data has meant that some of the data provided for the CY2020 APSR might look different or not be available as those sections have not had their logic revised/updated. DHS/SSA has worked to ensure a seamless transition into CJAMS and continues to review and validate the data from CJAMS.

Safety Outcome 1

Table 1 below represents DHS/SSA Safety Outcome 1 data from CJAMS and the Child and Family Service Review (CFSR) from January-December 2020

Table 1: Safety Outcomes CY2020

Safety Outcomes	***Overall Determination***	***State Performance***
Time Period: January-December 2020		
Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect	Not in Substantial Conformity	75% Substantially Achieved
Data Source: Online Monitoring System (OMS)		
Timeliness of CPS Response (Target: 90% or greater for abuse and neglect contacts.)		
Calendar Year	**% Required to be seen within the first day (abuse)**	**% Required to be seen within the First 5 days (neglect)**
2019	74%	79%
2020	90%	97%
Data Source: MD CHESSIE (2018- July 2020); CJAMS (October 2019 - 2020)		

Strengths:

As noted in Table 1 from January to December 2020, Maryland's performance on Safety Outcome 1 did not meet the standard for substantial conformity as only 75% of the cases reviewed received a substantially achieved rating for Safety Outcome 1. However, the trend is moving in a positive direction as this is an improvement from last year's (CY2019) CFSR performance of 67%. SSA continues to raise the timeliness of CPS Responses to LDSS leadership in the context of CFSR outcomes and audit findings and has provided technical assistance to jurisdictions who are experiencing unfavorable outcomes.

Concerns:

As noted in Table 1, only 75% of children reviewed through the CFSR were seen timely which does not meet substantial conformity and is also a decrease from two years ago. DHS/SSA also recognizes there is a huge disparity between the CFSR results noted in Table 1 and the CJAMS data noted in Table 2, specifically, 90% of abuse cases had contact within the first day of a report and 97% of neglect cases had contact within the first five days. This discrepancy may be explained by the fact that the CFSR reviews a small number of cases while the CJAMS data looks at the total population. In addition, DHS/SSA is continuing efforts to validate data extracted from CJAMS as this was a first attempt at pulling the data.

Activities to Improve Performance:

- Improve assessment data collection and reports to design and provide technical assistance as needed.

- Coordinate with the CFSR process to provide larger sample size reviews for discussion with the LDSS around Safety Outcome 1.
- Reissuance of policy and guidance around improving access to children and families who may be difficult to locate.

Safety Outcome 2

Tables 2 and 3 below represents DHS/SSA Safety Outcome 2 data from CJAMS and the Child and Family Service Review (CFSR) from January-December 2020

Table 2: Safety Outcome 2 CY2020

Safety Outcomes	***Overall Determination***	***State Performance***
Time Period: January-December 2020		
Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate	Not in Substantial Conformity	76% Substantially Achieved
Data Source: Online Monitoring System (OMS)		

Table 3: Safety Indicators CY2020

Statewide Data Indicator	**National Performance Target**	**Directions of Desired Performance**	**Baseline for State Data, Calendar Year 2018**	**State Data, Calendar Year 2019**	**State Data, Calendar Year 2020**	**MD Target for 2024**
Reentry to foster care in 12 months	8.1%	Lower	11.8%	10.1%	7.8%* COVID (Mar – Dec)	8.1%
Recurrence of Maltreatment	9.5%	Lower	10%	9%	5.3%	9.5%
Maltreatment in foster care (victimizations per 100,000 days in care)	9.67	Lower	11.4	10.1	12.36	9.67
Data Source: MD CHESSIE (2018- July 2020); CJAMS (October 2019 - 2020)						

Assessment of Performance:

Maryland did not meet substantial conformity between January 2020 and December 2020 for Safety Outcome 2 as only 76% of the cases reviewed received a substantially achieved rating (data source: OMS). However, this performance does demonstrate a positive trend with a 12.9 percentage point increase from CY2019 performance of 63%. Overall performance for CFSR Item 2 - Services to family to protect child(ren) in home and prevent removal or re-entry into foster care during CY2020 was 91% with a PIP target goal of 59%. CFSR Item 3 - Risk and safety assessment and management achieved the PIP target of 76% in CY2020 which is at the target goal. DHS/SSA did achieve a satisfactory outcome for the recurrence of maltreatment as it was only 5.3% down from 9.0% in CY2019 (data source: CJAMS). This is much lower than the national target of 9.5% and a 3.7% decrease from the last reporting period in CY2019. DHS/SSA child maltreatment of foster youth while in care increased this reporting period going from 10.1 to 12.36 (victimizations per 100,000 days). Re-entry into foster care rates have shown a continued decline over the last three calendar years, decreasing from 11.8% in CY2018 to 7.8% in CY2020 which is below Maryland's target of 8.1%. 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.

Strengths:
Overall, Maryland has demonstrated efforts towards improvement for safety outcomes. In the past, risk and safety assessments through SAFE-C, Maryland Family Initial Risk Assessment, and Maryland Risk Reassessment were not consistently or accurately leveraged in efforts to inform case and service planning. Efforts to improve this have been made through the implementation of the Integrated Practice Model (IPM) training that DHS/SSA has developed to increase engagement and teaming efforts between child welfare staff and families served in CPS, Family Preservation, and Foster Care programs.

Maryland has continued to make improvements to provide services to stabilize families and prevent a child's entry into foster care. This is shown by positive performance in the CFSR OSRI Item 2, Services to Family to Protect Children In Home and Prevent Removal or Reentry into Foster Care. In nearly 91% of cases the agency made efforts to provide services to the family to prevent entry or reentry into foster care. There is an improved practice of families being referred for safety related services which appears to have a positive impact on outcomes. This practice has been supported by the Service Array Implementation Team focusing on available services within the jurisdiction and identification of service gaps. While Maryland did not meet substantial conformity, the recurrence of maltreatment at 5.3% was well below the national target (9.5%) and indicates further improvement from the previous year where the rate was 9%. Headline indicators further support this finding. In CY 2020, 91% 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.

Additionally, 96% of children who received Family Preservation Services did not have a maltreatment report within one year according to Maryland's Headline Indicators. This performance exceeds the state goal of 93%. Thus, indicating that the vast majority of children who remain in their home are safe from maltreatment. While these are just two indicators of children's safety in their homes, it does demonstrate positive trends in Maryland. Additionally, efforts to implement the IPM will further encourage realignment and reassessment of in-home case planning through family engagement and teaming practices to keep families and children safe and stable.

Concerns:
While Safety Outcome 2 is rated at 76%, DHS/SSA aims to be within substantial conformity for this outcome with a target goal of 90%. Ongoing assessments of risk and safety were not consistently carried out when a youth in foster care had siblings who remained in the home. While there have been efforts for improvement, like the implementation of the IPM and its emphasis on family engagement and teaming, input from appropriate parties, like families, were not always obtained which may have resulted in inaccurate or incomplete assessments and safety plans that did not effectively address a child's safety needs. Maryland also needs to improve monitoring of safety plans that are implemented with families to ensure compliance.

Activities to Improve Performance:

- Revise and streamline collaborative assessment and service planning policies to support authentic partnership with families and their chosen supports to complete assessments and co-create service plans.
- Improve the collaborative assessment data at State and local levels to design and provide technical assistance as needed.
- Strengthen supervisor's skills to provide coaching to caseworkers to support skills and competencies in creating authentic partnerships with youth and families.

Permanency Outcome 1

Tables 4 and 5 below provide DHS/SSA's performance on permanency outcome 1 between January - December 2020.

Table 4: Permanency Outcome 1 CY2020

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

Table 5: Permanency Indicators CY2020

Statewide Data Indicator	National Performance Target	Directions of Desired Performance	Baseline for State Data, Calendar Year 2018	State Data, Calendar Year 2019	State Data, Calendar Year 2020	MD Target for 2024
Permanency in 12 months for children entering foster care	42.7%	Higher	37.5%	34%	30.8%* COVID (Mar – Dec)	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)	45.9%
Permanency in 12 months for children in foster care	31.8%	Higher	28.3%	20%	20.2%* COVID (Mar – Dec)	31.8%
Placement stability (moves per 1,000 days in care)	4.12	Lower	4.38	4.36	5.27* COVID (Mar – Dec)	4.12
*Data Source: MD CHESSIE (2018-2020(July); CJAMS (2019 (October) - 2020)						

Assessment of Performance:

Assessment of performance for permanency has been impacted as efforts to achieve permanency plans were unable to be achieved timely in some cases. Maryland's percentage of timely permanency within 12 months from the date a child enters foster care is 30.8% while Maryland's target is currently 42.7%. Permanency for children in 12 months for children in care for 12-23 months is currently 24.8% while Maryland's target is 45.9%. Permanency for children in foster care for 12 months is currently 20.2% 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 timely identifying appropriate permanency goals, 60% of cases reviewed were rated as areas needing improvement. In relation to achieving permanency timely,73% of cases reviewed were rated as areas needing improvement. It should be noted that Maryland's permanency numbers were likely impacted by the COVID-19 pandemic. During this time, those youth who would have ordinarily achieved permanency experienced a delay as courts were closed and determining options to shift to virtual platforms to conduct hearings.

Finally, placement stability rates have shown a slight increase in CY2020 with 5.27 moves per 1,000 days in care which is up from 4.36 moves reported in CY2019 and above the national target of 4.12 indicating that children are experiencing more moves in their foster care placements. DHS/SSA has also noted that providing permanence to youth via Reunification, Adoption and Custody/Guardianship (C&G) has decreased since last fiscal year. Reunification and Adoption has also decreased as a result of court closures. LDSS was unable to grant custody and guardianship, reunify families or provide adoption finalizations due to court closures as a result of the Pandemic. Upon sharing data with locals and having conversations, it was determined that the placement instability increase was not due to COVID but instead due to the lack of placement resources within the state. In addition, court closures have impacted the changing of permanency plans which has a direct impact on achievement of permanency throughout the state.

Strengths:
As stated above, Maryland made a few increases in the above permanency measures. Maryland has maintained an active Resource Parent Engagement Workgroup, SSA Permanency Workgroup, SSA CFSR quarterly reviews that resulted in stakeholder feedback, and has routinely distributed data to the local departments for their review and action. DHS/SSA has also actively participated in quarterly meetings with the Foster Care Court Improvement Program (FCCIP) Subcommittee and presented the CFSR permanency measures for their review. It was agreed that continued focus on the permanency outcomes and strategies to adjust the trend down of permanency outcomes 5 and 6 was necessary. A collaborative effort is underway via the FCCIP Ad hoc group that convenes meetings with DHS/SSA to work on the outcomes and to determine causes to the permanency outcomes. A joint technical assistance session facilitated by Chapin Hall is planned to gather more insight on Maryland's performance data. The data review will also include Court Performance and Timeliness Measures.

Concerns:
Overall, while COVID has impacted the number of timely permanency for youth, DHS/SSA is currently working with the LDSS to address how each jurisdiction was impacted by the Pandemic. Court closures were another barrier to timely permanency. In addition, the new state information system (CJAMS) has limitations that affect the ability to accurately evaluate the information available regarding the permanency outcome. The system is currently not able to effectively tell the individual jurisdictional story of barriers to permanency via generating a report. Therefore, the state will need to assess the impact via obtaining qualitative data from the locals. The state will need to determine whether the court closures caused a reduction in the finalization of C&G, reunification, and adoption finalizations or whether the cause was another reason. The impact of COVID may have played a role in the delay or absence of family and sibling visitation. The courts were closed from March 2020 - November 2020 which also made it

hard for mandated court visitation to occur where some visitations are ordered to be held at the courthouse location.

Activities to Improve Performance:
DHS/SSA is providing local permanency staff with education 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 addition, Table 6 below outlines the CY2020 status of additional activities identified to improve performance on Permanency Outcome 1.

Table 6: Activities to Improve Performance in Permanency Outcomes

Activities for Permanency 1	Target Completion Date
Permanency Outcome 1: Quality Services Reform Initiative (QSRI)	2022
Define quality residential treatment services, performance measures and the approach to rates setting for these services (including Medical Assistance rates for some services)	2019

2019 Progress: ***Completed***

- Fall 2019: The Placement & Permanency Implementation Team, collaborated with the Quality Service Reform Initiative (QSRI) to produce a vision document and call to action report entitled, "Maryland's Children's Quality Service Reform Initiative: A strategic approach to improving the quality of services for children in residential interventions and increasing the number of children services in family settings." That included the following core components of the QSRI to 1) establish clinical and provider criteria for residential interventions, 2) establish consistent rates for clinical and room/board services, 3) establish consistent referral and enrollment pathways, 4) support provider, agency and community readiness and workforce development, 5) establish performance measures and a CQI process as part of an updated contracting process and 6) develop and implement a transition plan.
- Fall 2019: Collaborated with the QSRI (which includes community/provider agencies and DJS) to develop a review process and tool for determining youth readiness for discharge in an effort to transition youth out of congregate care to family-based living environments. Decision made to pilot this process.
- Fall 2019: Decision made to pilot the process by staffing those youth who have remained in congregate care for 12 months or longer. The team identified the population, gathered and analyzed data and finalized the methodology. The team also developed a transition planning tool to assist the agency, provider and youth/family with the discharge and transition process.

2020 Progress: ***In Progress***

Full implementation of QSRI was expected to be complete in FY2022. The implementation has been delayed due to issues with procuring a new vendor to complete the rate development and actuarial services. The original vendor identified a number of challenges with adequate staffing that would impact their ability to complete the identified scope of work. The new implementation date is State Fiscal Year 2026. While the decision to pilot the review process and tool for determining youth readiness for discharge based on being in a congregate setting for 12 month or more was determined; the activities around implementing the pilot were delayed due to the Statewide Pandemic which shifted much to the state's focus to developing and implementing revised protocols related to providing child welfare services in ways that supports child, family, and staff safety and wellbeing. The expectation is to pilot this process in 2021. The delay in the activities around youth readiness for discharge were impacted by the Statewide Pandemic specifically related to court closures and reduced or halted provider admissions. Despite the delays experienced the following activities were completed during the reporting period:

- Summer 2020: The QSRI workgroup (which includes DJS, MDH, MSDE and other state agencies) made a decision on a proposed new rate methodology which uses the framework of the existing IRC process as a foundation. The proposed methodology moves away from individual rates based on

Activities for Permanency 1	Target Completion Date
Permanency Outcome 1: Quality Services Reform Initiative (QSRI)	2022

individual costs because there is a need for better predictability of costs for both the State and providers. The new methodology establishes direct care rates and clinical care rates.

- Summer 2020: DHS, DJS, and The Institute developed referral pathways and frameworks, integrating QRTP activities and current and proposed teaming protocols.
- Fall 2020: Continued collaboration with QSRI workgroup to finalize the vision document.
- Fall 2020: DHS Permanency and Placement Units and DJS Resource Unit trained on transition planning tool that will be used to transition youth from congregate care that have been in care for 12 months or longer.
- Winter 2020: The QSRI workgroup (which includes DJS, MDH, MSDE and other state agencies) drafted initial service descriptions, provider qualifications, and medical necessity criteria for the tiered residential intervention service, which has been reviewed by the Maryland Department of Health (MDH) to support alignment for a future submission of a Medicaid State Plan Amendment (SPA). These discussions with the QSRI workgroup discussions are on-going.
- Winter 2020: Implementation date for QSRI has been changed due to issues with the vendor to develop the rate. Request for Proposal (RFP) is being drafted to procure a new vendor to develop the rate and complete actuarial analysis. The proposed implementation date for QSRI is SFY2026.

Develop referral mechanisms and pathway documents for decision-making about a child's placement.	2019

2019 Progress: ***In Progress***

- Early 2019: Developed an enhanced placement referral and decision-making tool and process.
- Fall 2019: Began a review of the tool and process through the OISC and with LDSS leadership.
- November-December 2019: Developed a draft policy for the new placement referral and decision-making process and collaborated with LDSS and other team members to develop and finalize practice enhancements related to the use of congregate care in alignment with FFPSA. The team collaborated with DJS to finalize the state's process for the identification of Qualified Individual (QI) and use of QRTP. Concurrently, the team identified a QI nomination and selection form and initial outline of needed training requirements. The state's QI plan was included and subsequently approved in the state's title IV-E Plan.
- Spring 2020: The policy underwent further review by DHS/SSA's and final approval in late spring 2020. Additionally, the implementation team collaborated with LDSS and other team members to develop and finalize practice enhancements pertaining to the use of congregate care associated with FFPSA. During this period, the team collaborated with DJS to finalize the state's process for the identification of Qualified Individual (QI) and use of QRTP. Concurrently, the team identified a QI nomination and selection form and initial outline of needed training requirements. The state's QI plan was included and subsequently approved in the state's Title IV-E plan amendment that addresses QRTP provisions.
- December 2019: drafted QI and QRTP policy was completed and presented for review to LDSS leadership through the Affiliates and MASS-D meetings. In 2020, the revised policy will be presented to the OISC for approval.

2020 Progress: ***In Progress***

- January 2020-SSA program leadership met to review Family First requirements and implementation plan for alignment of the following policies.
- June 2020-Draft QRTP and QI Policy presented before the SSA Outcomes Improvement Steering Committee for review and feedback.
- September 2020-Draft Placement Referral Policy was presented for feedback before the Family Teaming Workgroup for alignment with the FTDM process.
- October – December 2020 – DHS/SSA partnered with the Children's Bureau to align the QRTP with FFPSA provisions. Final edits are expected to be completed in the first quarter of 2021.

Activities for Permanency 1	Target Completion Date
Permanency Outcome 1: Quality Services Reform Initiative (QSRI)	2022
Begin using a new transition planning tool with the goal of transitioning children out of group homes (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 begin use of a transition planning tool for children and youth in congregate care 12 months or more. 2020 Progress: ***Delayed*** This activity has been delayed due the State Emergency related to COVID-19 and shortage of staff. DHS and DJS staff were not trained on the transition planning tool until December 2020. Additional training is required for DHS and DJS staff which is in the planning process and will be completed in Spring/Summer 2021.	
Begin implementation of strategies and tracking of performance data in pilot jurisdictions (new activity added)	2020
2020 Progress: ***Delayed*** This activity has been delayed due the State Emergency related to COVID-19 and shortage of staff. This activity cannot be completed until pilot activity is initiated and in order to begin the pilot specific training will need to be provided. DHS/SSA does anticipate that the pilot activity will be completed in 2022.	
Identify strategies through root cause analysis (new activity added)	2020
2020 Progress: ***Delayed*** This activity has been delayed due the State Emergency related to COVID-19 and shortage of staff. This activity is based on the above activities related to initiating the pilot and implementation of strategies and tracking for performance measures. It is expected that this activity will be completed in 2022.	
Train child Placement & Permanency Units and Providers on new tools and process (new activity added)	2020
2020 Progress: ***Delayed*** This activity has been delayed due the State Emergency related to COVID-19 and shortage of staff. This activity is based on the above activities related to initiating the pilot and implementation of strategies and tracking for performance measures. It is expected that this activity will be completed in 2022.	
Provide technical assistance to LDSS and private provider agencies related to decision making about child placement.	2020
2020 Progress: ***Delayed*** This activity has been delayed due the State Emergency related to COVID-19 and shortage of staff. This activity is based on the above activities related to initiating the pilot, implementation of strategies and tracking for performance measures and training to LDSS and Providers on the new tools and process. It is expected that this activity will be completed between 2021-2024	
Analyze CQI related to the appropriate placement efforts and placement stability and refine practice based on results.	2020-2024
2020 Progress: ***Delayed*** This activity has been delayed as the Appropriate Placements workgroup is waiting on more systemic data.	

Activities for Permanency 1	Target Completion Date
Permanency Outcome 1: Quality Services Reform Initiative (QSRI)	2022
Review Headline data for Placement Stability process (new activity added) The process will ensure that children are placed in the most appropriate placements the first time and monitor the reduction of placement disruptions	2020
2020 Progress: ***Delayed*** This activity was delayed during this reporting period as the QSRI process related to transitioning youth from Congregate Care was still being implemented and DHS/SSA will need training on the implementation process.	
Revise policy as needed (one on one) in the Placement & Permanency Meeting process (new activity added). Draft revisions made to 1:1 policy in July, awaiting final approval.	2020
2020 Progress: ***In process*** ● December 2020: DHS/SSA reviewed and revised previous 1:1 policy to include timeframes around the utilization of the behavioral supports and reporting of expenditures. ● The 1:1 policy is currently pending leadership approval. It is anticipated to be finalized in early Spring of 2021.	
Center for Excellence in Foster Family Development Resource Parent Training Model Development	2020
2020 Progress: ***In Process*** ● During this reporting period, DHS/SSA, in partnership with the University of Maryland, made strides in developing the site selection process and documents designed to identify jurisdictions to implement the identified model. Selection documents developed were vetted by the CfE Advisory Board, which includes representation of Resource Families. ● November 2020 - Initiated the procurement process with the identified model purveyors but the completion of the procurement process has been delayed. The delay in the procurement process has impacted the ability to complete training, implementation, and evaluation activities. ● November 2020 - Finalize the selection of the training module for the CFE. Resource Parents will be trained on an enhanced PRIDE training module centering on birth family engagement. Resource Parent training will also be tailored to resource parent needs utilizing the KEEP and KEEP SAFE training curriculum ● December 2020 - A virtual information session was held for local jurisdictions to review the site selection and application process which resulted in five jurisdictions submitting applications for consideration for the pilot sites for implementation. It is anticipated that pilot site selection will be completed by Spring 2021. ● The CFE Grant is in year 2 and in the final process of making a decision on the 4 LDSS sites. It is important to note that DHS/SSA has faced challenges in hiring the supervisor/analyst for the CFE but in spite of that, work has still continued. It is anticipated that both positions will be filled by late Spring 2021.	
Procurement for in-person/virtual Post Adoption Services	2020
2020 Progress: ***In Process*** Two Post Adoption Service contracts have been procured and implementation will begin in early Spring 2021. Services will include assessments of youth and families who have finalized Adoptions in Maryland and the provision of individual/group therapy for families.	
Begin a process to transition youth out of congregate care and into family settings.	2021

Activities for Permanency 1	Target Completion Date
Permanency Outcome 1: Quality Services Reform Initiative (QSRI)	2022
Implement Placement Referral process statewide to target placement stability	2021
2019 Progress: ***In Progress*** ● Referral Policy is being finalized. 2020 Progress: ***Completed*** ● December 2020: Placement referral process was finalized.	
Design and implement CQI protocols, including performance data from providers	2021-2024
State Agencies continue to collect and analyze CQI data and reconcile it with cost data, making providers financially whole for two years after implementation of new rates.	2022

Permanency Outcome 2

Table 7 below provides DHS/SSA's performance on permanency outcome 2 between January - December 2020.

Table 7: Permanency Outcome 2 CY2020

Permanency Outcomes	***Overall Determination***	***State Performance***
Time Period: January-December 2020		
Permanency Outcome 2: The continuity of family relationships and connections is preserved for children	Not in Substantial Conformity	67% Substantially Achieved
Data Source: Online Monitoring System (OMS)		

Analysis of the Data:

DHS/SSA has met 67% conformity in this permanency outcome. The state is committed to partnering with families and children to ensure connections are kept when youth are placed in care. When the socially distancing mandate resumed in November 2020, the state office issued guidance for in-person visitation to resume which included parent/child/sibling visitation. Each of the 24 LDSS were asked to assess the safety of youth, family, resource parents, and caseworkers when the guidance was lifted.

Strengths:

DHS/SSA has made improvements in this area during this reporting period. The state met its targeted goal for placement with siblings at 81.5%. DHS/SSA has drafted a policy related to fostering partnerships between resource parents and families of origin. The policy and accompanying webinar are designed to reorient the partnership between resource parents and families of origin to ensure relationships and connections are maintained for children in foster care. The policy and webinar development will include parents with lived experience and families of origin. In addition, DHS/SSA CFSR results have shown marked improvements in

the following areas: placements with siblings (84.2%), visiting with parents and siblings in foster care (74%), preserving connections (83%), relative placements (73%) and relationships of child in care with parents (77%), all of which have shown an upward trend since last reporting period.

Concerns:
DHS/SSA is challenged in meeting substantial conformity for permanency outcome 2 as the state is only at 67% conformity. Most of the youth in Maryland's foster care system are placed in relative placement. These placements allow for kin connections to be maintained with both youth and biological parents. When youth are placed with relatives, the families of origin are able to facilitate visitation between parents and siblings on their own without state supervision. The state will need to determine whether the court closures caused a reduction in the finalization of C&G or whether the cause was another reason. The impact of COVID may have played a role in the delay or absence of family and sibling visitation. The courts were closed from March 2020 - November 2020 which also made it hard for mandated court visitation to occur where some visitations are ordered to be held at the courthouse location. Other possible delays may have been relatives unable to obtain necessary mandated requirements such as health and fire inspections due to state/local inspector delays. Many of these entities were also paused as a result of COVID which would have further delayed home approvals for kin caregivers.

Activities to Improve Performance:
DHS/SSA has identified the following activities to improve performance on Permanency Outcome 2:

- The resource parent engagement workgroup will be working on policies connected to fostering relationships between both birthparent/families of origin, resource parents and youth.
- DHS/SSA is continuing to move forward with the implementation its five year Center for Excellence in Foster Family Development (CfE) designed to support the partnership resource families and families of origin to ensure family relationships and connections are preserved for children in foster care, facilitate permanency for youth via reunification, and prevent congregate care placements. Over the next several reporting periods, DHS/SSA will continue with its CfE implementation plan to augment resource parent training and implement identified evidence-based models (Keeping Foster and Kin Parents Supported and Parenting Through Change-Reunification Trained) in select pilot jurisdictions.
- 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.

Well-being Outcome 1

Table 8 represents DHS/SSA Well-being Outcome 1 data from the Child and Family Service Review (CFSR) from January-December 2020.

Table 8: Well-being Outcome 1 CY2020

Well-being Outcomes	Overall Determination	State Performance
Time Period: January-December 2020		

Well-being Outcomes	Overall Determination	State Performance
Well-being Outcome 1: Families have enhanced capacity to provide for their children's needs	Not in Substantial Conformity	39% Substantially Achieved
Data Source: Online Monitoring System (OMS)		

Assessment of Performance:
The CFSR results for Well-Being Outcome 1 show that 39% of the cases reviewed were identified as a strength which is an increase from the 31% noted in DHS/SSA's Child and Family Services Plan (CFSP) and the 22% noted in the previous APSR report. Data reflects LDSS staff are assessing the needs and services of children, parents, and foster parents and providing services to meet needs when identified in addition to improvements with visitation between the agency children and parents. Furthermore, more parents and children are involved in the case planning process. The state was able to achieve the identified PIP target for CFSR items related to identifying needs and providing services to children, parents and foster parents, involving children and families in case planning, conducting caseworker visits with children and families.

Strengths:
The agency continues to progress in the right direction for Well-Being Outcome 1. The agency has seen improvements in the quality of how LDSS staff are assessing the needs and services of children, parents, and foster parents and providing services to meet needs when identified. In addition, the agency has seen improvements with visitation between the agency children and parents. The agency anticipates continued progression with the training and coaching to Child Welfare Workforce on the Integrated Practice Model and several goals and activities related to enhanced teaming with parents and caregivers as well as service providers. Implementation efforts support the agency's continued progress in this area to include the agency's quality assurance process, enhancing the efficiency of assessment tools to appropriately assess the child's well-being needs and the revision and enhancement of training for the Child Welfare Workforce. These activities are described in more detail in CFSP Goal 2: Strengthen workforce knowledge and skills to support the full implementation of Maryland's Integrated Practice Model (IPM), Goal 3: Strengthen Maryland's CQI processes to understand safety, permanency, and wellbeing outcomes and 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.

Concerns:
CY2020 CFSR data indicates the agency needs to continue to improve the practice of assessing and providing services to biological parents State stakeholder interviews revealed one major barrier to improvement in CFSR items 12B, 13, and 15 was attempting to engage parents who are perceived as difficult to work with and engaging parents who are involved on an involuntary basis. 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 struggle to make concerted efforts to locate, routinely follow-up with, and meaningfully engage parents, specifically biological fathers. The agency believes this is due to not initially gathering information about the biological father and assessing the relationship between the biological

father and child while working with the family. Also, the lack of effective partnerships between workers, families and service providers lead to inaccurate assessments and an inability to identify the right services to meet their needs. This is reflected in caseworker visits with parents, family involved in case planning and needs and assessments of services to bio parent's performance data. The state began IPM training in the summer of 2020, full implementation of the IPM will lead to improving well-being outcomes.

Activities Improve Performance:
Planned activities targeted at improving performance for Well-being Outcomes 1, are described in CFSP. Please see Update to the Plan for Enacting the State's Vision and Progress Made to Improve Outcomes Goal 2 (page 90), 3 (page 100), and 5 (page 112) sections for updates on planned activities.

Well-being Outcome 2

Tables 9 and 10 represent DHS/SSA Well-being Outcome 2 data from CJAMS and the Child and Family Service Review (CFSR) from January-December 2020.

Table 9: Well-being Outcome 2 CY2020

Well-Being 2 Outcomes	Overall Determination	State Performance
Time Period: January-December 2020		
Well-being Outcome 2: Children receive appropriate services to meet their educational needs	Not in Substantial Conformity	94% Substantially Achieved
Data Source: Online Monitoring System (OMS)		

Table 10: Education Indicator CY 2018-2020

Education Measure	*Target*	*CY2018*	*CY2019*	*CY2020*
Children entering foster care and enrolled in school within five days	85%	76.7%	81%	43%
*Data Source: MD CHESSIE (2018-2020(July); CJAMS (2019 (October) - 2020)				

Assessment of Performance:
During calendar 2020, CFSR item 16, which assessed children receiving appropriate services to meet their educational needs received, a substantially achieved rating at 94%. During CY2020 all Maryland schools and students shifted to 100% virtual learning as a result of the COVID-19 pandemic. To support the transition to virtual learning the state provided resources to aid with technology, services to meet individual academic needs and enhanced partnership with school personnel to ensure needs were met.

Unfortunately, children entering foster care and enrolled in school within five days was 43%, a significant decline from 2019 and is significantly off-trend for Maryland. The agency contributes a number of factors to this decline largely impacted by the disruption of schooling caused by the

pandemic. The process for timely school enrollment was impacted due to stay at home order, schools closed, reduced hours and teleworking of staff. Many of the existing challenges with timely enrollment such as identifying points of contact and coordination needed between all parties were exacerbated by the pandemic. Many schools' enrollment processes transitioned to online only. This decline reflects the national data around school enrollment during the pandemic.

Strengths:
Throughout the year, the agency worked to enhance partnerships needed to respond to enrollment barriers brought on by the pandemic. As the pandemic evolved, the agency saw more communication and collaboration amongst education partners. In addition, CFSR case reviews found that, in general, the educational needs of children in foster care were being appropriately and adequately assessed and addressed. At the state level, as well within each local department, LDSS and school systems are continually working to enhance coordination and communication around the education needs of children in care. The enhancements made to the education tab in CJAMS, allows workers to better retrieve and review school documents and education entries. This has supported the improvement in assessments of education needs and services.

Concerns:
While data showing some progression, the state did not meet the identified CFSR target of 95% of all cases showing strength for this outcome. Through qualitative data analysis resulting from technical assistance provided to the LDSS, some 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. Timely enrollment into school for children who enter care continues to be a mutual responsibility between the LDSS caseworker, the Local Education Authority (EA) 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 out of home placement are enrolled in school and have access to the education services, there needs to be stronger collaboration and communication between all parties.

Although MOAs exist between the LDSS and LEAs, not all staff are aware of these MOAs and their role in implementing the requirements. Some local school staff are uninformed or ill-informed about the requirements for school enrollment. Some school staff are requesting a number of documents that are not readily available in order to enroll the child in school which is against policy and practice and lengthens the time for enrollment.

There are concerns that exist around the right people being involved in the decision-making progress of the student. This includes ensuring that appropriate and necessary people attend the best interest determination meetings. Concerns include 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 within another jurisdiction.

With the onset of COVID-19 and schools in Maryland school's transitioning to virtual learning only, the challenges that existed with school enrollment and meeting students' educational needs

were exacerbated as most people were teleworking. The focus of 2020 for education focused on working to mitigate emerging and existing barriers between the LDSS and LEAs. The agency worked with MSDE and all local school liaisons to create a feedback loop for updates and dissemination of information as COVID progressed. The agency surveyed the LDSS and foster parents to better understand the challenges being faced due to distant learning during and support the LDSS, the students and caregivers with virtual learning. Survey focused on understanding issues of childcare, communication with school systems, technology and WIFI needs, special education and access to education resources. The agency created a reference guide tool to support parents and youth during COVID 19. Throughout 2020, the agency participated in various state and federal town halls, webinars, technical assistance meetings, focused on supporting youth and families during the pandemic and addressing education related needs. The agency also collaborated with American Bar Association and other state Every Student Succeed Act (ESSA) point of contacts during the pandemic to gather information on how to support children & families.

Table 11: Activities to Improve Performance: Well-being Outcome 2

Activities for Educational Needs (Well-being 2)	Target Completion Date
Assess barriers around navigating education services for children in care by developing and disseminating an education survey and follow up to LDSS staff, resource parents and private providers	December 2019
2019 Progress: ***Completed*** ● August 2019: Developed a survey, in collaboration with the health and education workgroups, to assess barriers to navigating education services. ● August 2019: Survey was distributed to all 24 LDSS, treatment foster care agencies, residential treatment providers, and resource parents. ● September 2019: Survey results analyzed and showed the following: 415 respondents completed the survey. Of these, 59% were resource parents, kinship parents, or private providers, and 41% respondents were LDSS staff. The results of the survey were analyzed by the Institute, reviewed by the education workgroup, and are being used to develop cross system strategies to improve outcomes.	
Based on survey results, develop targeted interventions to assist the LDSS staff with ensuring they are able to coordinate education services to make sure identified needs are met.	September 2020
2020 progress: **Completed** ● January 2020: Through the implementation structure of the Education workgroup survey results were presented to stakeholders to allow for input and development of targeted interventions and strategies that can be addressed across themed focus areas that impact timely enrollment such as policy and training, transportation, enrollment, academics, special education and coordination of services. ● January 2020: Partners and stakeholders working with the agency to address education goals were tasked with sharing survey results with their agency and staff and developing targeted interventions to address on their end in collaboration with SSA. This includes representation from local administrators from each county, Maryland State Department of Education, Resource Parent Association, kinship parents, Child Welfare Academy, and treatment foster care providers. ● February 2020: Due to the large number of barriers and contributing factors identified, strategies and interventions were prioritized, and a work plan was developed to address over a period of time. ● February 2020: Agency conducted training to the agency private providers such as Treatment Foster Care agencies focused on the requirements of enrollment of youth in school due to placement change, coordination of services and how to support youth in that transition.	

Activities for Educational Needs (Well-being 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
2020 progress: **In Progress** ● December 2020: SSA and Maryland State Department of Education (MSDE) held meetings with leadership and research and data units of each agency focused on improving data sharing between agencies. At the meeting, each agency identified their data needs, reasons for data, intentions on how the agency plans to use the data and the limitations of each agency's data system were discussed. MSDE was able to clarify which data they are able to provide, and which data points are locally collected. ● During the meeting several strategies were explored. such as re-establishing the State level Data Sharing Exchange Agreement between the agencies that expired, as well as the need for updates and enhancements to Memorandum of Agreements that exist between all 24 Local Department of Social services and Local School Agencies to include data sharing. ● Next step plans include identification and review of all educational data points requested from MSDE by the agency to determine feasibility and accessibility of data.	
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

Table 12: Activities to Improve Performance: School Enrollment

Activities for Measure: Children enrolled in school within 5 days	Target Completion Date
Assess barriers to timely school enrollment by developing and disseminating an education survey and follow up to LDSS staff, resource parents and private providers	December 2019
2019 Progress: **Completed** ● August 2019: Developed a survey, in collaboration with the health and education workgroups, to assess barriers to timely school enrollment. ● August 2019: Survey was distributed to all 24 LDSS, treatment foster care agencies, residential treatment providers, and resource parents. ● September 2019: Survey results analyzed and showed the following: 415 respondents completed the survey. Of these, 59% were resource parents, kinship parents, or private providers, and 41% respondents were LDSS staff. The results of the survey were analyzed by the Institute, reviewed by the education workgroup, and are being used to develop cross system strategies to improve outcomes. ● December 2019 through January 2020: Regional conferences facilitated by DHS/SSA and MSDE to assist in assessing barriers related to timely school enrollment.	
Coordinate with MSDE to develop processes that will enhance collaboration between the LDSS and the Local Education Agencies (LEA) around timely school enrollment.	June 2024
2020 Progress: **In Progress** ● November 2020: Review existing MOUs between LDSS and LEA. ● December 2020: MSDE and SSA met to identify gaps that exist within agreements and areas needing enhancements to strengthen the coordination of service outlines in MOAs. ● December 2020: SSA and MSDE met to begin the process and series of meetings focused on developing cross training on enrollment requirements and best practices for children placed in out of home. Training scheduled for August 2021.	

Activities for Measure: Children enrolled in school within 5 days	Target Completion Date
● SSA and MSDE staff are currently preparing for webinars and technical assistance meetings targeted to all agencies and staff as part of school enrollment to be held in September 2021.	
Conduct monthly 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
2020 Progress: **In Progress** ● Jan-August 2020: SSA education specialist monitored timely school enrolment on a small sample of cases and provided technical assistance to LDSS focused on addressing barriers. Monitoring and technical assistance provided revealed the need for more LDSS staff training and access to tip sheets focused on best interest determination meetings and better coordination and communication with prior and receiving schools when a new school is identified as a result of placement. ● September 2020: agency built-in alerts in CJAMS to support case workers in retrieving school records and documenting education entries.	

Well Being Outcome 3

Tables 13 and 14 represent DHS/SSA Well-being Outcome 3 data from CJAMS and the Child and Family Service Review (CFSR) from January-December 2020.

Table 13: Well-being 3 Outcomes CY2020

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

Table 14: Health Indicators CY 2018-2020

Health Measures	*Target*	*CY2018*	*CY2019*	*CY2020*
Comprehensive Health Assessment for foster children within 60 Days	90%	92.5%	90%	66%
Annual Health Assessment for foster children in care throughout the year	90%	88.4%	84%	51%
Annual Dental Assessment for foster children in care throughout the year	60%	69.3%	66%	45%
*Data Source: MD CHESSIE (2018-2020(July); CJAMS (2019 (October) - 2020)				

Assessment of Performance:

For CY2020 timely comprehensive exams for children and youth in care was 66%. Timely Annual exams was 51% and timely annual dental exams was 45%. Health performance measures for CY2020 reflect a significant decline from 2019; whereas, CY2018 and 2019 showed a decrease of less than 4% for each health performance area. DHS/SSA's Well-Being health

measures overall have shown progress. DHS/SSA believes the significant decrease is a direct result of the COVID-19 pandemic public health crisis. Specific COVID-19 restrictions included Maryland's State Health Secretary's order to suspend all elective and non-urgent medical procedures until after the state of emergency. This allowed for a health care provider's clinical judgment as to what procedures were "critically necessary for the maintenance of health for a patient," with subsequent guidance from the Maryland Department of Health's clinical team and Medicaid clarifying that there was provider discretion to determine what preventive care was necessary. During the initial stage of the pandemic, health care providers were prioritizing the identification and treatment of ill individuals and altering practice procedures, reducing primary care access and leveraging telehealth technology; this allowed for the assurance of only clinically necessary visits during the time of extensive community viral transmission. Due to both the challenge of reduced access and the benefit of limiting youth and resource family possible community exposure, DHS temporarily modified time frames for the initial health screening and comprehensive health assessments, while prioritizing EPSDT health care services for the younger children in foster care and the administration of immunizations required for schooling and child care.

Since the state's last report on Well-Being Outcome 3, children receive adequate services to meet their physical and mental health needs, the state's CFSR performance item 17 and 18 in this area increased by 28%. Overall, 85% of the cases reviewed showed a strength in accomplishing this outcome compared to 57% reported previously. In reviewing statewide data from CJAMS versus the CFSR outcomes data, there are several factors that may be impacting the differences seen in the two data sources. In addition to the delays of exams due to the pandemic as described above, the CJAMS data extraction is limited to capturing accurate staff documentation of the completion of initial health, comprehensive health, annual health and annual dental appointments. In addition, this was the agency's first attempt at extracting this data from a new system, and it is possible that the CJAMS data extraction may have missed some reports also contributing to lower outcomes. Whereas the CFSR does not typically capture initial and comprehensive assessments, it is more likely to include the assessment of children who have been in foster care more than 12 months. Additionally, CFSR data does not rely solely on the documentation within the electronic case record. It includes the qualitative data learned from agency, child or foster parents. The agency made notable improvements in the CFSR Well-Being Outcome 3. The agency continued to conduct health monitoring utilizing the child welfare systems Out-of-Home Milestone Report. The monitoring process showed timely and accurate data entry remained an area that required attention, and the agency's Health Workgroup initiated steps, a root cause analysis, to further explore the contributing factors. Technical assistance provided to the LDSS addressed accurate documentation but also included state level partners such as Maryland's Managed Care Organization (MCO) to support the LDSS with addressing some jurisdictional barriers.

In terms of mental health services during CY 2020, periodic surveys of LDSS conducted by DHS/SSA's Child Welfare Medical Director indicated that most services were provided via telehealth, with more in-person visits occurring towards the latter part of the year. While telehealth was reported to increase access in certain jurisdictions, with improved show rates noted, there were subsets of children and youth who did not adapt well to the virtual visit format, particularly the younger age groups. There were individual case reports of youth who refused

virtual mental health services. In those limited cases, LDSS worked to identify programs that were providing in-person visits. Limited access to technology resources (laptops, wireless networks, etc.) in more rural and remote jurisdictions was reported to impact access to mental telehealth care; utilizing one-time emergency funding, DHS/SSA purchased laptops for children and youth. Additionally, obtaining initial mental health evaluations, certificates of need and evaluations by psychiatrists generally continued to be challenging, due to the number of mental health providers available and existing wait lists.

Strengths:
This data reflects the state's continuous efforts to build state and local collaborations to improve communication and collaboration with LDSS staff, community providers, and Maryland's MCOs. Enhancing collaboration at the local level has supported improvements in coordination of health services to ensure health needs for children are met while in care. CFSR data indicates an upward trajectory for Well-Being Outcome 3; however, the state continues to address factors impacting progress in this area.

Concerns:
LDSS, health providers, and MCO's ability to share information is a major barrier. Often caseworkers rely on information received from resources parents (including private foster agencies) to ensure health services are received and adequately addressed. Caseworkers struggle with receiving this information in a timely manner as well as different methods used by health providers (assess a child's level of medical need, health plans clearly identifying the child's health needs) which impacts health services being scheduled or documented (hard file or in the state's child welfare electronic system).

Regarding mental/behavioral health, the agency has struggled to accurately capture data to reflect the overall mental health needs of children and youth in care in the electronic data system. Overall, this has been an area that needs improvement. The agency continues to strive to improve the quality of behavioral and mental health services data for children and youth in care. There continues to be collaboration between program staff and research and data team, LDSS and other state level partners, to ensure the system is able to capture accurate and complete mental health data to strengthen programming and services for children and youth in care. Through these enhancements of the health and mental health tabs in CJAMS, the agency will be able to more accurately determine the mental health needs of children in care and the services they receive to meet those needs in the near future.

Activities to Improve Performance:
During 2020, the state continued to collaborate with state partners conducting a root cause analysis (RCA) and on various technical assistance meetings to improve health outcomes for children in care. The RCA focused on understanding system challenges (state and local), what contributes to the variations across jurisdictions, where are the particular problem areas for child welfare and MCO's, how does service differ across age groups, who is most at risk of having unmet service needs including unmet dental services (e.g., individuals with certain needs), and what are barriers to best practice (e.g., culture and climate, policy, lack of knowledge and skills). Results of the RCA will identify problem areas for development of targeted strategies and plans

for program improvements. With the support of the Health Workgroup, the agency plans to begin this work by late summer 2021 and determine strategies based on the results by the end of 2021.

Technical assistance (TA) provided to the LDSS included MCO's and Maryland's state dental provider Skygen, LLC identifying specific jurisdictional challenges and potential solutions that can be supported at a state and local level. MCO's and Skygen, LLC sharing updated health provider directory lists, discussing the role of the SNC (supportive partner for caseworkers to ensure the child's health needs are met), and attending LDSS program staff meetings have been crucial to improving health outcomes.

Table 15: 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 2021
Conduct monthly 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.	March 2022
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.	June 2022

Systemic Factors

Systemic Factors include a number of areas that support the functioning of the state's child welfare system. Listed below are updates on any current or planned activities targeted at improving performance or addressing areas of concern identified for each systemic factor.

Statewide Information System

Analysis of performance:

As with Maryland's previous data system, CJAMS includes a section to capture basic demographics for every individual including date of birth, gender, race and ethnicity, and the address where they are living or where they were last living prior to entering foster care as well as descriptive data about the person. This section is also where the program assignments (Child Protective Services, Family Preservation, Foster Care) are documented, along with the start and end dates for that program. For children in foster care, there are sections for child removal and placement to include removal history, current placement along with the history of all placement dates and types and the start and end dates documented for each placement. If the placement is a treatment foster care program, the information includes not only the agency's address but also the specific treatment foster home information.

While there are areas in CJAMS for workers to enter data, it has been much more difficult to extract the data accurately. There have also been enhancements/changes in CJAMS in the 18 months since October 2019 when it was initiated in the first Maryland jurisdiction which also include new areas within the child welfare module. Report development and/or improvements

have taken much more time than anticipated, which has affected the ability of SSA/LDSS to monitor and ensure the accuracy of the data. Report logic errors have made it difficult to validate information that has been entered in CJAMS; case workers and supervisors are able to identify information in CJAMS that reports might show as missing. This has been done through data validation as well as review of the Out-of-Home (OOH) Milestone report which is produced daily for LDSSs. There have been weekly meetings since the spring of 2020 to discuss data inaccuracies which include basic case worker activities such as assessments, court hearings, case plans and education/health data in the report along with reviewing CJAMS to ensure that the data is entered and that it is accurate. Meetings also allow for the review of changes in Milestone reports to ensure changes are providing accurate data. These meetings include representatives from all jurisdictions along with MD THINK report staff and application representatives. In addition, additional reports development meetings have occurred bi-weekly for the last quarter of CY2020 to review new reports that can also ensure accurate data for all children served in Maryland.

Collaboration with the MD THINK teams working on the CJAMS application, Qlik reports and SSA continue to adapt and change as necessary to monitor and identify stories to continue to improve CJAMS and its functionality.

Strengths:
Many individuals at the local level have been willing to engage in a variety of meetings/sessions to discuss challenges and to troubleshoot and share knowledge about CJAMS and how it is working for each. This local input and commitment have been valuable to improving CJAMS and to ensure that progress continues to move forward in ensuring that functionality and accuracy meet CCWIS requirements. CJAMS basic functionality allows for basic information about children and their families, service planning, information about out of home placements, court information and contacts with families and children to be documented. Workers can access the application remotely allowing for documentation to occur in real time. It does appear that CJAMS does have better flow, allows for workers to see the number of days a case has been open and has worker and supervisor dashboards that allow for better monitoring of workload and approvals by differentiating them by type. There is also much greater collaboration between MD THINK and individual users when they report defects to the system allowing for quicker resolution of isolated, individual issues. Report census has improved due to the weekly meetings with local departments and review of front and back end data in CJAMS.

Concerns:
CJAMS is only one of the applications that MD THINK is working on in Maryland and as each application is rolled out, resources are shifted to the next application. This means that it is taking more time to create and implement enhancements that are needed to improve the functionality of CJAMS Child Welfare and Provider modules. Many Qlik (report platform) reports were initially created by just trying to modify the reports from Business Objects (MD CHESSIE report platform). As many of these older reports needed modification even before moving into CJAMS, it is necessary to revise most of the Qlik reports that have already been produced. Most of the past year has been focused on identified defects and this has not led to the desired outcomes. Milestone reports (used by most supervisors to monitor casework) improvements have focused on ensuring the accurate census for each of the programs and then to actual caseworker activities.

A new process to address reporting needs has just been identified which will involve reviewing modification/adaptation needs for all reports in production, those that need to be developed and those reports that are desired that were not previously identified which will allow the reporting team to determine the time frame for these reports. Basic monitoring reports are being prioritized with others further back. This also includes ensuring that federal reports are accurate. It is anticipated that it will take at least 6 months to get to all previously identified reports completed. An updated data catalogue/dictionary is also being requested to help identify what data tables the data in CJAMS is being stored in to ensure that the correct data is being included in reports. As changes have been made to the CJAMS application, it has been necessary to make modifications to the logic used to derive the data from the data tables to create reports and to obtain data for analysis. It has not been possible to keep using the same report logic in all circumstances.

Activities to Improve Performance:
Table 16 below outlines activities to improve performance in the Statewide Information System.

Table 16: 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
2019 Progress: ***In Progress*** During 2019 both Full Data Council meetings (January 17, April 12, and October 12) and Cross-Functional Data Council meetings (May 17, September 13, November 22) were held to focus on various aspects of data standards, data security, and data sharing. The results from the work during 2019 are as follows: ● Data Standards – Twenty (20) data elements have been identified to be standardized across agency information systems, and the timetable for achieving conformance has been extended in order to enable smooth data migration from legacy to new modern systems, including CCWIS. CCWIS is part of a three-program implementation (Child Welfare, Adult Services, and Juvenile Services), and at this time only the first of these CCWIS, has been launched. There will be more progress on reaching conformance during 2021. ● Data Security – Progress was reached for two key areas of data security for CJAMS: Single Sign On and Role Based Access Control (RBAC). These security features, it should be noted, have been refined and improved in 2020, however, basic sign on and roles functionality were launched in relation to the first implementation of CJAMS (Washington County, October 28, 2019). ● Data Sharing – Progress has been made in identifying the need for MOU (Memoranda of Understanding) among agencies. Details concerning the data interfaces needed were identified during 2019, in the form of bidirectional interfaces to be established between DHS/SSA and the Courts, Family Investment Administration (FIA), Medicaid/Behavioral Health/Psychotropic Medications/Vital Statistics (Maryland Department of Health), Education, Labor, Aging, Providers, and the Federal Social Security Administration. In addition, Maryland has successfully integrated data from the new CJAMS CCWIS into its ongoing federal program reports: NCANDS, AFCARS, Caseworker Visitation, and NYTD. 2020 Progress: ***In Progress*** During 2020 both Full Data Council meetings (January 24, July 24, October 23) and Cross-Functional Data Council Meetings (June 26, September 25, December 4) were held which focused both on data sharing, security and sharing as well as the implementation/roll out of the Child Welfare and Provider Modules throughout the course of the year along and how these interact with the larger MD Total Human-services Information Network (MD THINK).	

Current or planned Activity to improve performance	*Target completion date*
● Data Standards - These discussions not only concerned data standards for the CJAMS itself but also for MD THINK. Data migration occurred at various points throughout the first part of the year into the appropriate modules, Child Welfare (January - July 2020) and Provider (July 2020) from the SACWIS. There are 20 data elements identified for standardization throughout MD THINK and this will continue until all agencies become part of the larger system. One challenge has been the creation of "duplicate clients" which has involved a great deal of discussion to identify ways to resolve the issue as this can affect all agencies connected through MD THINK. At the end of CY2020, a data catalogue for the Child Welfare module of CJAMS was provided to SSA however there are modifications to the catalogue that are necessary before child welfare staff can provide details regarding the data elements. During December 2020, a data steward list was created to provide clarity of roles and responsibilities regarding establishing and maintaining data standards. There is also a guidance chart providing directives for executive, program, and IT stewards; the delayed implementation timelines will result in greater progress towards reaching conformance during 2022. ● Data Security - With all child welfare jurisdictions migration to CJAMS by the end of July 2020, DHS/SSA worked with partners at OTHS and MD THINK to approve the first version of the Role Based Access Control (RBAC) which was used as part of the launch for CJAMS. A working group was established under SSA's Systems Development team to hold periodic calls to address unforeseen scenarios related to SailPoint, the new software applications used for secured registration, as well as needed updates to the RBAC. This working group includes SSA Security Monitoring Team, OTHS Security staff and MD THINK application staff. OTHS began providing training sessions to socialize and train the security requirements of SailPoint and evaluation continues to ensure appropriate access for external contractors as well as various staff at SSA and the LDSSs. ● Data Sharing - MOU development continues with about half of the external MOUs created. The internal MOUs and the other external MOUs are in progress and concern elements of CJAMS and other parts of MD THINK that continue to be developed. Reporting processes are being developed in Qlik to share within DHS with external data sharing needs also being evaluated.	
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
2020 Progress: ***Delayed*** ● The State/local Modernization Network ended up being cancelled shortly after the beginning of the CY2020 in its formal structure. This was done in order to allow for focused participation on the work in relation to implementing the Child Welfare and Provider Modules within CJAMS along with validation of data migration efforts with MD THINK and the LDSSs. ● Throughout the course of CY2020 there were many groups/meetings convened to discuss the challenges around implementation along with making recommendations for improvements to CJAMS. Some of the groups have included members of the Modernization Network and others have included daily systems users to get their feedback about concerns and improvements. o Some of these groups were time limited and others continued past the end of CY2020. The focus of the groups continues to evolve as necessary to meet the needs of the local departments along with the enhancements/improvements to CJAMS. ● The Modernization Network will be repurposed to support current needs and expectations by users of the system during CY2021.	
Selected data elements will be reviewed as part of the CQI (Continuous Quality Improvement) and CFSR reviews that will be conducted on an ongoing basis, for data accuracy, reliability, and timeliness.	2021/monitored monthly
Develop data sharing master agreements that are coordinated through the Data Council to build trust among participating member agencies.	2022/monitor quarterly

Current or planned Activity to improve performance	*Target completion date*
Standards for Data Clarity	
Establish clear definitions of data elements and picklist values; and distribute data definitions throughout the interagency structure.	2022/monitor quarterly
Provide training and support on an ongoing basis in order to reinforce the reliable use of data elements.	2022/provided and monitored quarterly
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
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
Employ Master Data Management tools across the interagency structure to avoid duplicated clients and services.	2023/monitored monthly
Development of SmartLists to guide CJAMS users on upcoming priorities, helping them to plan their work time and address needs in a timely manner.	2023/provided and monitored quarterly

Case Review System

The case review system addresses the following areas to ensure that:

- Each child has a written case plan that is developed jointly with the child's parent(s) and includes the required provisions,
- A periodic review for each child occurs no less frequently than once every 6 months, either by a court or by administrative review,
- For each child, a permanency hearing in a qualified court or administrative body occurs no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter,
- The filing of termination of parental rights (TPR) proceedings occurs in accordance with required provisions,
- Foster parents, pre-adoptive parents, and relative caregivers of children in foster care are notified of, and have a right to be heard in, any review or hearing held with respect to the child.

Written Case Plans

DHS/SSA uses a few strategies to ensure that DHS/SSA engages families jointly in the development of case plans. The use of family involvement meetings is a primary mechanism outlined in policy as a practice expectation to ensure family engagement in key decisions. Monitoring data through CCWIS and self-report of jurisdictions throughout the State is used to measure how well the state is performing this case review function. Surveying families about satisfaction with and engagement in the development of written case plans practices through the bi-annually administered Family Involvement Meeting (FIM) feedback survey and Maryland's Continuous Quality Improvement focus groups, assists in monitoring how well FIMs are practiced. Case plans are required in policy for every family served in family preservation and foster care. DHS/SSA policy requires that Family Involvement Meetings

take place at key decision points including when considering separation of a child from their family; during youth transitional planning; when a change in placement is being considered; and when a change in permanency plan is being considered. Family Involvement Meetings (FIMs), also known as Family Team Decision Meetings (FTDMs), are used to collaboratively identify options, goals and steps that are used to work toward consensus and serve as a basis for the development of written case plans. The meetings are designed to include parents, children, youth, families, emerging adults, and their natural and community supports. Data has been monitored monthly through CCWIS and self-report data of local jurisdictions.

Assessment of Performance:
Child and Family Services Review data from 2020 reflected improvement in well-being item 13, parent involvement in case planning. Between periods 4 and 5, as an area rated a strength, this item increased from 24.39% to 47.5%. This exceeded our PIP target of 39%. As Family Involvement Meetings are a primary strategy for collaborating and jointly developing written case plans with families, success in these interventions contribute to outcomes reflected in data collected. Currently staff comprise a ratio of 38.9% of all FIM participation compared to 61.1% of children, youth, families, natural and community support participation, which is slightly higher than 2019 when child, youth, families, and natural and community supports made up 60% of FIMs. Our target ratio of participation rate for children, youth, families and natural and family supports is 70% to 30% staff, which speaks to the increased need for continued teaming and engagement with families. A FIM Feedback survey was administered statewide in March 2020 as well as October 2020. Of the 814 respondents who were family members, 49% were parents. The results indicated that 87.4% of families agreed or strongly agreed that they had an opportunity to share their thoughts and opinions at the meeting, which is a slight increase over last year's rate of 86%.

Family engagement in written case plan development was addressed in focus groups conducted by the University of Maryland Ruth Young Center as part of Maryland's continuous improvement process in October 2020. Workers as well as families were interviewed. Families indicated that FIMs were a process of collaboration in planning. However, it is important to note that outside of FIMs families may not feel fully included in the case planning process. Workers who participated in the focus groups indicated that they found it difficult to balance the goals required of the system with those of the family. A trend that emerged was that there was a high connection with court expectations and written service plans. At the same time, they also expressed that family involvement meetings are relied upon in the system to facilitate collaboration with families.

Strengths:
Results from the 2,409 FIM Feedback surveys administered CY2020 show a high overall satisfaction rate amongst FIM participants (youth, families, community supports, and staff), a high rate of satisfaction of the services that were offered through the FIM process, 87.4% of families also agreed or strongly agreed that they had an opportunity to share their thoughts and opinions at the meeting. This rate increased slightly over last year's rate of 86%.

Concerns:
There is a concern about the staff to family member ratio in FIMs. This discrepancy seems reflective of the need to improve engagement and teaming practices with families. It is hoped

that training the workforce in the Integrated Practice Model will improve FIM family and natural support participation rates, and more importantly, improve the use of teaming as a core practice throughout child welfare system involvement. Our current theory of change around FIM participation is that improved engagement and teaming skill building of the workforce will lead to increased participation of family and community supports in FIMs and increased use of FIMs at key decision points.

Plan to Improve Performance:
A strategy to address these concerns has been the implementation of the Integrated Practice Model which began in July 2020 with the introduction of Module 2: Teaming in August 2020. In addition to the training, an IPM Learning Collaborative offering coaching to supervisors that focused on engagement and teaming began in August 2020. Training and coaching will continue across the State in 2021 and are expected to support continued increases in engagement and participation of families, youth, children, vulnerable adults and their natural supports in FIMs.

DHS/SSA is working toward improving the rate of involvement in case planning through capturing not only the rate of completion of FIMs at critical decision points, but also with capturing more specific qualitative data related to collaborative practices in family teaming and case plan development in CY2021.

Periodic Reviews, Permanency Hearing, Termination of Parental Rights (TPR), and Notice of Hearings
Periodic review and permanency hearings are scheduled in coordination with the court, attorneys, and local staff. Periodic review hearings are scheduled at the previous hearing to support a 6-month cadence while permanency hearings are scheduled every 10 or 11 months to consider any scheduling conflicts or continuances. In addition, the state has emphasized the importance of data accuracy and quality regarding the different types of court hearings and reviews, along with information regarding timeliness of permanency hearings (including TPR filings), and hearing notifications to foster parents. DHS/SSA experienced difficulty in extracting a number of data elements to support the State's understanding of performance and functioning as the state transitioned to a new data system in CY2020.

Period Reviews
Analysis of the data:
In the last quarter of 2020, DHS/SSA began to assess the accuracy of documenting periodic reviews in CJAMS by extracting data from CJAMS and comparing the number of periodic reviews that were documented with the number of periodic reviews that should have occurred. Table 17 below indicates the documentation of periodic reviews highlighting those jurisdictions missing documentation indicating lack of data entry or the hearing is overdue. During CY 2020, 3,760 youth should have received periodic reviews however only 434 (11.55%) youth had a periodic review hearing documented in CJAMS. Out of the 15 LDSS reviewed, four (Baltimore City, Prince George, Montgomery and County) have demonstrated higher levels of inaccuracies in their data related period reviews.

Table 17: Jurisdictions with Periodic Review Documentation Errors

Jurisdiction	Number of Youth where period review was documented	Total Number of Periodic Reviews that should have occurred	Current Error %
Anne Arundel	22	116	19%
Baltimore City	253	1922	13%
Baltimore County	4	43	9%
Calvert	2	60	3%
Carroll	8	59	14%
Cecil	1	126	1%
Dorchester	1	12	8%
Frederick	4	80	5%
Harford	13	227	6%
Howard	1	61	2%
Montgomery	92	427	22%
Prince George's	18	422	4%
St. Mary's	1	73	1%
Washington	13	108	12%
Wicomico	1	24	4%

Data Source: CJAMS November 2020

Strengths and Concerns:
Although DHS/SSA was able to obtain preliminary data on periodic reviews during this reporting period from 15 of the 24 jurisdictions, an ongoing systematic approach has not been finalized and the findings still do not demonstrate systematic functioning. SSA is providing technical assistance to the LDSS to improve upon documenting when periodic reviews occur. As such, the state must further explore how we will obtain this data in order to assess periodic reviews occurring timely.

Plans for Improvement:
DHS/SSA plans to finalize data reports allowing for regular access and review of the timeliness of periodic reviews in the next reporting period.

Permanency Hearings
Assessment of Performance:
As with periodic review hearings data, DHS/SSA experienced similar challenges with extracting data from CJAMS. Despite these challenges, DHS/SSA has been reviewing the CFSR data that would be most impacted by the timely permanency hearings. DHS/SSA remains below the target of 60% on Item 6 Achieving Reunification, Guardianship, Adoption or other Planned Permanency Living Arrangements, with 24.7% of cases reviewed rated as a strength. In addition, the state is examining the impact of court closures in response to COVID-19 has on the ability to hold permanency hearings and ultimately achieving timely permanency.

Strengths and Concerns:
While DHS/SSA has initiated the exploration of available data to extrapolate the timeliness of permanency hearings, the state is aware that this data does not fully address this issue. More

appropriate data has been difficult to extract from the new data system as the state transitioned to statewide implementation in CY2020.

Plans for Improvement:
While DHS/SSA integrated ticklers and a reporting system into the new child welfare data system to capture permanency hearings and ensure they are occurring, the state is not able to extract the data from the system at this time. The state is working to be able to extract this data in the next reporting period to ensure the ticklers are working. The DHS/SSA program leadership did meet with the LDSS on a weekly basis to provide updates regarding the integration into the new system and address any anticipated barriers and challenges. DHS/SSA has initiated discussion of this challenge within the Permanency Workgroup and is currently strategizing on ways to further address the challenge regarding resource parents being informed of court hearings.

Terminating Parental Rights (TPR)
Assessment of Performance:
DHS/SSA continues to have limited ability to track the timeliness of filing TPR petitions as the LDSS attorneys file TPR petitions; which does not always involve the input of a caseworker, thus leading to the caseworker's lack of knowledge about the actual TPR petition date. In addition, DHS/SSA has been unsuccessful in obtaining TPR filing data from the court liaisons. While CJAMS includes functionality to track the filing of TPR, DHS/SSA has experienced difficulty in extracting accurate data due to the transition to the new child welfare data system.

Strengths and Concerns:
In CY 2020, DHS/SSA, via the Permanency Workgroup, initiated a discussion regarding the desire to understand timeliness of youth's TPR filings. This discussion provided qualitative feedback from the LDSS and Permanency Workgroup members, which includes CIP, indicating that there are delays in TPR filings which may be resulting in foster youth's permanency not being achieved timely. To better understand this hypothesis and determine any potential root causes, additional data from the courts and the LDSS such as the number of TPR filings and the dates in which the filings have been requested from the courts and CJAMS to support a more complete analysis. DHS/SSA continues to be aware that changes need to occur with regards to data availability for timeliness of TPR filings. This impact has directly reflected the decrease in permanency to adoption.

Plans for Improvement:
DHS/SSA is developing plans to obtain the needed quantitative data for the next reporting period. A request has been made to the CIP to request specific data on TPR filing. In addition, the Permanency Workgroup is working to develop a survey of the LDSS to determine what the root causes could be for TPR filing delays.

Notification of Hearings
Assessment of Performance:
DHS/SSA is still in the process of developing a systematic way of ensuring that caregivers are notified of court hearings. DHS/SSA has met with the LDSS leadership as well as the Maryland Resource Parent Association and the Maryland Foster Parent Ombudsman to ensure that

caregivers are aware of their right to be notified and be heard at all court hearings regarding youth in their care. MRPA provides education to resource parents via monthly educational webinars and local resource parent association meetings. Due to COVID, the annual survey was not conducted at the Spring/Fall 2020 Resource Parent Conference as the conferences were not held. In addition, due to COVID-19, the courts in Maryland were closed thereby eliminating any hearings that Foster Parents would have normally received notification.

Strengths and Concerns:
With the development of a new child welfare information data system, a notification tickler has been developed to indicate when notification of court hearing has been sent to resource parents. DHS/SSA is currently working with the LDSS to document when resource parents actually received the notification. DHS/SSA is continuing to determine the effectiveness of the ticklers in the system and fully implement an approach to LDSS documentation of notifications of hearings.

Plans for Improvement:
DHS/SSA will need to ensure through technical assistance that local jurisdictions strengthen parental involvement, are cognizant of data entry to ensure data collection and that DHS/SSA develops a reliable process for timely hearing notifications. DHS/SSA is currently working on a more standardized process of how the LDSS can ensure resource parents, pre adoptive parents, and relative caregivers are notified of court hearings and documentation to ensure those parents were given the right to be heard in judicial proceedings. Due to the impact of the pandemic, DHS/SSA did not have an Annual Resource Parent Conference for Spring or Fall of 2020, the vehicle by which parent surveys are typically distributed. DHS/SSA does plan to resume surveys in the Spring of 2021. In addition, SSA plans to have the LDSS resource home workers forward the survey to resource parents in Winter of 2021.Table 18 below outlines the CY2020 status of additional activities identified to improve performance in Case Review systemic factor.

Table 18: Activities to Improve Performance

Current or planned Activity to improve performance	Target completion date
Targeted Regional Meetings with LDSS staff and Affiliate meetings to identify and resolve barriers to notifications.	Semi Annually
2019 Progress: ***In Progress*** ● DHS/SSA is currently in the development stages of adding the court related activities above to CJAMS. Once this is completed, SSA can begin to track/monitor these activities. ● DHS/SSA is in the second year of working with the Capacity Center for states regarding Foster Parent Engagement. Activities which have taken place thus far include: ○ October 2019: Completed a root cause analysis and identified the needs for resource parents in the state. ○ November 2019: Developed a theory of change using analyzed data collected. ○ Upcoming activities include an assessment of the Maryland Resource Parent Association by developing and disseminating a survey and the development of family teaming practice profiles to ensure the resource parents' voice is heard. 2020 Progress: ***In Process*** ● DHS/SSA is still in the developmental stages of tracking court related activities in DHS/SSA is hopeful that more data will be available during the next reporting period. Due to the new system integration DHS/SSA	

Current or planned Activity to improve performance	Target completion date
has been unable to address the notification barriers directly with quantifiable data, however SSA has developed a working tickler with CJAMS to be able to report out data regarding the timely notifications of hearings. SSA continues to inform the LDSS leadership via business objects regarding the status of the notification of court hearings. In addition, SSA has initiated discussion of this challenge within the Permanency Workgroup and is currently strategizing on ways to further address the challenge regarding resource parents being informed of court hearings. A root cause analysis was conducted regarding timeliness of TPR filings and additional data has been requested from the courts. In addition, the Permanency Workgroup is currently in the process of requesting TPR filing data from CJAMS as well.	
Improve data input through development of the court domain within CJAMs that allows for the appropriate differentiation between court hearings.	2020/Quarterly reviews
2020 Progress: ***Delayed*** Court hearing information is included in CJAMS however the state has experienced delays in extracting and validating data pulled from the system.	
Provide training and Technical Assistance (TA) with the Local Department of Social Services (LDSS) on the differences between court hearing types to ensure accurate documentation and understanding.	2020/Quarterly reviews
2020 Progress: ***Delayed*** DHS/SSA is delayed in providing technical assistance to the locals on court hearing differences due to hiring freezes but in place during the COVID-19 pandemic resulting in the ability to fill vacancies. These staff shortages also impacted DHS/SSA's ability to provide virtual trainings on court differences due to resource home staff shortages.	
Continue to work with Foster Care Court Improvement Project (FCCIP) on court data and connecting DHS/SSA with the information more easily.	2020-2024 (semi-annually)
2020 Progress: ***In Process*** DHS/SSA continues to work with the FCCIP on obtaining TPR and permanency review hearing related data. This information has been requested by the court liaison as well as the LDSS. There is FFCIP representation on the Permanency Workgroup and court related feedback has been provided on the barriers to accessing court data. DHS/SSA is working with FFCIP to develop a plan to address any barriers.	
Ensuring supervisors have access to Business Objects to access monitoring reports and understand how to use these reports.	2020
2020 Progress: ***Completed*** During CY2020, LDSS supervisors continued to have monthly access to Business Objects/Qlik to monitor reports and technical assistance in the form of meetings for question and answer sessions.	
Add additional data fields in CJAMS to monitor TPR filing, compelling reasons not to file, reassessment of reasons.	2020/semi-annual reviews
2020: ***In Process*** December 2020: DHS/SSA has included data tickler fields to monitor TPR filing, compelling reasons not to file, and reassessments in CJAMS. DHS/SSA has been unable to monitor the effectiveness of the tickler fields due to delays in extracting and validating data pulled from the system.	
Develop a unified process in CJAMS for hearing notifications.	2020
2020 progress: ***Completed***	

Current or planned Activity to improve performance	Target completion date
December 2020, notification of hearing tickler was placed in CJAMS. DHS/SSA will review and test to ensure the notification is working correctly.	
Develop a monitoring system for hearing notifications ● Review resource home records in MD CHESSIE/CJAMS. ● Contact LDSS, ask if the caregiver was notified about the hearings, and request documentation from LDSS via contact notes. ● Contact resource parent, ask if the notification was received from LDSS.	2020/quarterly
2020 Progress: ***Delayed*** DHS/SSA experienced staff shortages during COVID-19 as a result of a statewide hiring freeze. Due to these ongoing vacancies monitoring and technical assistance related to notification of hearings has been delayed. Virtual trainings on court differences due to resource home staff shortages.	
Develop a unified process in CJAMS for hearing notifications.	2020
2020 Process: ***Completed*** December 2020: Process was developed in CJAMS to indicated when court hearings have been documented.	
Develop a monitoring system for hearing notifications.	2020
2020 Progress: ***Delayed*** DHS/SSA has been unable to develop a monitoring system in CJAMS to report data during this period.	
Partner with Capacity Center for States around foster parent engagement.	2021

Quality Assurance System

Assessment of Performance

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.

Maryland has a quality assurance (QA) system that is functioning statewide and aligned with federal standards. DHS/SSA has performance measures for safety, permanency and well-being outcomes, known as Headline Indicators. DHS/SSA generates and distributes dashboards reflecting statewide and local department performance regularly. To elucidate the practice that may impact the performance on the Headline Indicators, Maryland continues to conduct qualitative case reviews (MD CFSRs) monthly in a small, medium, or large jurisdiction 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 2020, 10 local departments were reviewed spanning the two review periods: Prince George's, Cecil, Dorchester, Baltimore City, Charles, Washington, Somerset, Kent, Caroline, and Harford. Maryland is currently in period 7 of the ongoing case review process. Maryland implemented stakeholder focus groups in October 2020. 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 2021.

The MD CFSRs use 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 that 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 results.

Strengths
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. These discussions are critical for identifying trends across program and service areas and assessing progress meeting performance goals. During these discussions, stakeholders reflect on practice strengths and barriers to performance and specify contributing factors and root causes to further analyze and address in improvement planning conversations. The CQI Unit develops and shares presentations and summary analysis of local and statewide CFSR performance each quarter to LDSS and SSA leadership. 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.

Over the last year, Maryland completed development of a QA Review process with local departments of social services (LDSS). This process includes semi-annual reviews for all service areas, with the exception of protective services which are reviewed quarterly, allowing each LDSS to critically assess the quality of practice and local level processes. This initiative involves case-level and resource-provider level reviews to support an ongoing understanding of LDSS performance related to national and statewide standards. These efforts will inform opportunities to improve practice and ensure quality service delivery for children and families receiving CPS, Family Preservation, and Foster Care services. In addition, these reviews facilitate targeted course corrections where needed in local jurisdictions. 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 across Child and Family Services Review (CFSR) 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 LDSS to monitor their own performance to guide locally driven and developed improvement efforts.

Plans for improvement
Over the next year, Maryland will enhance the evidence we use in CQI by implementing 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. Maryland will also fully implement the LDSS Quality Assurance review protocol to identify key process and policy compliance. SSA will continue to work with local departments to strengthen their local CQI practices and increase access to CFSR outcomes by internal and external stakeholders.

Staff Training

The staff training system addresses statewide functioning of a training system that includes initial and ongoing training for all staff who deliver services pursuant to the CFSP and includes the basic skills and knowledge required for their positions.

Pre-Service

DHS/SSA through its partnership with the Child Welfare Academy (CWA) continues to provide pre-service training for all newly hired child welfare workers and supervisors throughout the state. Pre-service training is mandated by state legislation and is designed to enhance worker knowledge of child welfare theory, policy, research and practice, and build upon worker competencies and skills to prepare them for the child welfare workforce. Participants must take a standardized competency exam following training, and upon passing with a 70% or higher score, are able to serve children and families in their respective jurisdictions. Beginning in March 2020 pre-service training was transitioned to a virtual format in response to the COVID-19 pandemic to ensure any new staff were able to receive the necessary pre-service training. In addition to shifting to a virtual format, DHS/SSA completed a redesign of its pre-service training system with the goal of enhancing how well the state prepares new staff to carry out the duties of their position. Due to this shift, the data provided reflects the original pre-service provided as well as the redesigned pre-service.

As part of the original pre-service format a total of six pre-service sessions were offered between January and August 2020 with a total of 152 staff completing the original training series. Data from the CWA 2019 and 2020 Annual reports show that 92% (N=152) of participants were satisfied with the overall quality of the training series, and 90% (N=152) believed the training was impactful and relevant to their current work. Additionally, 82% (N=152) felt confident that they would be able to integrate what they learned in training into their work within two months of completing the training.

These ratings align with previous evaluation periods (CY2018 and CY2019) which consistently show a 90% or above satisfaction rating with quality and applicability of the pre-service training. The CY2020 data results also coincide with qualitative data from the SSA-CQI 2020 Focus Group Report where participants described the overall quality of pre-service training as timely, informative and pertinent to their work.

The redesigned pre-service training series was completed and launched in September 2020. The series infuses the values, principles and core practices of the IPM throughout the curricula and training modules. There is also a stronger focus on issues of Secondary Traumatic Stress, Safety Culture, Social Justice and Racial Equity. In addition to classroom instruction, e-learning, field experience and simulation activities have been added to support the transfer of learning for staff. Two “new” sessions were offered between September and December 2020 with a total of 32 participants completing the training.

A Pilot Progress Report was completed by the Child Welfare Academy in January 2021 to evaluate the success of the first two pre-service cohorts/sessions. Data from the report showed that 94% (N=32) of participants indicated that they were very satisfied with the overall quality of training and newly added instructional and learning modalities. Equally, 94% (N=32) of

participants indicated that they believed the training prepared them to effectively perform their work duties. Additionally, 86% (N=32) of participants felt confident that they would consistently apply what they learned in training into their work. Qualitative feedback from the Pilot Progress Report showed that while participants were satisfied with the quality of training, and valued the training content, several participants believed the extended time of the series (now 8 weeks rather than 6 weeks) was too long and that some content was repetitive.

A total of 184 new child welfare staff were hired in CY2020 (inclusive of 152 staff from the original training series and 32 staff from the redesigned training series) and completed the competency exam. Data from the CWA 2020 Annual Report shows that 92% (N=184) of staff passed the exam on the first attempt, 6% passed on the second attempt and 2% did not pass the exam after the allowable 3 attempts. Annual Reports show that the majority of pre-service participants (above 90%) pass the competency exam with the first attempt. This has been a consistent outcome for 3 consecutive years.

From January to August 2020 new hires continued to be trained under the Maryland CHESSIE (Maryland Children's Electronic Social Services Information Exchange) database system to input and monitor child/family progress. However, with the roll out of CJAMS (Child Juvenile and Adult Services Management System) in 2020, the pre-service redesign included the successful integration of CJAMS.

Following pre-service training, the Foundations Training is also required for newly hired child welfare staff. This series offers more in-depth training in the child welfare specialization areas including Child Protective Services, Family Preservation, Foster Care, Adoptions and other Permanency and Placement Services. Other Foundations courses include Human Sex Trafficking and a Secondary Traumatic Stress series. The LGBTQ Competency Training will also be rolled into the Foundations curriculum. The Foundations series will continue to be modified by the redesign team to better meet the training needs of staff. One major change in the series is staff must now complete the Foundations track within one year of completing pre-service rather than the two-year period that was previously allotted. This change will help build a knowledgeable, informed and prepared workforce more expediently.

Strengths:
Ratings for overall satisfaction with pre-service training remain consistently favorable. Moreover, staff continue to evaluate the training as relevant to their work. It is also evident that the pre-service training adequately prepares the majority of staff to pass the competency exam and assume their casework duties. Both quantitative and qualitative data from several reporting sources (CWA Annual Reports, CQI Focus Group Report and Pre-service Pilot-Progress Report) indicate that a quality and effective pre-service training series is in place to successfully train/educate and prepare newly hired child welfare staff.

Concerns:
While satisfaction ratings of the pre-service training remain high, it should be noted that evaluations are administered immediately after training is completed. So, while staff are able to evaluate the quality of training presentations and have the initial belief that training is relevant to their work, interim processes need to be implemented to evaluate.

There is also incongruence between the number of staff who complete pre-service training and those who complete the Foundations training. The time allotted to complete the Foundations Training is two years and staff have stronger completion rates of the courses that are offered immediately after pre-service. Foundations completion rates will continue to be tracked quarterly and reports will be provided to SSA and LDSS Leadership to assist with tracking staff completion of the full series.

Ongoing Staff Training

A comprehensive in-service training series is offered to meet the on-going and more specialized training needs of child welfare staff. The 2020 in-service training catalog offered 215 distinct courses to 4,259 (duplicative count) staff participants throughout the year (CWA 2020 Annual Report). Favorable attendance numbers suggest that staff are taking advantage of the trainings available to them. In March 2020, all in-service courses were transferred to a virtual format due to the COVID-19 pandemic. Though still a vigorous training series, there were noticeably fewer in-service courses offered this CY than in previous years. This is largely due to the integration of the IPM into the training series, and the accelerated rollout of this priority training. The high enrollment for this training required multiple courses to be offered in close succession. Interim Progress Reports from the CWA show that 66 IPM trainings were offered between July-December 2020 with 2,092 staff (duplicative count) participating in the training modules. Of the approximately 3,200 staff, 1,125 staff participated in Module I: Authentic Partnership and Engagement, 745 staff participated in Module II: Teaming and 222 staff participated in Module III: Assessing, Planning, Intervening, Adapting and Transitioning. The IPM trainings are offered and must be completed in sequence. At the end of the reporting period many staff were at the beginning of the IPM training cycle (Module I). We expect that those who completed the first module will complete the required 2nd and 3rd modules during the next reporting period.

In addition to the IPM, the in-service series offers a host of courses to support child welfare practice and skill building to include ethics, trauma responsive intervention, family violence, grief and loss, effective assessment and motivational interviewing. Trainings also support various DHS/SSA initiatives including the Substance Exposed Newborns (SENS) Policy, LGBTQ Competency, and Human Trafficking. Courses were also added to support worker resiliency and Secondary Traumatic Stress particularly related to the COVID-19 crisis. In-service training supports the licensing renewal requirements for Bachelor's Level Social Worker, Master's Level Social Work, Certified Social Worker and Certified Social Worker-Clinical by providing Continuing Education Units (CEU's) for training hours completed.

Data from the CWA 2020 Aggregate In-service Training Report shows that 96% (N=4,259 duplicative count) of participants who submitted evaluations believed that in-service trainings provided them with useful information that would make them a more effective worker or supervisor. Similarly, 93% (N=4,259 duplicative count) of participants who submitted evaluations indicated that trainings they completed were relevant to their work, and 87% (N=4,259 duplicative count) of participants who submitted evaluations felt confident that they would be able to integrate what they learned in training into their work within two months of completing the training.

These satisfaction results are corroborated by qualitative data from the Continuous Quality Improvement 2020 Focus Group Report. Respondents indicated that they were very satisfied with the quality, accessibility and breadth of the in-service training series. They further shared that the IPM trainings were particularly informative, and that some trainings taught specific skills such as effectively engaging families and community partners which would be beneficial in their work.

Focus Group respondents also shared concerns. While some were appreciative of the robust training series, others expressed "training overload" and believed that required trainings interfered with other important duties. Respondents' feedback on the CJAMS Training was also varied. Some believed the training was informative, well presented and easy to comprehend while others believed the training was complicated and required technical expertise that some workers may not have. Others expressed that the sessions were overcrowded making it difficult to ask questions or seek clarity on training content.

Work to improve the in-service training series continues. In July 2020, the Workforce Development Network (WFD) began reviewing existing in-service training modules to ensure content and language alignment with the IPM. There are approximately 350 in-service training modules that need to be reviewed. This structured review process will continue with the goal of reviewing 100 current and newly added in-service courses per year. The in-service training catalog will also continue to be updated annually.

Strengths:
The in-service training series continues to cover a wide spectrum of content to support SSA and local department initiatives and meet the diverse training needs and interests of staff. Staff registration and attendance rates remain favorable.

Data from the CWA Annual Report and CQI Focus Group Report reinforce that a significant number of staff are satisfied with the overall quality of in-service trainings and believe trainings are relevant to their work. This indicates that the series is effectively meeting staff knowledge and skill development needs and ultimately strengthening the child welfare workforce.

There were several mandatory in-service trainings offered in CY2020. These include the IPM, CJAMS, and LGBTQ Competency training sessions. These trainings were tracked by the DHS-LMS (HUB) or CWA-LMS (Idealist) for registration, attendance, and completion. The completion numbers for the IPM training during CY 2020 are highlighted above in the On-going staff training section of this report. Similarly, according to the DHS-LMS interim tracking report, 55 CJAMS sessions were offered between July to December 2020 with 1,674 of the estimated 3,200 state child welfare staff completing the training during this period. Also, according to the CWA quarterly attendance spreadsheet, 288 child welfare staff completed the LGBTQ Competency Training in CY2020. This attendance rate is on par with previous years with 295 staff completing the training in CY2019 and 301staff completing the training in CY2018. There are approximately 1,200 child welfare staff who still need to complete the LGBTQ Competency Training, and training opportunities will be increased to accommodate this number. The goal is to have all staff trained by December 2021 and the training series will be "rolled into" the Foundations Training Track in January 2022.

Concerns:
As with pre-service training, participants complete in-service training evaluations immediately after the training, and there is no process in place to evaluate the long-term effectiveness or applicability of the training when staff are performing their work. Developing interim post-training evaluations was a 2020 goal for the WFD Network. Other competing priorities including the development and implementation of the pre-service training series, initial revamping of the in-service course catalog and the transition of all training sessions into a virtual format contributed to the delay in achieving this goal, however this goal will be reintroduced to the WFD Network as a priority with a projected timeframe for completion.

Additional unmet goals include developing/identifying required in-service training modules for staff and developing a standardized plan to effectively address training no-shows. These remain priorities for the WFD Network. There are also concerns as to whether the number of remaining existing staff will receive/complete the LGBTQ Competency Training within the projected time frame due to statewide emphasis on the IPM and CJAMS required trainings.

Table 19 below, provides updates on activities planned to improve statewide functioning of DHS/SSA's training system.

Table 19: Activities to Improve Performance

Current or planned Activity to improve performance	Target Completion Date
Child Welfare Training System	
Partner with local departments to implement "group think" networks to openly discuss satisfaction of pre-service and in-service trainings and recommendations for change	September 2020 Quarterly Reviews
2019 Progress: ***In Progress*** ● A group think activity to discuss pre-service and in-service training occurred in the November 2019 WDN meeting. However, this forum is limited to a small number and more intentional and inclusive activities are needed to fully and successfully achieve this goal. ● A group think with assistant directors occurred in January 2020 to discuss the current training system. This allowed for direct firsthand feedback regarding training and recommendations for change. Recommendations in turn, were provided to the training redesign team in December 2019. 2020 Progress: ***Completed*** ● January-September 2020 "group think" sessions inclusive of local department staff continued during bi-monthly WFD Network meetings. These sessions were used to openly brainstorm ideas in the review and redesign of the pre-service training series. These group think/ planning sessions contributed to the structure, and content and curriculum development of the series. ● A group think session with the local department assistant directors did not occur as planned. However, the redesigned pre-service series was presented to them for feedback and final approval before being launched in September 2020.	
Partner with the Child Welfare Academy (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
2019 Progress: ***In Progress*** ● Staff can currently register for current training through the CWA LearnCenter Database.	

Current or planned Activity to improve performance	Target Completion Date
• DHS/SSA and CWA have developed a training redesign team in November 2019 to enhance and modify all components of the current training system. This team will continue to work to determine which training modules can be changed to an e-learning platform. • The training team began discussion of teaching formats including on-line learning in November 2019. Recommendations regarding e-learning training will be included in a survey disseminated to child welfare workers statewide. This is tentatively scheduled for February-March 2020. Recurring themes from the surveys will give insight to the planning team in aligning specific course content with specific training modalities. • Once the new training series is launched CWA will continue to provide monthly reports to monitor registration, attendance and completion rates of training. This data report will be shared with program supervisors and assistant directors monthly. 2020 Progress: ***In Progress*** • May 2020: Participants now register for SSA trainings sponsored through CWA on the Institute for Innovation and Implementation database system- Ideas@the Institute. • March 2020: All SSA/CWA trainings were configured to virtual training format due to the COVID-19 crisis. • Several identified trainings in both the pre-service and in-series will remain virtual beyond the COVID-19 crisis when face-to-face instruction reoccurs. Having a cluster of identified on-line classes is intended to increase staff attendance in trainings because there is not a travel factor, and also to increase successful completion rate of trainings. • April 2020: Satisfaction surveys were disseminated to local department supervisors and assistant directors to evaluate effectiveness of original pre-service training series and recommendations for change. The surveys showed that supervisors were requesting more on-line training opportunities for staff to better support their demanding work schedules. • A similar survey will be administered to gather information and recommendations for the in-service series. This did not occur in 2020 due to intentional focus on the pre-service redesign. It is projected that this will occur by 9/2021. • CWA continues to provide monthly training attendance and no-show reports to SSA, who in turn shares information with respective local department assistant directors. Discussion among SSA Workforce Development and the assistant directors has led to standardized procedures for handling attendance and no-show issues, but a formal plan has not been developed due to other competing program priorities. This goal will be reintroduced to the WFD Network and an implementation plan will be completed and submitted to the local department assistant directors by 12/2021.	
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
2019 Progress: ***In Progress*** • Redesign team was developed in November 2019 and meets bi-weekly for planning and review. • SWOT Analysis of pre-service training was completed in April 2019 by the core redesign team. in addition to a work plan to guide planning and development activities. • A Work Plan to guide training development activities was approved by SSA leadership in December 2019. The entire training series pre-service, foundations training and in-service will be redesigned in sequence starting with the pre-service training series. Projected date for completion of pre-service is April 2020. 2020 Progress: ***In Progress*** • January -September 2020: Original pre-service and foundations trainings series were reviewed by redesign team and several modules from the Foundations track were blended into pre-service to introduce pertinent content to workers earlier in their work experience.	

Current or planned Activity to improve performance	Target Completion Date
● January-September 2020: Redesign team met bi-monthly to redesign the training system. ● Due to the volume of work involved in redesigning a comprehensive training system, the original targeted completion dates were modified. Pre-service was completed and launched in September 2020 rather than April 2020 as originally projected. The Foundation track was also modified. ● July 2020: Design team began reviewing in-service training modules to align language and learning objectives with IPM. There are approximately 350 training modules in the current in-service catalog and this number will increase to meet growing and diverse training needs of staff. ● December 2020: Design team proposed to stagger/pace the module reviews with the goal of reviewing 100 in-service training modules per year, beginning in January 2021.	
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
2019 Progress: ***Delayed*** CWA has an evaluator on staff and an initial meeting with the evaluator will need to be scheduled to outline data analysis protocols and reporting expectations. This is projected for February 2020 and evaluators will be invited to WFD Network Meeting. Recommendations from the evaluators will be helpful in the redesign of the training series. 2020 Progress: ***Delayed*** ● Minimal progress has been made with this and the CWA evaluator remains underutilized by DHS/SSA. This goal will need to be reintroduced to the WFD Network. Meeting with the evaluator must take place to outline data and reporting expectations. At this point, the CWA evaluator does not attend bi-monthly WFD Network meetings.	
Consult with CWA to discuss in-service trainings that receive unsatisfactory ratings, discuss needed modifications and need for continuation of training	Monthly
2019 Progress: ***In Progress*** ● Review of ratings data occurs during monthly DHS/ SSA and CWA planning and review meetings. Unsatisfactory ratings are given intentional discussion, ensuring that trainers were being best matched with training content. Unsatisfactory ratings and strategies to improve them were discussed in November and December monthly meetings between SSA and CWA. This discussion and training in general became a standing agenda item for this team in December 2019. ● CWA has added to its cadre of full-time training staff, and various topics have been reassigned to trainers to align with specific areas of expertise. To date, there is no evidence that these reassignments have improved training ratings; however, data will continue to be reviewed on a monthly basis to determine any pertinent fluctuations in ratings. 2020 Progress: ***In Progress*** ● January-December 2020: DHS/SSA and CWA continued to meet monthly to: o Review training data and discuss effectiveness of specific training modules and the training system. Unsatisfactory ratings are given intentional discussion. There have been noted instances of content changes based on feedback from training participants. For example, the IPM Modules are offered in both one full day and two half day formats based on recommendations from participants. Additionally, the LGBTQ Competency Training content has been modified to incorporate a stronger focus on best practice language and accessing specific services for youth in care. The format has also changed to include more interactive vs. instructional activities. This too was the result of feedback and recommendations from training participants. o Review and modify training roster in monthly meetings and various topics have been reassigned to trainers to align with specific areas of expertise. To date, there is no evidence that these reassignments have had a direct impact on training ratings; however, data will continue to be reviewed on a monthly basis to determine any pertinent fluctuations in ratings.	

Current or planned Activity to improve performance	Target Completion Date
Partner with CWA and local departments 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
2019 Progress: ***In Progress*** ● DHS/SSA and CWA are currently working to develop a larger cadre of trainers to support statewide training efforts. It is believed that peer-to-peer training might increase relevance and familiarity of training content through connections with actual work experiences. Peer-to-peer trainers will be used in both the IPM and redesigned pre-service training rollouts. New roster of trainers was completed in December 2019. Adding qualified trainers will be an ongoing effort and monitored quarterly. 2020 Progress: ***In Progress*** ● January 2020: New roster of trainers was completed. DHS/SSA and CWA are continuing to develop a larger cadre of trainers to support statewide training efforts. Trainers with lived experience have been added to the training roster and are particularly involved in IPM in-service trainings. Trainers from the local departments have supported peer-to-peer trainings in the pre-service and in-service series. Adding qualified trainers will be an ongoing effort and monitored quarterly.	
Request "no show" training data from CWA to strategize with local departments to ensure attendance and completion of trainings	Quarterly/Annual Reviews
2019 Progress: ***In Progress*** ● DHS/SSA and CWA are currently working to develop a larger cadre of trainers to support statewide training efforts. It is believed that peer-to-peer training might increase relevance and familiarity of training content through connections with actual work experiences. Peer-to-peer trainers will be used in both the IPM and redesigned pre-service training rollouts. New roster of trainers was completed in December 2019. Adding qualified trainers will be an ongoing effort and monitored quarterly. ● Beginning November 2019, DHS/SSA provided quarterly training attendance and no-show data to all local department assistant directors. Currently there are no standardized procedures for addressing accumulated staff no shows and directors and supervisors handle this issue internally. ● DHS/SSA will determine statewide procedures and protocols. As a starting point, DHS/SSA has met with leadership staff from the DHS Learning Office to discuss how their office addresses no shows. It was explained that specific statewide trainings are stipulated in staff annual performance evaluations and that accumulated no shows and non-completion of trainings must be reflected in interim evaluation ratings. ● DHS/SSA will discuss with assistant directors the feasibility of this or similar practices in relation to required trainings for child welfare staff. This is projected for February 2020. 2020 Progress: ***Delayed*** ● January-December 2020: DHS/SSA continued to provide training attendance and no-show reports to local department assistant directors on a quarterly basis; however, there is still no standardized process or procedures for handling "no shows" and jurisdictions handle the matter differently. The assistant directors have expressed agreement that a standardized process might be helpful, but no plan has been developed. This priority will be reintroduced to the WFD by 6/2021 with the goal to develop standardized "no shows" by 1/2022.	
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	Monthly

<table>
<tr><th>Current or planned Activity to improve performance</th><th>Target Completion Date</th></tr>
<tr><td colspan="2">2019 Progress: In Progress
● CWA provides monthly training reports to DHS/SSA. Training evaluations continue to yield positive results. Data will continue to be monitored and recommendations for change will occur accordingly.
2020 Progress: In Progress
● CWA continues to provide monthly training reports to DHS/SSA, and training evaluations remain favorable. Data will continue to be monitored and recommendations for change will occur as needed.</td></tr>
<tr><td>Share data from training reports with DHS/SSA Workforce Development Network (WDN) to further identify and support training needs of staff</td><td>Monthly</td></tr>
<tr><td colspan="2">2019 Progress: In Progress
● Data from training reports is shared with WDN bi-monthly. The Network must become more intentional in connecting data with recommended training needs. An ad hoc subcommittee of the Workforce Development will assume this task of data analysis and specific training recommendations. This subcommittee has not yet been developed as most network members are currently working on the pre-service redesign.

2020 Progress: In Progress
● Pertinent training data reports continue to be shared with WDN bi-monthly; however, The Network must become more intentional in connecting data with recommended training needs. The DHS/SSA Research and Evaluation Team will provide training to WFD Network to educate on how to effectively use data to develop, evaluate and complete committee goals. This training will be scheduled by 6/2021. The WFD Network will work to recruit membership from the SSA Research and Evaluation Team and the SSA Evaluation even if on an as needed basis.
● In June 2020 an ad hoc subcommittee of the Workforce Development was developed to assume the task of data analysis and specific training recommendations. However, progress towards this goal has been delayed due to the priority of pre-service redesign and roll-out. This goal will be reintroduced to the WFD Network by 6/30/2021.</td></tr>
<tr><td>Partner with CWA and local departments 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</td><td>Quarterly/Annual Reviews</td></tr>
<tr><td colspan="2">Progress 2019: Delayed
● This process has not been started. The WDN will develop a training follow up survey. CWA will be responsible for administering the follow up survey and providing necessary data analysis in monthly and annual reports.

Progress 2020: Delayed
● This process has been delayed due to the COVID-19 crisis and shift in agency and program priorities. The WDN, which includes representation from CWA, will develop a follow-up training survey. CWA will be responsible for administering the survey and providing necessary data analysis in monthly and annual reports.</td></tr>
<tr><td>Establish ongoing training standards and requirements for all child welfare staff to maintain well-prepared workforce
○ determine required number of training hours
○ determine required training modules for workers and supervisors
○ require trainings for both licensed and unlicensed staff</td><td>December 2020
Annual Reviews</td></tr>
<tr><td colspan="2">2019 Progress: Delayed</td></tr>
</table>

Current or planned Activity to improve performance	Target Completion Date
• The WDN will identify and recommend on-going in-service training requirements for all child welfare staff and present recommendations to OISC and local department assistant directors. Training standards will include the required number of training hours per year prescribed content areas and monitoring procedures. The Network is currently working on the pre-service redesign. 2020 Progress ***Delayed*** • This process has been delayed due to the COVID-19 crisis. The primary focus for 2020 was the redesign and roll-out of the pre-service training series. An implementation plan will be developed by the WFD Network by 12/2021 to include the development of a subcommittee with representatives from WFD, DHS/SSA leadership, and LDSS, a proposal around ongoing training standards and requirements, and statewide rollout approach.	
Consult with DHS/SSA Workforce Development Network (WDN) to further analyze program and evaluation data to identify and support training needs of staff.	Bi-Monthly
2019 Progress: ***In Progress*** • The evaluation and redesign of the training system is an on-going process. The re-design of pre-service began in December 2019. The WDN will continue to review program and training reports to support data analysis and make recommendations for training revisions. The WDN will also meet with the program evaluator for detailed data analysis and findings to support continued training needs. 2019 Progress: ***Delayed*** • This process has been delayed due to COVID-19 crisis. The WDN will continue to review program and training reports to support data analysis and make recommendations for training revisions. The WDN will also meet with the program evaluator for detailed data analysis and findings to support continued training needs.	
Develop a monthly resource home milestone report to track all resource home compliance which will include training (pre- and in-service) training data.	2020
2020 Progress: *Delayed* DHS/SSA is still awaiting the development of the resource home milestone report.	
Resource Parent Training	
Provide technical assistance to the LDSS to ensure that documentation of training is accurately recorded.	September 2019 Annual Reviews
2019 Progress: ***Completed*** • June 2019: Initiated technical assistance provided to the LDSS regarding resource home documentation upon request. 2020 Progress: ***Delayed*** • DHS/SSA was delayed in this activity due to a shortage of resource home staff and the delay of the resource home milestone report.	
Implement a management level review of Corrective Action Plan (CAP) responses to improve the quality of the responses and increase effectiveness (OLM).	2019/Monthly
2019 Progress: ***Completed***	

Current or planned Activity to improve performance	Target Completion Date
• Monthly: Meetings scheduled to review each Corrective Action Plan submitted for compliance with COMAR by the Licensing Coordinator and Program Manager. Program Managers ensure the CAPs are detailed and have target dates that are appropriate to the violation. The CAP response form has been redesigned to provide clear, detailed, and specific timeframes for becoming COMAR compliant. 2020 Progress: ***In Progress*** • Monthly meetings to review CAP responses continued during the reporting period.	
Revise the monitoring process to include quarterly monitoring of major regulatory standards. Currently the Licensing Coordinators are required to meet all the licensing requirements over the 2-year licensing period (OLM).	2020/quarterly
2020 Progress: ***Delayed*** Delayed due to the State of Emergency, however Licensing Specialists performed the revised monitoring process for two months (January - March 12, 2020). On March 5, 2020 the Governor issued an Executive Order suspending the legal time requirements. The Executive Order was extended March 17, 2020 and June 3, 2020. On March 9, 2021, the Governor lifted the suspension on legal time requirements and required all private provider re-licensures completion by June 30, 2021. Licensing Specialists are performing the task to relicense all private providers that were not relicensed in 2020. The revised monitoring process will resume in 2022.	
Develop and Implement a structured follow-up to CAP responses and repeat findings (OLM).	2020/Quarterly
2020 Progress: ***Ongoing*** Licensing Specialist, 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	

Foster and Adoptive Parent Training

The provider training system ensures that training is occurring statewide for current or prospective foster parents, adoptive parents, and staff of state licensed or approved facilities that addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children.

Public Homes

Analysis of the Data:

DHS/SSA continued to provide training to current and prospective foster parents and adoptive parents. DHS/SSA worked with the Maryland Resource Parent Association (MRPA) and Child Welfare Academy (CWA) to ensure that all resource parents are provided with training that addresses the skills and knowledge needed to carry out their duties about foster and adopted children. During this period, resource parent trainings were adjusted to virtual learning to ensure that resource parents were able to access training while at home due to COVID-19. SFY2020 data (Table 20 below) from the Child Welfare Academy indicates that resource parents continued to register and attend training sessions that addressed the skills and knowledge needed to carry out their duties with regard to foster and adopted children.

Table 20: SFY20 Resource Parent Training Registration and Attendance Numbers

Quarter	Number of Resource Parents Registered	Number of Resource Parents Attended
Quarter 1	491	279
Quarter 2	823	558
Quarter 3	904	357
Quarter 4	1,115	1,050

A higher number of families registered than attended training sessions and, compared to previous year data, resource parent participation decreased. DHS/SSA learned, through MRPA, that these decreases were influenced by resource parents having technology connectivity issues as well as struggling to balance attending sessions with assisting youth who were learning virtually and working full-time. As a result, DHS/SSA met with CWA to address challenges and developed plans to incentivize resource parent training to increase virtual resource parent participation beginning in Spring 2021.

In April 2020, MRPA conducted a survey of resource parents to assess parents' satisfaction with the MRPA and LDSS. Some of the questions queried about training availability for Resource Parents. Resource parents indicated they would like more accessibility with regards to training options. In addition to the survey results, the Center for Excellence steering committee completed a cross training analysis. After reviewing the results of both assessments, it was determined that the current pre-service training needed to be augmented to include more training around fostering the birth family connection. DHS/SSA is currently working on expanding additional pre/in service training curriculums to resource parents. This new curriculum has been developed and is currently in the process of being piloted through the state's Center for Excellence Grant in Foster Family Development. This grant will provide additional training to resource parents who are working with birth parents/families of origin. The training intends to enhance the skills and knowledge of the resource parents who have already received the state mandated pre-service PRIDE Hybrid Training Curriculum. In addition, the state has continued its current contract with the Child Welfare League of America to continue providing pre-service training to both public/private resource home providers.

Strengths:
DHS/SSA continued to issue reports to the LDSS on a monthly basis to track their individual compliance with resource home training requirements. The new child welfare data system is currently tracking resource home compliance via ticklers to provide additional technical assistance as well as data reporting however extracting and validating the data has been a challenge. This data will be reported during the next reporting cycle.

Concerns:
While reports are provided to locals, there remain challenges with creating a statewide report via the Resource Home Milestone Report. This report is still in progress as DHS/SSA transitions to a new child welfare data system. The development of the report has also been hampered by extraction challenges that the state has experienced as CJAMS was implemented statewide in

CY2020. As a result of this delay, DHS/SSA has been challenged in its ability to monitor the local resource home progress in improving the training system and ensuring background checks are monitored for resource parents. In addition, DHS/SSA has suffered a staff shortage in the area of resource homes, therefore there is limited staff resources to monitor and oversee the LDSS compliance. It is the hope that the state will have more qualitative data within the next reporting period.

Private Homes
As a result of the COVID-19 pandemic, two executive orders were issued in relation to the training requirements impacting group homes and private foster homes:

- Pursuant to the Executive Order authorizing suspension of legal time requirements, the listed regulatory 14.31.06.05 F (1) time frame requiring annual training for Residential Child Care Program Employees who provide direct care to children is conditionally suspended. Where the time requirement is suspended, the suspension will continue no later than the 30th day after the date by which the state of emergency related to COVID-19 is terminated and the catastrophic health emergency is rescinded.
- Due to the global pandemic any certifications, recertification of foster parents and adoption home studies or reconsiderations that have a due date beginning March 12, 2020 were suspended until 30 days after the State of Emergency is terminated, and the catastrophic health emergency is rescinded.

Once the state of emergency has ended all Group Home and Private Resource Home staff and parents are required to have all training outlined in COMAR.

In CY2020, OLM developed mechanisms to address the health crisis. Initially DHS/OLM held weekly provider conference calls with licensed providers (RCC and CPA). After two months OLM switched to bi-weekly provider conference calls to provide clarification and training on COMAR requirements during the pandemic. DHS's OLM also held quarterly meetings with all of the licensed providers (RCC and CPA) to provide training on COMAR requirements as well as review current trends and youth needs, etc. (example: Reasonable and Prudent Parenting, Grief and Loss, LGBTQ).

Analysis of the Data:
Table 21 below outlines training compliance for Group Homes/Residential Child Care Centers (RCC) for CY 2020. Current group homes data shows that the compliance rate for training has improved over the past year.

Table 21: Training compliance for Group Homes/Residential Child Care Centers (RCC) CY 2020

# of RCC employee records reviewed*	Compliant for Training	Non-Compliant for Training
65*	**63 (99%)**	**2 (1%)**

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

Table 22 below outlines training compliance for Child Placement Agencies (CPA) for CY 2020. Private resource homes data show a compliance rate of 97%. OLM will continue to develop improved monitoring techniques to obtain a goal of 100 % compliance.

Table 22: Training compliance for Child Placement Agencies (CPA) CY 2020

# of CPA home records reviewed*	Compliant for Training	Non-Compliant for Training
61*	**59 (97%)**	**2 (3%)**

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

Strengths:
Even though COMAR does not require quarterly monitoring of private providers the data shows that increased and consistent monitoring results in a higher percentage of compliance. Program Managers and Licensing Coordinators schedule meetings to review private provider corrective action plans. Program Managers ensure CAPs are detailed and in compliance with COMAR. Licensing Coordinators are required to monitor compliance by completing a periodic visit with the provider before the CAP can be considered resolved.

Concerns:
The Office of Licensing and Monitoring has no concerns with applying COMAR standards equitably across the private providers community.

Activities to Improve Performance:
Table 23 below provides updates on activities implemented to improve performance.

Table 23: Activities to Improve Performance

Current or planned Activity to improve performance	Target Completion Date
Implement a management level review of Corrective Action Plan (CAP) responses to improve the quality of the responses and increase effectiveness (OLM).	***2020/Monthly***
2020 Progress: ***Ongoing*** Monthly: Meetings held to review each Corrective action plan submitted for compliance with COMAR by the Licensing Coordinator and Program Manager. Program Managers ensure the CAPs are detailed and have target dates that are appropriate to the violation. The CAP response form has been redesigned to provide clear detailed and specific timeframes for becoming COMAR compliant.	
Provide technical assistance to the LDSS to ensure that documentation of training is accurately recorded.	***Ongoing September 2019 Annual Reviews***
2019 Progress: ***In Progress*** September 2019: Began providing technical assistance to the LDSS regarding resource home documentation when requested. 2020 Progress: ***In Progress*** January 2020: DHS/SSA has continued to provide technical assistance related to the documentation of training.	
Develop a monthly resource home milestone report to track all resource home compliance which will include training (pre- and in-service) training data.	***2020***
2020 Progress: **Delayed** DHS/SSA is still in the process of developing the resource home milestone report.	

Current or planned Activity to improve performance	Target Completion Date
Revise the monitoring process to include quarterly monitoring of major regulatory standards (interviews, youth record reviews, staff record reviews, foster parent record reviews, physical plant inspections etc.). Currently the Licensing Coordinators are required to meet all the licensing requirements over the 2-year licensing period (OLM).	***2020/quarterly***
2020 Progress: ***Delayed*** Due to the State of Emergency, Licensing Specialists performed the revised monitoring process for two months (January - March 12th.). On March 5, 2020, the Governor issued an Executive Order suspending the legal time requirements. The Executive Order was extended March 17, 2020 and June 3, 2020. On March 9, 2021, the Governor lifted the suspension on legal time requirements and required all private provider re-licensures completion by June 30, 2021. Licensing Specialists are performing the task to relicense all private providers that were not relicensed in 2020. The revised monitoring process will resume in 2022.	
Develop and Implement a structured follow-up to CAP responses and repeat findings (OLM).	***2020/Quarterly***
2020 Progress: ***Ongoing*** 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

The service array and resource development system functioning ensure that the following array of services is accessible and individualized to meet the unique needs of children and families served by the agency in all jurisdictions covered by the CFSP:

- Services that assess the strengths and needs of children and families and determine other service needs;
- Services that address the needs of families in addition to individual children in order to create a safe home environment;
- Services that enable children to remain safely with their parents when reasonable; and
- Services that help children in foster and adoptive placements achieve permanency.

Assessment of Performance:

As described in Maryland CFSR Final Report the State was not in substantial conformity in demonstrating that the required individualized array of services was accessible statewide. During the reporting period the agency made progress towards enhancing the Service Array and service availability, as indicated in the latest CFSR outcomes. The agency is making strides and seeing improvement in providing service to protect children in their homes and prevent entry removal or re-entry into foster care (CFSR Safety Outcome 2; Item 2) and in assessing needs and providing services to children , families, and resource parents (CGSR Well-being Outcome 1, Item 12) The most recent CFSR data shows improvement in both areas. For Services to Families to protect children in their homes and prevent removal or re-entry into foster care (Safety Outcomes 2) the most recent CFSR data showed a 93% strength rating which is significantly above the state's target of 59%. Likewise, for assessing needs and providing services to children, parents and resource parents (Well-Being Item 12) the most recent CFSR shows a 44% strength rating which

also exceeds the state target of 37% and the rating from the previous quarter which was 23%. CFSR data also indicates there is a need to enhance services that assess the strengths and needs and services to Parents as reflected by only 41% of cases reviewed were rated as strength.

While progress is being made, qualitative data obtained through multiple data sources, such as state CQI Qualitative Focus Group interviews conducted in 2020 and feedback from Service Array Implementation Team members, were in alignment with results from the previous community partnership survey conducted in 2019. The same areas of service needs remain consistent across sources. The top themes that were consistently mentioned include appropriate mental health counseling/psychiatric services, services for co-occurring mental health and substance abuse disorders, inpatient substance abuse treatment, a lack of child psychiatrists and trauma-informed therapy, housing assistance, transportation, and Shelters. Results from the Community Partnership Survey indicate that over half (63%) of Child Welfare staff rated the need for Mental Health Counseling/Psychiatric Services, Housing Assistance, Transportation, and Shelters as high.

In assessing the needs of children in foster and adoptive placements to achieve permanency, DHS/SSA made concerted efforts to understand and address the needs of children with complex behavioral health needs who were placed in hospital settings beyond medical necessity. During CY2020, there were 396 youth hospitalized of which 67 (17%) were in a hospital overstay status. Based on the information analyzed over the last calendar year the following trends were noted as a causal effect to hospital overstay:

- Lack of availability to psychiatric residential treatment facilities;
- Lack of appropriate psychiatric residential treatment facilities;
- Lack of appropriate step down residential childcare placements; and
- Lack of appropriate discharge planning.

Strengths

As described above, the agency continues to progress towards enhancing the Service Array and service availability, as indicated by the latest CFSR outcomes. Throughout this reporting period, the agency worked towards improvements in addressing the needs of families and individual children in order to create a safe home environment and enable children to remain safely with their parents when reasonable. One key strategy was to develop and capitalize on community partnerships to strengthen the full array of services, including prevention services. The activities related to this effort are described in Updating the State's Vision Goal 5 on pages 110-113.

Additionally, the agency worked towards expansion and support to the array of services, resources, and evidence-based interventions available across child welfare, this is evident by the work being done to implement Family First Prevention Services Act. With the implementation of Maryland's Title IV-E prevention plan, Maryland will increase the number of families who can be served with high-quality clinical models such as Healthy Families America, Functional Family Therapy, Parent Child Interaction Therapy, Multisystemic Therapy and other evidenced-based interventions that the agency plans to include in its array of services.

In November of 2020, SSA began the Strategic Service Array Assessment and Planning Process which brought together LDSS and other local agencies (health, juvenile services, Local

Management Boards, Private agencies who deliver community-based prevention services (e.g., mental health, substance use, early childhood and home visiting services) and Family advocates. One of the strategies around this effort included bringing together system partners to support an enhanced approach to teaming aimed to improve collaboration and communication in the development of local service arrays. Two webinars were held; one in November and one in December. Both with over 140 participants each session in attendance being involved in the Strategic Service Array Assessment Process to team and identify services needed within regions to better support families. This effort is evident of a state and local collaborative teaming approach that is underway to better support service provision to families and in particular prevention services

To address the concerns related to quality collaborative assessments, the agency developed the goal to revise processes for collaborative assessments and developing service plans to facilitate partnership with families, including consistently identifying & engaging the family/youth's chosen supports. The progress and update for this goal can be found under Goal 1 Objective 1.1 on pages 85-87.

To address the hospital overstay issue, DHS partnered with several State entities to develop a cross agency plan to expand the existing service array to meet the needs of these children. The draft plan was completed in April 2020. Teams to address the different areas of the plan were formed and began meeting in June 2020.

Concerns

While progress exists, identified concerns remain. Maryland's PIP convening revealed that 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 resulting in a limited understanding of what other agencies can offer a family. Families too often receive basic referrals versus facilitated and warm-handoffs and coordinated services. Families report going through multiple systems in search of the support they need, becoming increasingly more 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.

CFSR data indicates there is a need to enhance services that better assess the strengths and needs and services to Parents. CFSR Item 12B (Needs Assessment and Services to Parents) reflected that only 41% of cases reviewed were rated as strength. The agency utilizes the Child and Adolescents Needs Assessments (CANS) to assess need for services and develop service plans for each family. Prior assessments on the use of functionality of the agency's collaborative assessments (CANS, CANS-F) shows challenges with meaningful use of these assessments. For the CANS-F, strengths and needs tend to be under assessed (57% of families assessed had no needs identified and 56% had no strengths identified). Due to unavailability of CANS data, this information is reflective of 2019 data, the most recent data available. This theme of underassessment has been consistent over the years.

Activities to Improve Performance:
Table 24 below outlines activities identified to improve performance and the status of each activity.

Table 24: Activities to Improve Performance

Current or planned Activity to improve performance	Target completion date
Revise process for collaborative assessments and developing service plans to facilitate partnership with families including consistently identifying & engaging the family/youth's chosen supports.	2019-2020
2019 Progress: ***In Progress*** ● July - December 2019: Listening session held with local departments. Information gathered used to revise the TA content. ● December 2019: DHS/SSA revised the technical assistance traditionally offered to LDSS in use of the CANS and CANS-F assessment instruments to align with the Integrated Practice Model. Technical assistance was designed to train supervisors and staff in meaningful use and the practice of collaborative assessment while using the tool. Sessions with supervisors focused on data and documentation accuracy that may support staff in improving assessment and engagement skills. Sessions with staff focused on use of the assessment tools in the context of the practice of engagement and assessment. ● A pilot of this approach is planned for March 2020 in at least one jurisdiction. 2020 Progress: ***In Progress*** ● January-May: Continued revised format of offering technical assistance to local departments with an emphasis on collaboration and teaming. In the meantime, "Module 3: Assessing, Planning, Adapting and Transitioning" of the Integrated Practice Model (IPM) was developed to build in the content of these technical assistance sessions and to promote consistency in a collaborative approach to assessment, planning, and customizing plans to optimally support families. ● November 2020: LDSS were asked to submit a coaching plan worksheet that identified areas where coaching and technical assistance could support improved outcomes for each jurisdiction. Prior to this, LDSS was provided a coaching toolkit featuring information to support improved teaming with community partners. Further TA and coaching to optimize use of community service arrays was introduced. ● October - December 2020: Module 3 of the IPM was rolled out to the workforce across the State. This module supports the workforce in building skills of collaboration and team building in order to maximize and strengthen use of community resources.	
Develop and capitalize on community partnerships to strengthen the full array of services, including prevention service.	2019-2021
2019 Progress: ***In Progress*** ● January 2019 through June 2019: DHS/ SSA's Service Array Team continued to utilize the Community Partnership and Service survey findings and response around technical assistance and support needed, to identify service needs and strengths/gaps in LDSS partnerships with local agencies/systems and service providers and to inform the Service Array Implementation Team's planning efforts for Child Welfare as well, inform other service array initiatives such as those related to the Family First Prevention Services Act. ● April 2019: SSA developed targeted activities through Maryland's Program Improvement Plan (PIP) to improve performance in this area, 2020 Progress: ***In Progress*** ● May –December 2020: Service Array Team targeted partnerships needing strengthening and conducted outreach to participate in local and state service array implementation.	

Current or planned Activity to improve performance	Target completion date
● August 2020: Module 2: Teaming of the Integrated Practice Model was rolled out to workers and supervisors around the State. The training incorporated specific use of service mapping as a tool in practice. This particular tool guides discussion with families to better identify service needs and services that may already be in place for families, children and youth when building a team. ● October - December 2020: Module 3: Assessing, Planning, Adapting and Transitioning of the IPM was rolled out to the workforce across the State. This module supports the workforce in building skills of collaboration and team building in order to maximize and strengthen use of community resources while also identifying needs of families, children and youth. ● November 2020: LDSS were asked to submit a coaching plan worksheet in preparation for IPM coaching that identified areas where coaching and technical assistance could support improved outcomes for each jurisdiction. Prior to this LDSS was provided a coaching toolkit featuring information to support improved teaming with community partners. Further TA and coaching to identify service array needs, optimize use of community service arrays, and better team with community partners was introduced as a resource. ● Local Departments identified specific needs in their coaching plans where technical assistance and support around community partnership development was needed. Further coaching and follow up was then planned for LDSS that indicated this kind of TA and support was needed. ● December 2020: LDSS received data packets which included Community Partnerships survey results to utilize in strengthening their local service array and selection of evidence-based interventions to implement. ● Jan-December 2020: Progression towards Goal 4, Strategy 3 of the Program Improvement Plan: Strengthen System Partnership to Best Serve Families: Improve teaming across local agencies and organizations in support of families. ○ SSA developed a Teaming with Partners to Best Serve Families Module that was included with the IPM trainings completed in October through December 2020. Accompanying the module included the "Tools to Support Improvement in Teaming with Partners" kit that was made available to LDSS programs. The kit included Lessons Learned: Coordinating Community Partnership Meetings, Capacity Building Center for States, Change and Implementation Practice on Teaming, Collaboration Readiness Checklist, and the newly developed Maryland Child Welfare Services Continuum. Refer to additional updates outlined under table for goal 5.	
Conduct Town Halls and develop Local Calls to Action to engage community partners in meeting the needs of children and families	2019-2021
2019 Progress: ***In Progress*** ● August 2019: DHS/SSA began efforts to support local departments in planning local town hall events resulting in the development of a number of tools/templates. Planning efforts included the engagement of local departments, Court Improvement Program, and technical assistance providers. Several local departments held town hall meetings and feedback from these convenings was used to refine tools/templates. ● September 2019: sample agenda and PowerPoint developed. ● Fall 2019: Town Halls were held in two jurisdictions. ● December 2019: DHS/SSA began reaching out to the remaining locals to begin planning additional town halls. 2020 Progress: ***Completed*** ● August - September 2020 held four virtual town hall sessions with 100 - 200 participants at each session. Virtual town hall sessions included guided discussions to highlight Maryland's Child Welfare System Transformation, opportunities for partnering with a wide array of stakeholders related to DHS/SSA's strategic vision and the integrated practice model, and support the formation of coalitions to develop prevention-focused services, supports, and improved models for working with families.	

Current or planned Activity to improve performance	Target completion date
Utilize lessons learned from Title IV-E Waiver Demonstration Project to expand the utilization of evidence-based practices across the child welfare continuum.	2019-2021
Progress: ***Completed*** ● November 2019: Reviewed the EBPs implemented through the Title IV-E Waiver, implementation lessons learned, and CQI and/or evaluation data to determine a list of EBPs to continue beyond the Title IV-E Waiver. ● Between November and December 2019: This list of EBPs was aligned with criteria for potential inclusion in the Family First Prevention Services Act Evidence Based Clearinghouse. ● As a result of this analysis, approximately twelve evidence based and/or promising practices will be continued beyond the end of Maryland's Title IV-E Waiver.	
Strengthen allocation process to local departments that maximizes available funding and addresses service gaps.	2020 and Annually
2020 Progress: ***Delayed*** Initial conversations were held in 2020 between SSA, Budget and Finance, and Local Departments. Due to competing priorities related to COVID-19 further conversations have not occurred. It is anticipated that these conversations will reconvene in 2021 as part of FFPSA Implementation Team.	
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
2020 Progress: ***In Progress*** ● Language was revised in contracts/agreements with placement and other providers in January 2020. Revisions remain. ● Technical assistance made available to providers in collaborative assessment and use of the CANS was updated to reflect IPM language and aligned with contract language in January 2020.	
Conduct ongoing CQI to assess outcomes, identify strengths and areas needing improvement, and implement improvement plans as needed.	2021-2024

Individualization of Services

As described in state CFSP, Maryland CFSR Final Report results indicated that the State was not in substantial conformity in Systemic Factor item 30 (Individualization of Services). Maryland's PIP convening revealed that the needs of families are broad and the challenges they face are often complex, individualized services can often be left to the worker's discretion and staff are not always aware of available services and are not ensuring that family assessments identify specific needs that inform tailored services, Families too often receive basic referrals versus facilitated and warm-handoffs and coordinated services.

Throughout this reporting period, the agency worked towards improvement in this area. In an effort to expand access to individualized, prevention evidence-based services as part of Family First Implementation, the agency provided support and technical assistance to the LDSS in conducting inventory of local program and service needs. This effort began in the fourth quarter of 2020 and is currently in progress. The information obtained through this effort will inform the identification, scale up and expansion of prevention evidence-based practices to address child and family needs in their homes and communities.

Ensuring children and families receive unique and individualized services are a mutual responsibility across agencies serving the families. The agency utilizes a broad network of public and privately-run programs to meet the individualized needs of children and youth involved with the system, In June of 2020, the agency conducted the Maryland Program Questionnaire (PQ) with the goal of gathering detailed information about the services offered and youth served by programs that are contracted for out of home care by the agency. The PQ was completed by 125 community based or non-community based residential programs that are contracted by DHS/SSA within and outside of Maryland. The PQ examines Program Type & Services, Youth Served, Medical/Health Services, Substance Use Disorder Services, Mental Health/Psychiatric Services, Educational Services, Career & Technology Education/Employment Services, and Basic Program Information. The agency utilizes this information conducted through the PQ to identify gaps in services among providers; improve service matching by creating program referral protocols based on youth characteristics, including identified risks, needs, and strengths and improvements to contracting services to ensure providers are able to meet the individualized and unique needs of children and families. Some common identified gaps in individualized services provided include housing support services, spiritual developments, on-site childcare, multilingual services, aftercare services, fire setting treatment, treatment for sexually exploited children and developmentally/intellectual disability services

An important strategy for supporting the workforce in meeting the needs of families has been the training in the Integrated Practice Model. One of the training modules specifically builds skills around assessing and planning to support individualized service needs of families, children, youth and vulnerable adults as well as the nuances in identifying and coordinating services and creating family-driven plans to meet those needs. As DHS/SSA began to train staff and supervisors in the Integrated Practice Model in 2020, a review of evaluation feedback from training participants shows that the training approach reflects a different approach to assessing, planning, intervening, monitoring, adapting and transitioning with families than how they are currently practicing. In response to "how different is the material in the training from the way you are currently practicing?" (a rating of 0=not different at all and 10=extremely different) on average, yielded an average score of 6 for Module 3: Assessing, Planning, Adapting and Transitioning indicating a perceived difference among staff. The provision of further coaching and technical support in implementation of the practice model is designed to address this difference and improve how services are individualized and identified in partnership with youth and families.

Despite some of the struggles with standardizing an approach to comprehensively meeting service needs, there has been some improvement in demonstration of meeting service needs of families between period four (10/1/19-3/31/20) and period five (4/1/20-9/30/20) of the CFSR in specific safety and well-being items related to ensuring families, children, youth and vulnerable adults are engaged in services to meet their needs. Table 25 below reflects the percentage of cases reviewed that were rated in substantial conformity during each review period.

Table 25: CFSR Performance CY2020

CFSR Item	Period 4: 10/1/19-3/31/20	Period 5: 4/1/20-9/30/20
Safety Item 2: Services to Family to Protect Children in the Home and Prevent Removal or Re-Entry into foster care.	75%	100%
Well-being Item 12: Needs and services of child, parents, and foster parents	23.08%	41.79%
Well-being sub-item 12A: Needs assessment and services to children	79.69%	80.06%
Well-being sub-item 12B: Needs assessment and services to parents	20.03%	38.98%
Well-being sub-item 12C: Needs assessment and services	68.57%	85.29%

Agency Responsiveness to the Community

DHS/SSA continued to engage in ongoing consultation with Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals, objectives, and annual updates of the CFSP and services under the CFSP are coordinated with services or benefits of other federal or federally assisted programs serving the same population

Data to demonstrate current functioning and assessment of progress

DHS/SSA continued to utilizes its implementation structure, in particular the Outcomes Improvement Steering Committee (OISC) and the DHS/SSA Advisory Board, 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 as well as coordinating services or benefits of other federal or federally assisted programs service the same population.

Assessment:

During 2020, the SSA Advisory Board met quarterly and utilized a standardized agenda which includes items for discussion including data and evidence to understand system performance as well as upcoming priorities. Many of the 2020 discussions focused around Maryland's response to the COVID-19 pandemic and how best to support the children, families, and staff and ensure safety and well-being. In addition, feedback was sought in relation to many of DHS/SSA's transformation efforts including the implementation of the IPM, FFPSA, and race equity in child welfare. Finally, Maryland's CFSR and Headline Indicator data were shared regularly allowing for discussions related to improving performance and recommended adjustments to goals and objectives.

In addition to the SSA Advisory Board, the OISC met every other week during 2020. To support the integration of key priorities, including the CFSR, PIP, and FFPSA, into ongoing discussion, these topics become standing agenda items with the goal of ensuring ongoing discussions related to performance and the implementation of goals and objectives to improve outcomes.

For additional information related to DHS/SSA's Implementation structure and the role of other teams and networks role is 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 Collaborations Section, pages 9-12.

Strengths and Concerns:
DHS/SSA has been successful in the last year in consistently holding team, workgroup, and advisory meetings as well as reviewing membership regularly to ensure that all groups are inclusive of key stakeholders. Despite this, concerns have still been raised that there are not always opportunities for stakeholders to provide feedback and participate in the development of policies and practices on the front end. As a result, DHS/SSA continues to explore opportunities to make improvements in consulting with stakeholders in regard to the CFSP, APSR, goals, and objectives. Table 26 below highlights updates to planned activities to improve performance.

Table 26: Activities to Improve Performance

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
2019 Progress: ***In Progress*** Implementation Teams/Workgroups monitored representation of participating agencies/organizations and identified any gaps: ● March 2019 through December 2019: SSA Service Array Implementation Team and the associated Health and Education workgroups continued to monitor membership to ensure inclusivity and representation of the various agencies that partner with child welfare to serve families. It was noted that membership has fluctuated throughout the year, and there is still a need for increased representation in the areas of mental health provider agencies, mental health psychiatric services, home visiting services, housing assistance, transportation, and housing supports. ● December 2019: The WDN initiated outreach efforts to recruit parents and youth for the Network. Plans are in place to add at least one additional private service provider. ● March 2019 and September 2019: Integrated Practice Implementation Team established additional workgroups to increase membership as described in the Collaboration section of this report. 2020 Progress: ***In Progress*** ● The IPM Implementation Team's Family Teaming Workgroup recruited additional attorneys and a retired judge to become members. ● An additional workgroup aimed at outreach to court partners is forming in 2021.	
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
2019 Progress: ***In Progress*** ● Early 2019: Data Analytics Network began to review potential data reports to ensure that data dashboards are user-friendly and allow for data-informed decision-making. ● October – November 2019: Regional meetings included the sharing of both the dashboards to those supervisors who attended and provided means in which they can be used by locals to evaluate their practice.	

Current or planned Activity to improve performance	Target completion date
● November 2019: Most recent CFSR results posted to the internal and external DHS website. ● Quarterly in 2019: Most recent Headline indicators posted to the internal DHS website as well as emailed to each of the local departments. ● Headline indicator dashboards are also produced for each of the locals for meetings around their CFSR results so that they can compare their outcomes with their trend data. *New for 2020: In the next year, 2020, additional storyline indicators (those that support the headlines) will begin to be posted on the Knowledge Base so that local departments can access them as needed for the work that they do. As Maryland transitions to CJAMS, the headline indicators dashboard will be shifted to Qlik which will allow each local to access their own information without having to wait on SSA to provide the information. This will be happening during CY2020 and would probably require modifications to the dashboards as a new platform will be utilized. 2020 Progress: ***Delayed*** In 2020, DHS/SSA implemented a new child welfare data system. With the implementation of a new system existing data reports needed to be validated to ensure accuracy which delayed refinements and enhancement to headline indicator dashboards.	
Develop a schedule to regularly review and clarify goals, objectives and updates of the CFSP with stakeholders and as part of DHS/SSA's Implementation Structure.	2019 and Semi Annually
2019 Progress: ***In Progress*** ● June, July, November and December of 2019: Initiated a root cause analysis within the Protective Service/Family Preservation, Placement and Permanency, and Service Array Implementation Teams to begin the process for integrating an approach to regularly review and clarify goals, objectives and updates of the CFSP. This review was supported by the CQI Network and addressed the following outcomes: permanency for youth in care for two years or more, reentry rates and item 12 of the CFSR. Please see the Updates Goals and Objective section for details on these reviews. 2020 Progress: ***Ongoing*** ● CFSR PIP included as a standing agenda item as part of the bi-weekly OISC meetings with a review of most recent CFSR data reviewed every six months. ● CFSR data included as part of the quarterly SSA Advisory Board meeting every six months. ● Implementation Teams, Networks, and Workgroups continue to utilize a standardized work plan to track status of the implementation of activities identified in the CFSP and identify barriers to implementation. The work plan continues to be reviewed as a regular agenda item at the OISC allowing for conversations related to implementation status and problem solve solutions to implementation barriers.	
Increase stakeholder accessibility of headline indicators and the CFSR results dashboards.	2020
2020 Progress: ***In Process*** The CFSR Performance Report continued to be posted to the internal and external DHS platforms. The results were shared and discussed with the Implementation Teams, Outcomes Improvement Steering Committee, Foster Care Court Improvement Program, and SSA Advisory.	
Enhance State CQI cycle to support regular reviews of progress, identify areas of growth, and test out small measures of change.	2020-2021
2020 Progress: ***In Process***	

Current or planned Activity to improve performance	Target completion date
• Through the existing CQI process, stakeholders were engaged in local department 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. • Through the IPM Supervisory Learning Collaboratives, LDSS supervisors developed small tests of change based on CFSR results and IPM practice they wished to enhance.	
Monitor implementation of CQI cycle making adjustments as needed.	2021-2024

Coordination of other Federal Programs

Assessment of Performance

Maryland maximizes on many opportunities to leverage federal and federally assisted programs serving the same populations with DHS programs and other Maryland state agencies. These coordination efforts involve Federal programs supported through the Department of Housing and Urban Development (HUD), U.S. Department of Labor and the U.S Department of Agriculture (USDA), U.S Department of Labor (DOL) and the Department of Health and Human Services (HHS). A few of the DHS child welfare services that are connected through these coordinated efforts are Out-of-Home programs such as Foster Care, Kinship Navigator, and RB 21 (John H. Chafee).

Maryland's youth and children in foster care are supported through the Family Investment program to provide access to healthy food and nutrition through the Supplemental Nutrition Assistance Program (SNAP) benefits. In 2020, there were 1337 children receiving support from SNAP. During the Pandemic Electronic Benefit Transfer (P-EBT), funds were distributed to 1520 students in out-of-home placements.

The partnership between DHS and DHCD centers around housing initiatives to promote safe and stable housing for youth and young adults transitioning from care. DHCD serves as the grantee for the federally assisted housing programs that the LDSS utilize on behalf of our youth and young adults. The New Future Bridge subsidy program (NFBS) is a medium-term rental subsidy program that provides twelve months of rental subsidy to youth aging out of foster care and survivors of sex crime including sex trafficking, intimate violence, domestic violence, and sexual assault. This program is available statewide to the populations as described above. NFBS accepted 100 applications of which 46 applicants were youth transitioning from care.

The Family Unification program (FUP) is a program that uses Housing Choice Vouchers (HCVs) to provide rental subsidy to families for whom lack adequate housing which is a contributing factor in the imminent placement of the family's child or children in out-of-home care or delays the discharge of the child or children to the family from out-of-home care. Families who are recipients of these vouchers have no time limitations placed on the FUP vouchers. These vouchers can also be accessed for youth who are at least 18 and not more than 24 years old, who left foster care at age 16 or older or will leave foster care within 90 days and are homeless or at risk of homelessness. Youth accessing these vouchers are limited to 36 months of housing assistance. This partnership with DHCD exists for the following Maryland counties: Allegany, Carroll, Caroline, Dorchester, Frederick, Garrett, Kent, Somerset, Talbot,

Wicomico and Worcester counties. There were a total of 93 combined youth and families who accessed vouchers during the 2020 calendar year. FUP has a capacity of 100.

Strengths
The majority of children in foster care received SNAP benefits throughout the 2020 calendar year. These benefits supported and improved access to healthy meals to children in care. During the pandemic an increase of children in care were eligible and received additional access to healthy meals by receiving the P-EBT.

The NFBS medium term rental subsidy program supported transitional aged youth at a rate of 46% of all participants who received housing subsidies. Providing stable and affordable housing for youth transitioning from care.

FUP has proven to be a staple in ensuring families and transitional aged youth have access to safe and affordable housing through receiving housing stability for up to 36 months. The FUP program consistently maintains near to if not at capacity annually.

Maryland's proposed enhanced kinship navigator model creates a single point of access for kinship caregivers who may come to the local department of social services (LDSS) as an FIA customer or may come to the attention of the LDSS through the child welfare system. This approach will allow a more targeted strategy to identify and outreach to more eligible kinship families and ensure access to essential state and federal services and benefits such as temporary cash assistance, Supplemental Nutrition Assistance Program (SNAP), Medical Assistance, and job readiness and employment services offered through Workforce Innovation and Opportunity Act (WIOA). One of the reasons for this system change is to ensure better coordination of services, streamline the enrollment process, and improve the connection of these services for those eligible.

Concerns
Maryland is consistently and progressively aligning our CFSP with coordinated services and benefits with other federal or federally funded assisted programs. However, there are opportunities for growth in the area of partnering with the state and all local housing authorities to secure safe and stable housing for youth and young adults who are transitioning into adulthood through the Fostering Independence Initiative (FYI). While this housing subsidy program is similar to FUP, FYI addresses support only to foster youth who are leaving foster care within 90 days and are at risk of homelessness. Since the establishment of FYI, there is a consensus to reverse previous insufficient collaborative efforts, lack of community partnerships, misleading and lack of knowledge on eligibility and requirements as they were all contributing factors leading to less desirable outcomes and overall low housing stability for youth and young adults. See the John H. Chafee section on pages 133 – 140 for additional information on what Maryland has done to improve in this area.

In addition, Maryland is challenged in establishing better mechanisms to partner with other federal programs that serve the same populations. While a number of connections exist with a number of other federal programs, DHS/SSA needs to identify opportunities to strengthen

partnerships that allow for better coordination with other federal programs for which children and families are eligible.

Activities to Improve Performance
Ongoing coordination efforts among Maryland state agencies include the Maryland Department of Housing and Community Development and the State Department of Education (MSDE). Federally supported educational programs for young learners such as early head start and head start programs are amongst one of the areas DHS/SSA and MSDE are concentrating on to better connect Kinship providers to these services to ensure better outcomes for children in their care.

In regard to Kinship Navigation, opportunities for improvement include the development of cross agency training for staff to create consistent ongoing communication, service coordination, and data sharing. The desired outcome for ongoing collaborative efforts between Kinship Navigation and FIA programs is to mitigate barriers to accessing services and evaluating effectiveness of those services provided.

Maryland continues to look for ways to create opportunities to support youth independence when implementing and providing services that promote sustainability and growth for young adults transitioning to adulthood. One strategy used is infusing well-being benchmark themes during youth transition planning to ensure youth recognize the resources available to them so they remain connected to physical and mental health care treatment and providers in addition to having access to medical insurance through provisions set forth by the Centers for Medicare and Medicaid services (CSM) which is operated through the Department of Health and Human Services (HHS).

Foster and Adoptive Parent Licensing, Recruitment, and Retention
The statewide foster and adoptive parent licensing, recruitment, and retention system is functioning to ensure that:

- State standards are applied to all licensed or approved foster family homes or childcare institutions receiving title IV-B or IV-E funds;
- Criminal background clearances as related to licensing or approving foster care and adoptive placements and a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children is in place statewide;
- Processes for ensuring the diligent recruitment of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed occurs statewide; and
- Processes for ensuring the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children occurs statewide.

Standards Applied Equally
During this reporting period, DHS/SSA and LDSS continued to ensure that state standards were applied to all licensed public/private or approved foster family homes and childcare institutions. All resource providers undergo recruitment, standardized training, and licensing processes to become resource parents as well as re-licensing requirements. DHS/SSA staff shortages exacerbated by a hiring freeze issued by the state hampered the ability to monitor these activities

as in years past. As the state continues to recover from the impact of the pandemic, plans are in place to return to regularly monitoring this element and report during the next reporting period.

Private Homes (RCC and CPA)
Due to the global pandemic any certifications, recertification of foster parents and adoption home studies or reconsiderations that have a due date beginning March 12, 2020 were suspended until 30 days after the State of Emergency is terminated and the catastrophic health emergency is rescinded. Once the state of emergency has ended, all Private Resource Homes are required to be certified as outlined in COMAR.

In the calendar year of 2020, OLM developed mechanisms to address the health crisis. Initially DHS/OLM held weekly provider conference calls with licensed providers (RCC and CPA), to share resources, address overall provider concerns, and to address plans for youth who tested positive for COVID-19. After two months OLM held bi-weekly provider conference calls for the rest of the year. The conference calls provided clarification and training on COMAR requirements during the pandemic.

Child Placement Agencies and Residential Group Homes
DHS's OLM is responsible for ensuring that group homes and child placement agencies are in compliance with requirements related to the 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 exceptions or waivers pertaining to the RCC licenses or the CPA home certifications.

Assessment of Data:
Tables 27 and 28 provide CY2020 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 27: Residential Child Care (RCC) Programs (CY 2020)

# of RCC Providers	# of Site Visits	# of Site Visits that Met Requirements	# of Site Visits that Resulted in a CAP
29 (DHS)	62	8 (13%)	54 (87%)

Table 28: Child Placement Agencies (CPA) homes (CY 2020)

# of CPA Home Records Reviewed	# Met Requirements	# Needed CAP
61*	49 (80%)	12 (20%)

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

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 2020,

there are approximately 1556 certified CPA homes by Child Placement Agencies. All programs are monitored quarterly by OLM and monthly reports are reviewed by Quality Assurance staff. Annually, a random sample (10+10% with max 20) of CPA home records is reviewed by Licensing Coordinators. Calendar year 2020 compliance rates are listed below for Residential Child Care programs and CPA homes.

The data shows a need for RCC 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.

Strengths:

- Quarterly monitoring of providers allows 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. The data shows quarterly consistent monitoring has resulted in provider's maintaining compliance with the regulations pertaining to treatment foster parent recruitment. The data related to RCC's include CAPs related to all COMAR violations. OLM has noticed that a large percentage of CAP violations in Residential Child Care Program are related to physical plant violations. These violations result in the increased number of non-compliance with RCC programs.
- Quarterly Provider Meetings allows private providers to ask questions and inform OLM of issues with performing services. Quarterly meetings are opportunities to provide COMAR interpretation and training on new licensing requirements, training on current placement trends and a platform to share other related information from the Department of Human Services, Social Services Administration.

Concerns:

Residential Child Care Programs appear to have a higher rate of non-compliance compared to the previous year. The data includes COMAR violations in all areas not just those related to recruitment and retention. Future data collection will capture specific violation related recruitment and retention. Furthermore, due to the state of emergency during 2020, OLM was unable to fully monitor all programs and gather sufficient data to compare to the previous year.

Criminal Background Checks

The state was unable to provide data relative to criminal background clearances for public foster parents during this reporting period. The state integrated a new child welfare system and while it is fully functional, the state has experienced challenges extracting data and determining its accuracy. In addition, as a result of the COVID-19 pandemic DHS/SSA encountered staff shortages as a result of hiring freezes issued by the state. Both factors inhibited the ability to perform independent auditing of this systemic factor.

While challenges were experienced related to monitoring criminal background checks related to licensing or approving foster care and adoptive placements, DHS/SSA continued processes to address the safety of children in foster care and adoptive placements. DHS/SSA receives the maltreatment reports of all youth in care. DHS/SSA will analyze the report and review for indicated and named unsubstantiated findings to determine if there were criminal charges.

DHS/SSA utilizes this data to provide additional technical assistance to the LDSS when there is an indicated finding to ensure there was corrective action taken against the resource parent when applicable. In CY2020, DHS/SSA received 20 public resource home maltreatment allegations submitted by the LDSS, in which 6 were indicated, 4 were ruled out, and 10 were unsubstantiated. This data shows a slight increase compared to CY2019.

In addition, the LDSS continue to practice the process of obtaining the LDSS Director's waiver when a resource parent has an indicated finding of abuse/neglect. These dispositions will reflect on the resource parents criminal background record. If waived, this documentation is placed in the system of record as evidence of compliance. DHS/SSA is responsible for reviewing the system of record to ensure that there is evidence of the Director's waiver.

Strengths:

In the development of the new child welfare system, DHS/SSA has requested a reporting tickler to indicate when providers both public and private have indicated maltreatment findings.

Challenges:

Due to the development of the new system, DHS/SSA is unable to provide an analysis of the data for this reporting period. Also, due to resource home shortages, SSA was unable to oversee the monitoring and provide technical assistance for the provider criminal background requirement.

Private Resource Homes (CPA and Residential Group Homes):

Due to the global pandemic, a suspension of any certifications, recertification of foster parents and adoption home studies or reconsiderations that have a due date beginning March 12, 2020 until 30 days after the State of Emergency is terminated and the catastrophic health emergency is rescinded. Once the state of emergency has ended, all Private Resource Homes are required to have federal clearances as outlined in COMAR.

Analysis of Data:

All Residential Child Care Providers (RCC) and Child Placement Agencies (CPA) are required to receive and review criminal background checks. RCC personnel records must contain documentation of the criminal background check request and a copy of the initial outcome and any periodic updates. Employees are not allowed to have unsupervised contact with the children until the RCC provider has received the results of the criminal background check. Per the Family First Prevention Services Act, all adults working in the RCC facility must have criminal background checks. Child Placement Agencies 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.

Incidents of maltreatment regarding a CPA or group home are reported to the LDSS/CPS unit, OLM, and private provider agency. With CPA homes, they are placed on hold pending the investigation and youth are removed, if warranted. DHR/OLM receives the reports when there is an indicated maltreatment finding. 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.

Child Placement Agencies and Residential Child Care providers are required to submit a Critical Incident Report Form to DHS/OLM via the olm.incidents@maryland.gov email account. This email account is monitored daily by a Program Manager, who processes all reports as part of coverage responsibilities. All incidents are reviewed, logged, and forwarded (as appropriate) to DHS/OLM and DHS/SSA staff for further review, investigation 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.

Listed in Tables 29 and 30 below is the CY2020 federal clearance compliance data for Residential Child Care Programs and CPA Homes. Overall, the data for private resource homes and private providers show an average of 99% compliance with criminal background checks and home study elements.

Table 29: Residential Child Care Programs (CY 2020)

# of RCC employee records reviewed	Compliant for Federal Clearance	Non-Compliant for Federal Clearance
65*	63 (99%)	2 (1%)

Table 30: CPA homes (CY 2020)

# of CPA home records reviewed	Compliant for Federal Clearance	Non-Compliant for Federal Clearance
61*	61 (100%)	0

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

Regarding DHS/OLM monitoring, these requirements are applied equally and there are no instances of exceptions or waivers in regard to the RCC licenses or the CPA home certifications. To ensure uniformity in private resource (CPA) homes, DHS/OLM is currently reviewing provider cases on a quarterly basis to ensure that standards are equally applied.

Strengths:

- Quality Assurance Coordinators reviews the provider safety report on a monthly basis. This report documents all new and current provider employees' clearances, private resource home clearances and home study elements.
- 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.

Concerns:

- OLM will consistently monitor and apply technical assistance and request corrective action plans when non-compliant.

Plans for next year:

OLM processes for monitoring in this area have been successful as seen in the data reported. Processes that are already in place will continue. In addition, Licensing Coordinators will be 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.

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 annual licensure period. The maximum number of records reviewed should not exceed 20 per category (youth records, foster parent records and personnel records) annually. Annually, the record review quota is divided by four.

Random samples of interviews with youth, foster parents and staff are also required quarterly. A minimum of 5 interviews with youth, foster parents and staff are performed over the course of an annual licensure period. The guidelines for interviews are:

- The foster parents of youth interviewed must be interviewed, and
- at least one staff member per site per shift.
- Interviews are divided over the four quarterly site visits.

The interview guidelines give OLM a broad picture of the providers services and compliance with COMAR.

OLM has been included in the development of CJAMS with the inclusion of two sections: the worker side and the provider portal. The provider portal was developed to enhance monitoring of the provider agencies. In July of 2020, four pilot providers were granted access to CJAMS.

Providers are required to enter:

- Employee information, such as certification, licensing, training, and clearances.
- Foster parent information, such as home study, demographic information for all household members, health and fire inspections, medical for all household members, clearances for all household members adult's 18 year and over and annual training.
- Providers can submit budgets, financial incident reports, change requests (waiver, address change, voluntary closure etc.), Corrective Action Plan (CAP) response and uniform incident reports via the portal.

CJAMS will allow OLM advance capabilities to monitor the private provider agencies. On the worker side of CJAMS, OLM Licensing Specialists will be equipped with a tablet that will allow them to log into CJAMS from the field.

- Licensing Specialists can compose the monitoring report and use monitoring tools (youth interview, record checklist etc.) while at the provider facility.
- Licensing Specialists can submit a corrective action plan to the provider.

- Licensing Specialist can submit a sanction to the provider
- Licensing Specialists can respond to provider change requests and CAP response.
- Licensing Specialists can view employee and foster parent data.
- Licensing Specialists can view uniform incident reports, budgets, and financial incident reports.

The full launch of CJAMS for OLM and providers will occur in the summer of 2021.

Diligent Recruitment

The state continued to be responsible for the development of the statewide recruitment and retention plan. Each LDSS also submitted local recruitment plans. Both plans must include strategies to recruit potential foster and adoptive families who reflect the ethnic and racial diversity of children in foster care in Maryland. When reviewing race and ethnicity data for youth in foster care and Resource Parents, in comparison to 2019, Maryland has shown improvements in ensuring resource parent racial composition was an accurate reflection of the number of youths entering care. The data outlined in Table 31 reflects increases in all racial compositions from 2019-2020 except for the American Indian population. This decrease may be indicative of the ICAWA law being adhered to thereby allowing youth who identify as American Indian to be placed within their respective tribes. In comparison to 2020, Maryland has improved upon the need for additional resource parents to meet the racial composition of youth in care for both public and private providers. As opposed to the previous year's racial/ethnicity data, DHS/SSA was challenged with the missing/unknown components, however the technical assistance provided to the LDSS has allowed this number to be more accurate. In addition, the system has improved in capturing the race and ethnicity of resource parents as noted by the decrease in unknown responses related to race and ethnicity. DHS/SSA ensures that resource parents are recruited based on the ethnic and racial diversity of children within the 24 local departments. The LDSS submit annual recruitment and retention plans to the state office and quarterly reports which focus on the recruitment and retention of resource parents. Many resource parents who are licensed continue fostering and often adopt and/or are awarded custody and guardianship of youth.

In addition, DHS/SSA has a policy that establishes guidance to the LDSS regarding waiting children. Each LDSS is responsible for ensuring that youth are profiled on the Adopt-us-Kids (AUK) website, if applicable. AUK is utilized in Maryland as a tool and encourages the profiling of adoptable youth. The central office is in communication with the national AUK liaison and helps facilitate the profiling of youth on the AUK website.

Table 31: Racial Composition of Youth in Care and Placement Providers

	Youth in care			Placement Providers Race and Ethnicity		
Race	**December 31, 2018**	**December 31, 2019**	**December 31, 2020**	**December 31, 2018**	**December 31, 2019**	**December 31, 2020**
Black	2,724 (59%)	2,574 (57.1%)	2,699 (60%)	729 (30%)	628 (28.4%)	1,670 (55.9%)
White	1,238	1,228	1,110	550	533	927

	Youth in care			Placement Providers Race and Ethnicity		
	(27%)	(27.2%)	(25%)	(23%)	(24.1%)	(31.0%)
Hispanic	319 (7%)	314 (7%)	344 (8%)	58 (2%)	50 (2.3%)	210 (7.0%)
Asian	33 (1%)	33 (1%)	30 (1%)	1 (0%)	40 (0.2%)	21 (0.70%)
American Indian/Native Hawaiian Pacific	1 (0%)	8 (0.25%)	8 (0.18%)	3 (0%)	5 (0.2%)	3 (0.10%)
All others* (Refused, Unable to Determine)	295 (6%)	50 (1.1%)	3 (0.07%)	1,091 (45%)	0 (0.0%)	0 (0.0%)
Missing/Unknown**	NA	302 (6.7%)	288 (6.4%)	NA	90 (4.48%)	157 (5.25%)
Total	4,610 (100%)	4,509 (100%)	4,482 (100%)	2,432 (100%)	2,210 (100%)	2,988 (100.0%)

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. DHS/SSA is working to reduce these numbers by ensuring workers work to obtain racial demographics and inputting the information into the system.

It is important to note that there were no resource parents that refused to provide racial demographic information and the data did not indicate the LDSS was unable to determine racial composition. In addition, missing/unknown information decreased from 44.8% to 5.25%. This information is reflective of the improvements and technical assistance DHS/SSA has provided to the LDSS regarding the importance of capturing racial demographic information as well as the enhancements made to the new child welfare information system. As outlined in the Statewide recruitment and retention plan, Maryland's African American youth population continues to be the greatest ethnicity in the child welfare system. As of December 2020, 58% of youth are African American, 29% are White, and 4% fall within the category of others. DHS/SSA will continue to work with the LDSS but specifically Baltimore City and Prince George's County as there continues to be the greatest need. Maryland is divided equally among female and male youth currently in care.

DHS/SSA has successfully achieved increasing the number of resource parents based on the number of youths in care. However, DHS/SSA will need to assess how to extract a data report from CJAMS during FY 21-22 to assess the "matching" of children entering care to resource parents based on racial demographics. This activity is directly related to the Resource Home Recruitment and Retention plan as outlined in the five-year CFSP. DHS/SSA also plans to procure services to conduct a statewide recruitment plan to increase the number of resource parents. The state will consider racial and ethnic diversity when looking at the activities within the recruitment and retention plan to address racial disproportionality and disparities). In addition, activities outlined in the Diligent Recruitment Plan as well as the Adoption Saving

Plan, responds to the Children's Bureau's Adoption Call to Action initiative which began in 2019. (See Diligent Recruitment Plan Adoption Savings Section for specific activities and details about the plans).

Strengths:
As of December 2020, CJAMS data reflects that DHSA/SSA has increased the number of youths in public resource homes (1,863) compared to private homes (1,429) which is one indication of the successful recruitment of resource families, specifically relative placements. In addition, DHS/SSA's recruitment efforts have resulted in the majority of youth 0-13 (82%) being placed in resource homes.

Challenges:
DHS/SSA is still challenged in data reporting due to the new child welfare system. Currently, the state is unable to make the correlation regarding "matching" foster youth to resource parents (including pre-adoptive resources) with the same racial demographic. In addition, the state was unable to monitor and assess the LDSS recruitment plans during this reporting period due to staff shortages within the central office as a result of hiring freezes instituted statewide.

Activities to Improve Performance:
As outlined in the Maryland Statewide recruitment and retention plan, the state office, as well as the local departments, continues to focus on increasing the number of resource parents to meet the racial composition of youth in care. DHS/SSA plans to have more qualitative data during the next reporting period to monitor these efforts. See Section on Post Adoption Savings for more details.

State use of Cross-Jurisdictional Resources for Permanency Placements
DHS/SSA continues to support youth being placed in Maryland from other states and works collaboratively with the local departments to ensure that home studies are completed within required timeframes. In addition, DHS/SSA uses the support of Tetrus/NEICE to calculate home study completions to ensure that the home studies are meeting the required timeframes. The data in Table 32 shows Maryland's performance between January and December 2020.

Table: 32 Home Studies Completed within 60 Days in CY 2020

	Home study not completed within 60 days		Home study completed within 60 days	
	CY2019	CY2020	CY2019	CY2020
Number of children:	468	474	181	216
Percent:	72%	69%	28%	31%

Data Source: ICPC Compact - NEICE

Analysis of the Data:
According to the National Electronic Interstate Compact Enterprise (NEICE) system, 31% of home studies submitted from other states were completed within 60 days. See chart above. In comparison to the previous year's rate of 28%, this is a positive 3% increase. This increase is believed to be due to greater proficiency with use of the NEICE electronic case management system.

The target for December 2024 is 60% of incoming ICPC home studies to be completed in 60 days. Although there was a slight increase, performance in this area continues to be a concern for Maryland as less than one third of the required home studies are completed within the 60-day timeframe. DHS/SSA will begin collecting data via a formal survey from each of the local departments in order to identify barriers and effective strategies to improve the number of home studies completed within the required timeframe.

Strengths:
All 24 local departments are actively utilizing the NEICE system and the DHS/SSA ICPC is able to review the information in a timely manner. DHS/SSA supports state and local staff in participating in ongoing training on the use of NEICE. The NEICE is a self-contained electronic case management system and record and transmittal delivery system between States, DHS/SSA and the 24 MD LDSS containing all relevant information related to cross jurisdictional placements. NIECE allows for automatic ticklers to be sent related to key activities associated with cross jurisdictional placements. These ticklers assist in ensuring timely processing of cases in 1-3 business days and processing all other correspondences in 3-5 business days.

DHS/SSA ICPC staff works closely with the local departments to address concerns raised by the LDSS, or by other States seeking timely information and reports. Maryland does not currently have a mechanism in place to collect and count the types and number of concerns but expect that these data will be available when ICPC activities are incorporated into CJAMS.

Concerns:
Local departments continue to experience challenges with completing home studies within the required time frame. As stated above, only 31% of home studies are completed within 60 days. While DHS/SSA has no qualitative data, based on regular conversations with LDSS to solidify cross jurisdictional placements the issue of timely completion of home studies has often been raised as a barrier.

Activities to Improve Performance:
The NEICE system automatically notifies and reminds users of pending due dates, via email messages/transmittals. This information is useful to provide opportunities to complete all required documents and activities in advance of the due date. In addition to this information, DHS/SSA provides weekly and as needed TA support to each of the local departments in order to assist with timely and quality completion of documentation. DHS ICPC will be surveying the local departments to identify barriers to completion of timely home studies. That information will be used to identify case specific and systemic barriers. DHS/SSA will work with other partnering agencies to explore remedies to any identified barriers. To further improve performance in this area, DHS/SSA will establish performance reports in March 2021 for each of the 24 Maryland LDSS to monitor timely completion. The report will include all pending and/or overdue home study assignments and will be distributed on a monthly basis beginning in March 2021. Structured TA sessions will continue on an as needed basis to address case related barriers and delays impacting timely submission of home studies. Also, DHS/SSA began meeting with MDTHINK in August 2020 to begin planning sessions to integrate ICPC in CJAMS. The plan is to have ICPC integrated by December 2021. The implementation of CJAMS will allow us to track timeliness of home studies for children being placed in Maryland from other states.

DHS/SSA to complete a root cause analysis to identify system barriers and develop potential interventions to support the timely completion of home studies.

Table 33 below outlines additional activities planned to improve performance of the statewide foster and adoptive parent licensing, recruitment, and retention system and the status of the implementation of the identified activities.

Table 33: 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
2019 Progress: ***Delayed*** ● DHS/SSA is delayed in implementing this activity. There are plans to provide further technical assistance in 2020, to expand use of federal grant secured by RESD&T staff in Spring 2021 and to proceed in 2021 with CJAMS on-boarding Statewide. 2020 Progress: ***In Progress*** ● DHS/SSA provides TA to each of the LDSS staff to help facilitate timely completion of home studies. MD-ICPC Specialists provide follow-up with each LDSS for the duration of the ICPC referrals work. Each of the LDSS acknowledge receipt of their ICPC case assignments and receive due date reminders from DHS/SSA staff, as well as automated notifications generated via the electronic case management system. ● Detailed reports containing due dates and a list of pending and overdue home study assignments are submitted to each of the 24 MD LDSS. The report is designed to assist the LDSS with planning activities and addressing identified barriers. DHS/SSA provides technical advice to eliminate barriers to timely completion of home studies. The LDSS are asked to document and inform DHS/SSA of what progress is made and of what is delaying their 60-day due dates. ● DHS/SSA provides on request refresher training on various aspects of ICPC Compact policy and on the use of the NEICE electronic case management system for all ICPC work in addition to E-Learning (400+ caseworkers in MD to date) and 24 hour available YouTube NEICE training on each section of the NEICE tool. MD LDSS ICPC Liaisons are also invited to monthly/quarterly NEICE refresher trainings conducted by the Tetrus/NEICE staff (on 11/18/2020, 1-3 PM and on 12/16/2020, 1-3 PM).	
Track/Monitor resource home study completion for 120-day compliance initial certification and 60-day ICPC completion.	Quarterly
2019 Progress: ***Delayed*** DHS/SSA has been delayed in developing the resource home monitoring report due to the new system development however we continue to provide TA to locals. 2020 Progress: ***Delayed*** DHS/SSA has been delayed in integrating NEICE and CJAMS due to the statewide roll out of CJAMS. It is expected to begin the planning for the integration in the next reporting period.	
Provide technical assistance to jurisdictions that indicate barriers to completion according to the milestone report.	Quarterly
2019 Progress: ***In Progress***	

Current or planned Activity to improve performance	Target completion date
July 2019: In lieu of the milestone report, conducted quarterly monitoring of resource home cases inclusive of ICPC home studies. See above auditing data. 2020 Progress: ***Delayed*** Due to the lack of resource home staff, DHS/SSA was unable to conduct resource home audits for this reporting period.	
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
2019 Progress: ***In Progress*** April 2019: Began discussions to incorporate ICPC home studies into the new system development. 2020 Progress: ***Delayed*** Due to the new child welfare system delays, the Resource Home Milestone Report has not been developed. DHS/SSA is partnering with MDTHINK to incorporate ICPC information into the new electronic case management system (CJAMS) and create an interface with the NEICE system in order to make ICPC information accessible for generating data reports and monitoring progress within and across jurisdictions.	
Provide technical assistance to the LDSS to ensure compliance and clarify any questions.	Quarterly
2020 Progress: ***In Progress*** Monthly: DHS/SSA documented and detailed each individual pending Interstate case, in messages to each ICPC Liaison and assigned home study worker, a reminder of the needed home study and requested status update reports on each pending case.	
Create and issue a memorandum regarding ICPC compliance to LDSS.	Annually
2019 Progress: ***Delayed*** ● DHS/SSA is delayed in implementing this activity. There are plans to create and issue memorandum in winter of 2020. 2020 Progress: ***In Progress*** ● April 2020: DHS/SSA MD-ICPC submitted a correspondence to each of the 24 LDSS containing County specific "pending" and "overdue" home studies and a reminder for timely home study completion.	
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
2019 Progress: ***In Progress*** April 2019: Began discussions to incorporate ICPC home studies into the new system development. 2020 Progress: ***Delayed*** Due to the new child welfare system delays, the Resource Home Milestone Report has not been developed. DHS/SSA is partnering with MDTHINK to incorporate ICPC information into the new electronic case management system (CJAMS) and create an interface with the NEICE system in order to make ICPC information accessible for generating data reports and monitoring progress within and across jurisdictions.	
Resource Parent Training	

Current or planned Activity to improve performance	Target completion date
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
2019 Progress: ***In Progress*** January 2019: The University of Maryland Child Welfare Academy issues a quarterly resource parent training calendar to the LDSS. This calendar is also posted on the MRPA website. 2020 Progress: ***In Progress*** The quarterly training calendar has been posted on the MRPA website to ensure resource parents have another means of accessing resource parent training.	
Re-institute the Quarterly Resource Home regional meetings to ensure communication from State level to LDSS is consistent.	2019/Quarterly
2019 Progress: ***Delayed*** ● October 2019: Developed and planned resource home quarterly meetings to be held in winter 2019, however due to challenges plans are now underway to start in fall of 2020. Implementation of regional meetings was delayed, due to staff shortages within the program. 2020 Progress: ***Delayed*** ● Implementation continues to be delayed in this area due to staff shortages within the program.	
Criminal Background Checks	
Explore options to get Live Scan electronic criminal history fingerprinting and CJIS clearances at each MD LDSS or in an adjacent LDSS location to assist with 60-day home study requirement.	2020
2020 Progress: DHS/SSA explored the ability to obtain the usage of Live Scan to obtain criminal history fingerprinting and CJIS but was unsuccessful. The state will continue to explore this option as well as look into other accessible resources.	
Cross-Jurisdictional Resources for Permanency Placements	
Review NEICE to determine best methods to complete home studies in 60 days.	Quarterly
2019 Progress: ***In Progress*** See State use of Cross-Jurisdictional Resources for Permanency Placements section.	
CJAMS will replace MD CHESSIE, and DHS/SSA plans to integrate NEICE with CJAMS.	2020
2020 Progress: ***In Progress*** ● Monthly: DHS/SSA participated in discussions regarding ICPC integration into CJAMS. ● December: Began Focus Groups meetings to support the development of user stories to describe the needed functionality within CJAMS.	
Resource and Adoptive Parent Training	
Review annual resource home survey data to determine the added supports resource parents need.	Annually

Current or planned Activity to improve performance	Target completion date
Progress: See Foster and Adoptive Parent Training section	
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
2019 Progress: ***In Progress*** January of 2019: Began partnering with the 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. This will be completed in May 2020. 2020 Progress: ***In Progress*** Piloted training has been developed through the Center for Excellence in Foster Family Development Grant to enhance the current in-service/pre-service resource parent training regarding the effects of secondary trauma. Implementation will begin once the first cohort of resource parents are selected.	
Work with the Center for Adoption Support and Education to train/strengthen the skills/knowledge of existing child welfare adoption staff.	2020
2020 Progress: ***In Progress*** Implementation of the Workforce Adoption Education and Post Adoption Services contract has been procured and is scheduled to begin in April 2021.	
Resource Parent Recruitment and Retention	
Utilize the Maryland Resource Parent Association, Foster Parent Ombudsman and State Youth Advisory Board to assist LDSS with targeted recruitment efforts to increase resource homes for African American, Asian and Hispanic youth in care.	Semi-Annually
2019 Progress: ***In Progress*** ● October 2019: The MRPA and Foster Parent Ombudsman became members of the foster parent engagement workgroup and are current champions of campaigning for the increase of resource parents for this population of youth. DHS/SSA plans to include the State Youth Advisory Board in the upcoming year. 2020 Progress: ***Delayed*** Due to other competing priorities within resource homes, this activity has been delayed.	
Partner with the Capacity Center for States to work on foster parent engagement initiatives centered on the recruitment and retention of resource home parents.	2019
2019 Progress: ***Completed*** ● December 2019: Partnered with the Capacity Center to develop a theory of change, updated work plan, assessment of the Maryland Resource Parent Association, and the development of a MRPA foster parent survey. The survey is being disseminated to public resource parents. 2020 Progress: ***In Progress*** DHS/SSA and the Capacity Center for States collected a survey of all MD local jurisdictions' resource parent associations to identify needs. The results were shared on the Maryland Resource Parent Associations (MRPA) website and with LDSS leadership, both the Maryland Resource Parent Association, LDSS, and SSA are currently planning action steps to address resource parent concerns within the survey.	

Current or planned Activity to improve performance	Target completion date
Meet with the Maryland's Commission on Indian Affairs to speak about child-specific recruitment for this population.	2020
2020 Progress: ***Delayed*** This activity has been delayed due to staff shortages at SSA.	
Adoption Call to Action	
Monitor and track LDSS utilization of AdoptUSKids website for photo listing of legally free and eligible for adoption as a means to obtain increased adoption finalization.	Quarterly
2019 Progress: ***In Progress*** ● DHS/SSA determined that the website is being underutilized; therefore, the policy will be assessed and revised to ensure compliance. In addition, technical assistance will be provided to the local departments on increased utilization. In November of 2019. 2020 Progress**: Delayed** ● Maryland's AUK Work Plan is currently pending at this time as the Permanency Workgroup has shifted focus on other areas of adoption/guardianship. Maryland will resume the AUK work plan which will include the continuation of the photo listing work by Fall 2021.	
Work with AdoptUSKids to implement a work plan to improve adoption practice and outcomes.	2019
2019 Progress: ***In Progress*** ● June 2019: Partnered with Adopt-Us-Kids to review and revise the AUK photo listing policy. ● October 2019: A representative of AUK joined the Placement and Permanency Workgroup where this work is being developed. The AUK member is still involved in the permanency workgroup and continues to work on the adoption assistance policies and the Adoption Call To Action priorities. 2020 Progress: **Delayed** Work plan with AUK is currently on hold.	
Include cultural competency as a component in the adoption competency training as well as in the recruitment efforts for additional resource homes.	2020
2020 Progress: **Delayed** Work plan with AUK is currently on hold.	
Explore with jurisdictions and AdoptUSKids, issuance of LDSS adoptive parents open to attending matching events to obtain cross jurisdictional adoptive resources.	2020/annually
2020 Progress: ***Delayed*** Maryland's AUK Work Plan is currently pending at this time as the Permanency Workgroup has shifted focus on other areas of adoption/guardianship. Maryland will resume the AUK work plan which will include the continuation of the photo listing work by Fall 2021. ● The Permanency Workgroup has formulated a sub-group to work on the Adoptions Assistance policy. The policy has been reviewed and the workgroup is currently developing an Adoption Assistance Caseworker and Parent Manual.	

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

In DHS/SSA's CFSP, five goals with related objectives and interventions were identified to enact the state's vision and improved outcomes. DHS/SSA CQI process, outlined on pages 115-116, has been utilized to identify and make any needed revisions to goals, objectives and interventions in future years. Outlined below is the State's progress in implementing the identified interventions.

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:

In 2020, DHS/SSA utilized the implementation of the Integrated Practice Model (IPM) training to lay the foundation for increasing the voice of lived experience in building partnerships with families of origin and youth. The IPM training, which rolled out to the workforce in July 2020, focused on engaging, teaming, assessing and planning with families, children, youth and the integration of these skills to increase youth and family voice in their child welfare experiences. CFSR measures of Safety 2 and Well-being 1 were monitored for progress as an indicator of achieving this goal. Significant progress was made in these areas in CY2020 with the number of cases rated in substantial conformity increasing by 13% points for Safety 2 and 17% points for Well-being 1 since CY 2019. DHS/SSA had also intended to monitor the completion rates for the CANS and CANS-F, however as a new data system was implemented statewide in CY2020 the state has experienced difficulties around extracting data from the system and assuring its accuracy. It is hoped that the collaborative assessment data will be provided in the next reporting period.

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

Rationale for Goal Selection:

- The Maryland CFSR Final Report results indicated that Well-being Outcome1 was not in substantial conformity, with an outcome of 31%.
- The Maryland CFSR Final Report and the feedback received during Maryland's PIP Convening showed:
    - Children, youth, parents and caregivers are not consistently treated as authentic partners in working towards goals of safety, permanency and well-being.
    - Youth and families experience their local child welfare agency and courts as disempowering.
    - Professionals do not engage and team with families and youth in ways that allow for their voice and expertise in their own experience to drive an understanding of their needs and the services that meet those needs.
    - Lack of engagement and partnering with families leads to inaccurate assessments, insufficient identification and referral to services that are tailored to the family or youth's needs, and inadequate efforts to identify and preserve children and youth's relationships with their parents, relatives and their communities.
    - Resource parents are not fully involved as part of the caring team; either as partners with the agency and courts or partners with families.
    - Missed opportunities to support families of origin in service of better relationships and outcomes for children.
    - Resource parents are not valued as part of the team, not consistently sought out for their knowledge about how youth and families are faring, and their capacity to become permanent resources is not appropriately factored into the team's decision-making.

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 in their homes whenever possible and appropriate will increase to 79% or higher by the conclusion of conclusion of the CFSP period (S 2)	69%	63%	76%			
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 (WB 1)	31%	22%	39%			
CANS compliance rate will increase to 80% or higher by the conclusion of the CFSP period	61%	53%	Not Available*			
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*			

*Due to Maryland's transition to a new data system the ability to extract CANS and CANS-F data has been delayed. DHS/SSA will provide CY2020 data as soon as it is available.

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%

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 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:
    - 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:

- Confusion related to correctly scoring items
- Difficulty in incorporating the CANS/CANS-F assessment into the development of action-oriented goals in the current Service/Case plan design in CHESSIE

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
2019 Progress: ***In Progress*** ● December 2019: Established baseline data around accuracy of assessments which was used to help inform the design of the TA approach. ● December 2019: Revised the technical assistance traditionally offered to LDSS in use of the CANS and CANS-F assessment instruments to align with the Integrated Practice Model. Technical assistance has been designed to train supervisors and staff in meaningful use and the practice of collaborative assessment while using the tool. Sessions with supervisors will focus on data and documentation accuracy that may support staff in improving assessment and engagement skills. Sessions with staff will focus on use of the assessment tools in the context of the practice of engagement and assessment. ● A pilot of this approach is planned for March 2020 in at least one jurisdiction. 2020 Progress: ***In Progress*** ● See Section 3. ● Building upon 2019 key activities that engaged stakeholders in identifying needed changes to existing teaming practices as well as to identify teaming models that have proven successful in local jurisdictions nationally, policy and training were developed to reflect these needed changes. These changes were built into the IPM training which was launched to the workforce in 2020. Technical assistance changes around use of the CANS and CANS-F were included in this training. ● To address the revamp of Family Teaming revisions we completed and internally approved the existing FIM (now Family Teaming) policy to align with the IPM Teaming model. Revisions to the policy included input from an array of stakeholders including LDSS staff and leadership, court partners, resource parents and families with lived experience.	
Strengthen the technical assistance provided to LDSS staff to support the effective implementation and meaningful use of collaborative assessments.	2019

Key Activities	Benchmarks for Completion
2019 Progress: ***In Progress*** ● July and December of 2019: Listening Sessions were conducted across the State which inquired about current practices around collaborative assessment in order to craft more meaningful and relevant technical assistance which aligns with the Integrated Practice Model. Feedback included specific needs around assessment and engagement. ● December 2019: Technical assistance was revamped to include hands-on exercises, specific work with supervisors in order to promote coaching of the tool with staff. ● A pilot technical assistance session is scheduled for March 2020. 2020 Progress: ***In Progress*** ● See Service Array Section. Pages 59-60 Activities Planned to Improve Performance: *Revise process for collaborative assessments and developing service plans to facilitate partnership with families including consistently identifying & engaging the family/youth's chosen supports.*	
Revise pre-service and ongoing learning opportunities to strengthen collaborative assessment skills in alignment with IPM.	2020
2020 Progress: ***In Progress*** ● See Staff Training Section, Page 48 Activities Planned to Improve Performance: *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.* ● See Service Array Section, Pages 59-60 Activities to Improve Performance: *Revise process for collaborative assessments and developing service plans to facilitate partnership with families including consistently identifying & engaging the family/youth's chosen supports.*	
Improve utilization of collaborative assessment data at State and local level to design and provide individualized, tailored technical assistance plans for locals.	2020
2020 Progress: ***In Progress*** ● Plans were developed to incorporate this data in IPM coaching strategies planned for 2021. This includes use of a skills-tracker in supervision and supporting supervisors in using this data to inform what gets addressed and managed in supervision.	
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
2020 Progress: ***In Progress*** ● Supervisors across the State were coached through an IPM Learning Collaborative as the IPM training was rolled out across the State in 2020. They were trained in the use of Plan, Do, Study, Act cycles which addressed some of the practices related to authentic partnership, collaborative assessment, and developing family/youth driven plans. ● Groundwork was laid for more intensive coaching around IPM implementation in 2021.	
Continue monitoring meaningful use of collaborative assessments.	2021-2024

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

Assessment of Performance:

The implementation of Maryland's Integrated Practice Model began in March of 2020 with the introduction of the practice model through the E-learning modules that were completed by staff through the end of July. The E-learning modules featured practice profiles of the IPM in order to give staff and supervisors a clear picture of what practice should look like in action and to test their knowledge of this vision. Supervisors and agency leadership took part in orientation and overview sessions about the implementation in July 2020. Training of current staff and supervisors started in July and coaching of supervisors through a learning collaborative started in August 2020. In September, a revised pre-service training was launched and is also now inclusive of the Integrated Practice Model. During the reporting period, CFSR measurements have increased with Safety item 2 increasing by 13% and Well-being item 1 increasing by 17%. Recurrence of maltreatment and re-entry from permanency rates both surpassed target outcomes indicating that training and coaching of the IPM are impacting outcomes.

Goal 2: Strengthen workforce knowledge and skills to support the full implementation of Maryland's Integrated Practice Model (IPM). (PIP Goal)
Rationale for Goal 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 Outcome 1: Families have enhanced capacity to provide for children's needs, 31% ○ Systemic Factors Initial Staff Training (26), Ongoing Staff Training (27), and Foster and Adoptive Parent Training (28) ● The following headline data are further examples of where lack of strong engagement skills affects outcomes: ○ Recurrence of maltreatment is at 10% ○ Reentry into foster care is at 11.8% ● Per MD CHESSIE data, DHS/SSA found that January 2018 - December 2018, the total number of providers was 1,555. Of the 637 established providers, 476, 75% completed 10 or more hours of in-service training within the required timeframe ● Results of key informant interviews conducted with families of origin to obtain feedback on Maryland's integrated practice model state revealed the following themes as being important in partnering with families: ○ Engagement and open communication ○ Comfort level with worker ○ Be able to see progress ○ Creating space for parents to share thoughts, feelings, and opinions ○ Access to information and understand my rights ○ Education on discipline and abuse ○ Clarity ○ Prevention

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. (S2)	69%	63%	76%			
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. (WB1)	31%	22%	39%			
Reentry rate from all types of permanency will decrease to 8% or lower by the conclusion of the CFSP period.	11.8%	10.1%	7.8%			
Recurrence of maltreatment rate will decrease to 9% or lower by the conclusion of the CFSP period.	10%	9%	5.3%			
The percentage of Foster Parents completing required ongoing training will increase to 95% or higher by the end of the CFSP period.	75%	82%	Not Available*			

*Due to Maryland's transition to a new data system the ability to extract Resource Parent training data has been delayed. DHS/SSA will provide CY2020 data as soon as it is available.

Key Activities	Benchmarks for Completion
Introduce the IPM to staff and stakeholders. (PIP Activity)	2019

2019 Progress: (PIP Goal 2, Intervention 1): ***Completed***

- May and July of 2019: Held a number of forums and meetings around the State between to build understanding of the Integrated Practice Model. These events included disseminating materials that outline the core practices, values and principles and what they look like in practice.
- July - December 2019: Every jurisdiction was given the opportunity to dialogue about the practice model as well as self-assess strengths and needs concerning the implementation of the IPM
- November - December 2019: Provided foundational training in the Safety Culture Model, a model of psychological safety, for local leadership. Supervisors have been given the opportunity to learn about the shifts that will be happening in training through coaching and transfer of learning.

Key Activities	Benchmarks for Completion
● October - December 2019: E-learning modules were developed to be launched to the workforce for the purpose of introducing the workforce to the practice profiles. The release of the E-learning modules is expected within the next few weeks.	
Disseminate practice profiles to LDSS and stakeholders.	2019
2019 Progress: ***Completed*** ● See Progress update for: Introduce the IPM to staff and stakeholders. (PIP Activity) ● 2020 Progress: ***Completed*** ● Practice Profiles were both operationalized and re-introduced in the IPM training that launched in July 2020.	
Develop and launch e-learning modules for prioritized practice profiles.	2019
2019 Progress: ***In Progress*** (PIP Activity) ● Jan - Dec 2019: Practice Profiles were finalized and approved. ● July – December 2019: IPM E-learning modules were developed with a plan to launch in 2020. 2020 Progress: ***Completed*** ● E-learning modules designed to introduce the workforce to the Integrated Practice Model practice profiles were launched in April 2020 and completed by the workforce in July 2020.	
Offer initial training on Maryland's IPM for existing staff, supervisors, management, and central office staff for current employees delivered statewide with the goal of catalyzing a shift in philosophy and practice statewide. (PIP Activity)	2019-2020
2019 Progress: ***In Progress*** ● May- July 2019: an initial training presentation was delivered across the State and at a DHS/SSA staff meeting to promote the philosophy and practice shift intended by the IPM. In December 2019, a more specific training was delivered to DHS/SSA's extended leadership team to demonstrate how the IPM is operationalized throughout the system. ● April 2019: Took initial steps to revise its pre-service and in-service training system. Through the development of a core team an assessment of the strengths, weaknesses, threats, and opportunities of DHS/SSA's current pre-service and in-service training system has been completed. ● December 2019: Work plan developed to guide the pre-service evaluation, revision and roll out implementation processes. ● Delays experienced in the development of IPM curricula as a result of a change in direction related to format and content have impacted the completion of the pre-service and in-service training. In addition, the desire to obtain additional data from internal and external stakeholders, including management, supervisory and direct case worker staff, to ensure the training system aligns with specific program and service needs, and enhances staff performance and the quality of services provided to children, youth, families has also delayed progress of this strategy. 2020 Progress: ***In Progress*** ● July 2020: Module 1: Authentic Partnership and Engagement Training launched as a virtual training across the State for staff, supervisors, and management. ● August 2020: Module 2: Teaming launched as a virtual training across the State for staff, supervisors and management. ● October 2020: Module 3: Assessing, Planning, Adapting and Transitioning launched as a virtual training across the State for staff, supervisors, and management.	

Key Activities	Benchmarks for Completion
Incorporate additional learning modalities (web-based/e-learning) that are aligned with the IPM to increase existing staff and supervisor access to the material and support ongoing skill-development. (PIP Activity)	2019-2020
2019 Progress: ***In Progress*** ● September 2019: Began the discussions related to the use of transfer of learning as a consistent part of its training system and developed initial transfer of learning tools tied to the IPM. ● October 2019: Provided IPM Kick Off discussion guides to local jurisdictions to support ongoing discussions about the IPM and prepare staff for the practice shifts expected with the IPM. ● Delays were experienced in fully conceptualizing and developing a transfer of learning approach to support the IPM as a result of changing direction related to format and content of the IPM initial training. 2020 Progress: ***In Progress*** ● August 2020: The IPM Learning Collaborative kicked off as a companion for supervisors to the training. ● December 2020: A directory of small tests of change developed in the IPM Learning Collaborative was developed and disseminated around the State.	
Develop and implement a coaching model for supervisors that involves observation, feedback, and peer learning and that occurs regularly following initial IPM training. (PIP Activity)	2019 - 2020
2019 Progress: ***In Progress*** ● October 2019: Integrated discussions around the benefits of coaching into existing regional meetings. ● December 2019: Began the exploration of coaching models that would be utilized following the initial IPM training and has also explored potential resources to build an initial set of coaches to support the implementation of the IPM. The State projects that this goal will be completed by quarter 3. ● December 2019: Initiated training and coaching with local department leadership utilizing the Safety Culture Model, designed to promote psychological safety and mindful organizing in order to mitigate the impact of secondary traumatic stress and improve worker well-being, training and coaching opportunities were provided to local department Directors, Assistant Directors, and Supervisors/Managers. 2020 Progress: ***In Progress*** ● August 2020: IPM Learning Collaborative was launched for supervisors as a means of supporting practice changes related to engagement and teaming; core practices of the IPM. ● December 2020: A more intensive means of coaching and supporting IPM implementation has been planned for 2021.	
Develop and disseminate additional practice profiles and e-learning modules as needed to enhance practice and in response to feedback and performance assessment.	2020-2024
2020 Progress: ***In Progress*** ● March 2020: E-learning Modules were released to introduce workers and supervisors to the practice profiles demonstrating the core practices and principles of Maryland's Integrated Practice Model. ● April 2020: A Practice Profile for Resource Parents was developed in the Maryland Resource Parent Engagement Workgroup.	
Provide guidance for supervisors to build transfer of learning opportunities into ongoing structured supervision.	2020-2024
2020 Progress: ***In Progress***	

Key Activities	Benchmarks for Completion
• July 2020: An orientation webinar was provided for supervisory leadership across the State concerning the roll out of the Integrated Practice Model and expectations for reinforcing transfer of learning as well as planning for the coaching phase of implementation. • August 2020: The Integrated Practice Model Learning Collaborative began being offered monthly for supervisors. This session provided support around transfer of learning from the IPM training as well as coaching.	
Provide transfer of learning activities periodically after training for current workers and supervisors on the IPM to practice skills learned through training. (PIP Activity)	2020-2024
2020 Progress: ***In Progress*** • July 2020: A transfer of learning tip sheet was designed along with the IPM curriculum to provide continuity of learning as well as transfer of learning between modules. Reinforcement of its use was also emphasized in the learning collaborative. • December 2020: A directory of small tests of change developed in the IPM Learning Collaborative was disseminated to participants to continue promoting transfer of learning and peer sharing.	
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

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 transfer of learning 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:
  - Systemic Factors Initial Staff Training (26), Ongoing Staff Training (27), and Foster and Adoptive Parent Training (28).
  - 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.
  - 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
  - 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.
  - 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

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 transfer of learning 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

what they learned, and believe they will see a positive impact if they apply the learning consistently.

Data source: SFY2018 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 transfer of learning and skill for staff and on-going coaching strategies to better enhance knowledge and skill development of staff.

Key Activities	Benchmarks for Completion
Revise pre-service and ongoing training curricula to align with and support implementation of the IPM (PIP Activity).	2019

2019 Progress: ***In Progress***

- April 2019: Took initial steps to revise its pre-service and in-service training system. Through the development of a core team an assessment of the strengths, weaknesses, threats, and opportunities of DHS/SSA's current pre-service and in-service training system has been completed.
- December 2019: Developed a work plan to guide the pre-service evaluation, revision and roll out implementation processes.
- Delays experienced in the development of IPM curricula as a result of a change in direction related to format and content have impacted the completion of the pre-service and in-service training. In addition, the desire to obtain additional data from internal and external stakeholders, including management, supervisory and direct case worker staff, to ensure the training system aligns with specific program and service needs, and enhances staff performance and the quality of services provided to children, youth, families has also delayed progress of this strategy.

2020 Progress: 2020 Progress: ***In Progress***

- January 2020: Reviewed Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis and current pre-service modules reviewed, work plan developed to revise pre-service training, and identified potential training methodologies, classroom instruction and e-learning options, tips sheets, and simulation opportunities.
- February 2020: Pre-service satisfaction surveys disseminated to DSS Local Departments Managers and Supervisors.
- March- April 2020: Survey data analyzed and used to guide framework design.
- April 2020: Redesign team began to redesign format and structure of the pre-service training series.
- May 2020: Pre-service framework completed, and curriculum design team identified.
- June-July 2020: Pre-service framework approved by DHS/SSA Leadership, Implementation Teams and LDSS Leadership and began review of in-service training catalog to align with IPM.
- July2020: Began pre-service curriculum development. existing pre-service curriculum enhanced/modified/deleted. Transfer of Learning (TOL) activities infused throughout the pre-service curriculum. Timelines and completion dates identified to ensure September 2020 roll-out.
- August 2020: Revised and finalized draft of pre-service series. Final curriculum vetted and approved by DHS/SSA Leadership, OISC, and Local Department Managers.
- September 2020: Revised pre-service launched. Orientation webinars disseminated to staff participants and supervisors. Cadre of staff volunteers identified to support pre-service simulation activities.

<table>
<tr><th>Key Activities</th><th>Benchmarks for Completion</th></tr>
<tr><td>Develop innovative transfer of learning activities into all pre-service and ongoing learning opportunities to support learning and adoption of IPM. (PIP Activity)</td><td>2019</td></tr>
<tr><td colspan="2">2019 Progress: In Progress
April 2019: Began the discussions related to the use of transfer of learning as a consistent part of its training system and developed initial transfer of learning tools tied to the IPM.
April – November 2019: IPM Kick Off discussion guides were provided to local jurisdictions to support ongoing discussions about the IPM and prepare staff for the practice shifts expected with the IPM.
Delays were experienced in fully conceptualizing and developing a transfer of learning approach to support the IPM as a result of changing direction related to format and content of the IPM initial training.
2020 Progress: 2020 Progress: In Progress
January 2020: Work plan developed to redesign pre-service training series
Redesign team reviewed current pre-service modules.
Redesign team identified potential training modalities for pre-service series: classroom instruction, e-learning modules, field experience assignments and simulation activities to enhance training system.
IPM incorporated into in-service training.</td></tr>
<tr><td>Develop a cadre of trainers available statewide who are able to deliver pre-service and ongoing trainings aligned with the IPM. (PIP Activity)</td><td>2019-2020</td></tr>
<tr><td colspan="2">2019 Progress: In Progress
December 2019: Identified a pool of trainers to train the launch of the IPM for the existing workforce. The training is currently being developed.
The plan is to train the pool of trainers in order to launch the IPM. It is expected that this will occur in late spring of 2020.
2020 Progress: Completed
January 2020: Cadre of trainers identified to support delivery of pre-service and in-service training series. Trainers include DHS/SSA, CWA and Local Department Staff in addition to Technical Assistance partners, interagency professionals and individuals with lived experience. The cadre of trainers offer diverse areas of expertise and work experiences. The training roster will be reviewed and updated annually.
June 2020: Additional trainers with demonstrated training experience were added to the cadre of trainers. Training pool was increased to meet pre-service rollout and on-going training need.</td></tr>
<tr><td>Develop coaching approach for pre-service training to support new staff in integrating IPM and learning skills needed to effectively incorporate skills needed to effectively partner with families into day to day practice (PIP Activity) PIP 2. 4</td><td>2020</td></tr>
<tr><td>2020 Progress: 2020 Progress: In Progress
January 2020:
Follow up coaching was offered and 12 out of 24 counties scheduled coaching calls.
Researched potential coaching models and identify potential model for implementation.
Initiated explorations and alignment of resources to ensure successful implementation.
July 2020: In addition to the learning collaborative that is being offered throughout IPM implementation, local jurisdictions have been given the option to customize and develop their own coaching plans post-IPM implementation</td><td>2020 -semi-annually</td></tr>
</table>

Key Activities	Benchmarks for Completion
that will build on the CQI efforts they are currently involved in, This model involves skills based coaching for all supervisors, with the option to use one of two identified models (Goal, Reality, Options, Will (GROW) Model or Fluent, Lead, Own, Withstand (FLOW) Model). This was developed in May 2020 and introduced via webinar to supervisors and LDSS leadership across the state in July 2020.	
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 -semi-annually
2020 Progress: 2020 Progress: ***In Progress*** ● January-December 2020: Satisfaction surveys continue to be administered immediately after each pre-service training module and in-service training session. Data results and recommendations from surveys are captured in monthly, quarterly and annual reports. ● December 2020-WFD Network discussed the need to develop a plan to administer interim evaluations of completed trainings. This plan, which includes focus groups/listening sessions, will be completed by 9/30/2021. WFD Network has clarified that the CWA evaluator will need to be involved in the process.	
Develop and implement a professional development module for supervisors on how to coach workers through supervision.	2020
2020 Progress: ***In Progress*** ● March 2020-The GROW Model was selected for the IPM Coaching. However, due to COVID-19 restrictions a learning collaborative alternative was planned for the IPM rollout. ● July 2020: An orientation to the virtual training for the IPM was held and introduced the GROW Model coaching and learning collaborative components of the IPM implementation to come. ● August-December 2020- Learning Collaborative introduced as a coaching mechanism during the IPM implementation. More intensive coaching using the GROW Model was postponed until 2021. It is the intention to use lessons learned from the IPM rollout to build this professional development module.	
Integrate coaching approach for pre-service training to support new staff in integrating IPM and learning skills needed to effectively incorporate skills needed of effectively partner with families into day to day practice	2020-2024
2020 Progress: ***In Progress*** ● January 2020: o Follow up coaching was offered and 12 out of 24 counties scheduled coaching calls. Coaching began with Washington County. o Researched potential coaching models and identified a potential model for implementation. o Initiated initial exploration and alignment of resources to ensure successful implementation. ● July 2020: o In addition to the learning collaborative that is being offered throughout IPM implementation, local jurisdictions have been given the option to customize and develop their own coaching plans post-IPM implementation that will build on the CQI efforts that they are currently engaging in. This model involves Skills-based Coaching for all supervisors, with the option to use one of two models (the GROW Model or the FLOW Model). This was developed in May 2020 and introduced via webinar in July to supervisors and LDSS leadership across the State. o A webinar was delivered to Supervisors and LDSS leadership to introduce Coaching and the development of customized coaching plans post-IPM implementation. A learning collaborative on teaming is starting to be offered in August 2020 as workers and supervisors are trained through a learning collaborative and regional assigned coaches will begin more focused coaching in January	

Key Activities	Benchmarks for Completion
after the virtual training is completed across the State. This delay is due to the need to convert the training to a virtual training because of COVID-19 restrictions. The revised plan is expected to speed the infiltration of training and coaching as it takes place concurrently rather than consecutively.	
Integrate innovative transfer of learning activities into all pre-service and ongoing learning opportunities to support learning and adoption of IPM.	2020-2024
2020 Progress: ***In Progress*** ● January -July 2020: Transfer of learning activities are also implemented into a variety of in-service trainings and included in module overviews and learning objectives. Given the volume of in-service trainings, identifying transfer of learning activities for each module may not be feasible. However, a general overview of the various transfer of learning activities utilized to augment learning will be captured in the introduction of in-service catalog. This will be completed by 9/2021. ● September 2020: Transfer of learning activities including e-learning, field experience assignments and simulation activities were successfully integrated throughout the pre-service training series to support learning of the IPM.	

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

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.

Goal 2 Objective 2.3: Integrate IPM language into provider contracts	
Measure for Objective 2.3*:* Integrate language into 100% of the Provider Contracts	
○ 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.	
Key Activities	**Benchmarks for Completion**
Develop standard contract language for providers that speaks to expectation of implementation of practice model with providers.	2019
2019 Progress: ***Completed*** July 2019: Standard language related to the IPM was identified and included in DHS/SSA's Request for Proposals (RFP) for private placement providers. 2020 Progress: ***Completed*** October 2020: DHS/SSA shifted from using an RFP process to procure placement providers. As an alternative to this approach, DHS/SSA included standard language related to the implementation of the IPM in the Residential Child Care Child Placement Agency Scope of Work, that contain the guidelines that Providers are measured by for compliance with their Sole Source Contracts with an effective date of July 1, 2020 - June 2022.	
Obtain agreements with providers to share vision and implementation strategies.	2019
2019 Progress: ***In Progress*** This activity will be completed in the first quarter of CY2020. The agreements will be in the provider proposal submissions that are due in February 2020. 2020 Progress: ***In Progress*** January - March 2020: DHS/SSA shifted from using an RFP process to procure placement providers. As an alternative to this approach, standard language related to the IPM was included with DHS/SSA's Residential Child Care and Child Placement Agencies (CPA) scopes of work.	
Explore methods to incorporate language in contracts, Requests for Proposals and policy directives.	2020
2019 Progress: ***Completed*** July 2019: This activity was completed as the language was included in the current RCC proposal and the CPA Contract. 2020 Progress: ***Completed*** October 2020: DHS/SSA included standard language related to the implementation of the IPM in the Residential Child Care and Child Placement Agency Scopes of Work, that contain the guidelines that Providers are measured by for compliance with their Sole Source Contracts with an effective date of July 1, 2020.	
Develop a common glossary of terms to include in solicitations.	2020
2020 Progress: ***Delayed*** Due to the impact of COVID-19 and priorities that emerged to manage the pandemic, this activity was delayed. It is hoped that as the recovery from the pandemic continues this activity will be able to be addressed in 2021.	
Partner with Provider Advisory Council to clarify terminology and strategies for the IPM.	2020-2024

Goal 2 Objective 2.3: Integrate IPM language into provider contracts	
Measure for Objective 2.3*:* Integrate language into 100% of the Provider Contracts	
2020 Progress: ***Delayed*** Due to the impact of COVID-19 and priorities that emerged to manage the pandemic, Provider Advisory Council (PAC) meetings were not held for much of 2020. However, in the Fall of 2020 DHS/SSA began conversations with placement providers to re-establish PAC. DHS/SSA has used this opportunity to review and revise membership and by-laws to ensure wider provider participation and enhance effectiveness of PAC meetings.	
Review and develop standard compliance reporting methods that align with the IPM.	2021
Monitor compliance with contract language and develop performance measures.	2021-2024
Customize technical assistance for providers based on need.	2021-2024

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

Assessment of Performance:

During the calendar year, DHS/SSA utilized the State and Local 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 data performance with internal and external stakeholders through the DHS/SSA Implementation Structure, SSA Advisory Committee, and 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 further analyze to address through small tests of change and improvement strategies. As reflected in the table below, during CY2020 Maryland achieved goals in items 16 and 17, increased performance in WB1 and S2, and performance in item 6 decreased. SSA believes the full implementation of the Integrated Practice Model will sustain outcomes and improve outcomes yet to be achieved. In addition to understanding performance on key measures, IPM training and learning collaboratives were developed integrating opportunities to make adjustments to support sustainable skill building related to authentic partnership and engagement, teaming, and assessing, planning, monitoring and adapting goals of families, children, 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 the table below. In order to support continued improvement in the Safety and Well-being outcomes and to turn the curve on item 6, coaching will be implemented to provide the workforce with tools to sustain key IPM practice shifts.

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

Rationale for Goal Selection*:*

- The Maryland CFSR final report results indicated the Quality Assurance Systems was 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.
- 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:
    - Posit 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

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 safely in their homes whenever possible will increase to 79% or higher by the conclusion of the CFSP period. (S2)	69%	63%	76%			
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%			
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. (WB1)	31%	22%	39%			
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. (#16)	79%	88%	94%			
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	58%	81%	90%			

5-Year Measures of Progress:	Baseline CY2018	2021 APSR CY2019	2022 APSR CY2020	2023 APSR CY2021	2024 APSR CY2022	2024 APSR CY2023
health will increase to 68% or higher by the conclusion of the CFSP period. (Item #17)						

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 fidelity, quality and impact of the IPM. Evaluations after training, transfer of learning, 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:
  - Posit 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.

Key Activity	Benchmarks for Completion
Identify methods for collecting data on fidelity, quality, and outcomes by: (PIP Activity) ● Cross-walking and aligning core practices with qualitative and quantitative data currently collected, such as OSRI, stakeholder focus groups, FIMs surveys, and MD CHESSIE field. ● Introducing, if needed, new mechanisms to collect data required to understand implementation of the IPM. ● Exploring alignment between provider data and agency data to understand IPM implementation.	2019

2019 Progress: ***In Progress***

- DHS/SSA is in the initial phase of IPM implementation and has put strategies in place to measure outcomes:
  - July 2019: An additional root cause analysis was completed resulting in the need to ensure the curriculum included strategies for strengthening workforce skills tied to core practices of the IPM and integrating the core practices throughout all child welfare system involvement with families. Root cause analysis took place in July 2019.
  - September 2019: Identified strategies to connect the outcomes of the root cause analysis with curriculum development for IPM training and policy revision.
- The continuing development of the IPM curriculum has included slight changes to the IPM training and learning objectives and discussions about outcome measures to be tracked.

2020 Progress: ***Completed***

- January - March 2020: Provider CANS and Agency CANS data TA were aligned and accuracy data measures across both provider and LDSS data sets determined to be a useful measure for the IPM. Other

Key Activity	Benchmarks for Completion
measures explored and solidified included FTDM participant data, FTDM utilization data, CFSR stakeholder, worker, youth and family focus group data were all proposed and approved as performance measures of the core practices of the IPM.	
Develop and finalize an evaluation plan for the IPM outlining research questions, data sources and data collection methods, analysis, integration with CQI processes, and reporting by: (PIP Activity) ● Researching questions to include assessments fidelity, quality, and outcomes. ● Including roles, responsibilities, and a detailed timeline that aligns the reporting schedule with DHS/SSA's CQI cycle. ● Intentionally aligning with CQI processes in order to obtain broad input on findings and produce rapid feedback about implementation, while also yielding summative findings following year 1 and at the conclusion of the PIP period.	2019-2020
2019 Progress: ***In Progress*** ● Fall 2019: Focus group questions were developed, and proposed outcome measures were presented to the Integrated Practice Implementation Team. It is anticipated that measures will be finalized in CY2020. 2020 progress: **Completed** ● January - March 2020: DHS/SSA, in partnership with Chapin Hall, identified research questions for the IPM evaluation plan. These research questions are designed to provide insights on statewide fidelity to the IPM following the initial IPM training rollout, assess changes in quality of practice related to the IPM, and determine outcomes related to child and family well-being and workforce practice. SSA finalized 13 IPM fidelity measures and created tools to support implementation. The logic model developed over the last year for the IPM is informing the operationalization of IPM performance and implementation measures. ● Fall 2020: Stakeholder focus groups were conducted to gather feedback on the implementation of the IPM. Additionally, IPM outcome measures were finalized and tools to support Supervisors in monitoring IPM practice were introduced to the Integrated Practice Implementation team.	
Complete Phase I implementation evaluation by: (PIP Activity) ● Focusing on training and coaching effectiveness, awareness, and understanding of the IPM, as well as an assessment of fidelity to core practices. ● Reviewing findings within DHS/SSA's implementation structure through existing CQI processes to inform adjustments to ongoing training and workforce supports.	2020
2020 Progress: ***In Progress*** ● January-December: DHS.SSA rolled out IPM authentic partnership and teaming modules to LDSS staff by the end of July 2020. Due to the pandemic, DHS/SSA developed, with support from training partners, an IPM web-based training for supervisors that previewed upcoming training modules and introduced a supervisory practice framework to promote CQI practice changes for LDSS staff post-training. This training to support LDSS staff in integrating the IPM values, principles and core practice skills into their day-to-day work, beyond the training. In order to achieve the practice changes associated with the IPM (e.g., collaborative assessment, family teaming, etc.) and ensure statewide awareness and understanding of the IPM, SSA implemented the LDSS-driven Learning Collaboratives and coaching model across the state over the last year. While initially designed as in-person Learning Collaboratives and coaching, SSA successfully adapted the approach to be virtual engagements in light of the pandemic and its restrictions. Delivery of the supervisory Learning	

Key Activity	Benchmarks for Completion
Collaboratives introduced and promoted transfer of learning strategies and initiated CQI of the IPM core practice skills with LDSS supervisors through plan-do-study-act cycles and small tests of change. Despite their virtual nature, the Learning Collaboratives gained momentum within most LDSSs across the state and elevated supervisors' commitment to designing and carrying-out small tests to improve their supervision and practice. Many LDSS supervisors have participated in follow-up sessions, beyond their initial participation, to address challenges and improve engagement, teaming and collaborative assessments with families and their workforce. Participants have also expressed interest in attending future sessions to continue their small tests of change. Building staff morale and bolstering engagement and teaming within their own supervisory teams have been recurrent themes in small tests of change, mostly in an effort to combat worker distress and fatigue secondary to COVID-19. In response to this positive response, SSA has chosen to continue the Learning Collaborative supervisory platform through 2021. Revisions and feedback for the learning collaborative as well as the trainings have been used to revise and finetune the training, inform revisions in the learning collaborative structure and build further coaching of the IPM across the State regularly throughout implementation. ● The CQI Unit has continued to leverage spaces within DHS/SSA's Implementation Structure to review program and performance progress following IPM training. This has allowed specific teams and units to identify workforce supports and training needs to further support implementation of the IPM. The CQI Unit has begun monitoring how the IPM core practices, principles, and values manifest in caseworker and supervisor interviews completed as part of the CFSR. The observed practices are discussed during the onsite Reviewer Debrief. While informal, these observations on how the workforce is incorporating the IPM into their work and reflections on practice have been helpful with identifying when jurisdictions could benefit from additional workforce support to reinforce the IPM. The IPM observations are noted in the CFSR Results Report and the local CIP if identified as an area of enhancement. IPM data will be reviewed during the Orientation & Practical Data meeting starting in 2021.	
Complete Phase II implementation and outcomes evaluation by: (PIP Activity) ● Focusing on an assessment of fidelity to core practices, quality, and outcomes for children and families. ● Reviewing findings within DHS/SSA's implementation structure through existing CQI processes and informing adjustments to ongoing training and workforce supports.	2021
Based on lessons learned, refine evaluation plan & practice.	2021-2024
CQI to improve implementation and outcomes of the IPM.	2021-2024

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 was 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.

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***

2019 Progress: ***In Progress***

- Early 2019: Data Analytics Network began to review potential data reports to ensure that data dashboards are user-friendly and allow for data-informed decision-making.
- October – November 2019: Regional meetings included the sharing of both the dashboards to those supervisors who attended and provided means in which they can be used by locals to evaluate their practice.
- November 2019: Most recent CFSR results posted to the internal and external DHS website.
- Quarterly in 2019: Most recent Headline indicators posted to the internal DHS website as well as emailed to each of the local departments.
- Headline indicator dashboards are also produced for each of the locals for meetings around their CFSR results so that they can compare their outcomes with their trend data.
- In the next year, 2020, additional storyline indicators (those that support the headlines) will begin to be posted on the KnowledgeBase so that local departments can access them as needed for the work that they do.
- As Maryland transitions to CJAMS, the headline indicators dashboard will be shifted to Qlik which will allow each local to access their own information without having to wait on SSA to provide the information. This will be happening during CY2020 and would probably require modifications to the dashboards as a new platform will be utilized.

2020 Progress: ***In Progress***

- The CFSR Performance Report continued to be posted to the internal and external DHS platforms. The results were shared and discussed with the Implementation Teams, Outcomes Improvement Steering Committee, Foster Care Court Improvement Program, and SSA Advisory Board.

Provide ongoing presentation to local departments to enhance the quality of the data and the capacity of staff use it effectively.	***2019 and annually***

2019 Progress: ***In Progress***

- January – December 2019: 22 jurisdictions participated in data presentations with their supervisors. Most of these jurisdictions also included their staff as well. Due to the size of some jurisdictions, this resulted in 38 meetings with 6 by WebEx and the rest in person. There were 8 presentations during the first quarter (Jan – Mar) 2019 and 8 more during the second quarter of 2019 (Apr – Jun). There were 12 presentations during the third quarter (July-Sept) and 10 during the fourth quarter of 2019 (Oct – Dec). These presentations generated a great deal of discussion and became longer as the year went on as more information was discussed and in more detail. Overall, these presentations were favorably received. Many staff members commented on how helpful this was as they now understood the importance of timely, accurate, and complete data entry. The efficacy of these presentations was also evident in the changes in the data that occurred following the various presentations. It has certainly helped with monitoring of Headline Indicators, one of the main tools that is provided to LDSS to utilize data in their program work.
- December 2019: A survey was provided to all locals at the end of the year to develop the presentations for CY2020 for supervisors and staff to complete. The survey contained questions about length of time as well as time of day, desired content areas as well as who should be part of the presentation. The results of the survey will be compiled, and a new training will be developed and provided to the locals.
- December 2019: Developed a standard, introductory training for all new staff in order to help those new staff in understanding the value placed on data and their role in ensuring the quality. Plans are to

Key Activity	Benchmarks for Completion
incorporate the training curriculum for new staff following their pre-competency training in March, April and June of 2020. 2020 Progress: ***Ongoing*** ● January-December 2020: 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 local departments throughout the year to enhance data quality and the capacity of staff to use it effectively in improvement planning. SSA leadership increasingly uses data in their day-to-day work. For example, leadership routinely incorporates data presentations in meetings to aid in decision-making. In addition, due to the pandemic and the various stay-at-home orders, DHS/SSA was particularly concerned with the pandemic's impact on substantiations and child safety and well-being. Rather than comparing data from the current month to the same month the previous year, maltreatment report rates and hotline call rates during the pandemic were compared to those from the previous summer in Maryland and nationally. This approach was developed in partnership with Chapin Hall thanks to an understanding that report rates naturally decrease due to school closings for the summer holiday. By doing this analysis, SSA's data analytics team found that the pandemic's decrease in maltreatment reports was comparable to periods when schools are normally closed, and that the risk of unreported maltreatment during the pandemic was not as significant as initially anticipated. This has enabled SSA leadership to more accurately understand the impact of the pandemic on child safety and well-being.	
Increase statewide accessibility of headline indicators and the CFSR results dashboards.	***2020***
2020 Progress: ***In Progress*** ● January-December 2020: The SSA headline dashboard and CFSR results are reviewed regularly in a variety of internal and external stakeholder meetings, and leadership and staff are actively aware of agency performance trends. Analysis of case review narratives completed through the CFSR process have provided DHS/SSA implementation teams with additional context for CFSR and headline indicator performance. These summary analyses have been particularly useful at providing actionable insights as to the root causes of key practice issues, especially related to permanency planning and teaming practices with families and the court, thus equipping them to develop targeted strategies for improvement.	
Develop and implement local quality assurance process to monitor compliance with state and federal regulations.	***2020 and biannually***
2020 Progress: ***Ongoing*** ● January-December 2020: The CQI Unit, in partnership with the University of Maryland School of Social Work Institute for Innovation and Implementation (the Institute) developed a QA Review process in partnership with LDSS to monitor compliance with state and federal regulations. These semi-annual reviews for all service areas, with the exception of protective services which is reviewed quarterly, allows each LDSS to critically assess the quality of practice and local level processes and align with the statewide QA process. The QA process is scheduled to be implemented in 2021.	
Enhance state CQI cycle to support regular reviews of progress, identify areas of growth, and test out small measures of change	***2020-2021***
2020 Progress: ***In Progress*** ● January-December 2020: Qualitative data collected through the state CFSR case review process using the narrative summaries from the On-Site Review Instrument (OSRI) have informed 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	

Key Activity	Benchmarks for Completion
growth to enhance service array quality and improve teaming efforts between the agency, court, and families. In addition, DHS/SSA continued to develop the CQI capacity to support ongoing monitoring and reporting of the state's Title IV-E Prevention Plan under the Family First Prevention Services Act. SSA participated in a multiagency workgroup with representatives from the Department of Juvenile Services (DJS) and Department of Health to build the CQI infrastructure for Family First reporting and claiming. This has involved leveraging the existing DJS and title IV-E waiver CQI process in addition to the statewide QA/CQI system. Ongoing enhancement to CJAMS are a vital component of this work to support the state's CQI cycle to review progress and identify areas of growth for Family First implementation. This will be especially critical for ensuring that the prevention service arrays within and across jurisdictions are targeted to meet the needs of children and families Maryland aims to serve.	
Monitor implementation of CQI cycle and local quality assurance process, making adjustments as needed.	***2021-2024***
2020 Progress: ***In Progress*** ● January-December 2020: 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 analysis, and develop strategies to address the priority areas needing improvement. CFSR and headline 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 analysis initiatives related to improving performance on OSRI items assessed through the CFSR process. Specifically, the DHS/SSA Service Array Implementation Team's Health Workgroup identified timeliness of initial and comprehensive health and dental assessments as key improvement areas to address. After conducting root cause analysis of these areas, the workgroup will hold focus groups and survey stakeholders to better understand the identified root causes related to workforce development, cross-systems training, and practice considerations.	

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

Assessment of Performance:

The connection between worker wellness, job satisfaction and ultimately worker retention is well understood, and although there were major shifts in agency and program priorities with the onset of the COVID-19 crisis, worker wellness remained a priority for DHS/SSA. As the COVID-19 pandemic advanced in CY2020 and stay at home orders were issued, DHS partnered with Maryland Institute of Emergency Medical Services Systems (MIEMSS) to provide webinars for staff designed to address mental health and wellness during the pandemic. Over 700 DHS staff participated in these sessions and following the sessions provided feedback requesting additional information for people experiencing feelings of isolation. Additional sessions are being considered for the next reporting period.

Outlined in DHS/SSA's 2021 APSR was the initial implementation of the Secondary Traumatic Stress (STS) Breakthrough Collaborative Series in seven local jurisdictions with plans to expand the opportunity to the remaining seventeen jurisdictions. Due to budgetary constraints DHS/SSA shifted its approach to improving worker wellness. DHS/SSA adjusted its strategy to intentionally integrate worker wellness and safety culture into pre-service and in-service training series. This shift was chosen as a way to support and enhance the roll out of the IPM and the Child Fatality review process, both of which began implementation in CY2020. DHS/SSA

intends to measure staff participation to assess reach as well as continue to monitor retention rates. DHS/SSA noted a slight increase in retention rates from 42% in CY2019 to 49.6% in CY2020.

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

Rationale for Goal Selection:

- On average, 88% of caseworkers hired between SFY 2015-SFY 2018 retained their employment within their first year. The percentage decreases over the length of employment, dropping significantly after 5 years of employment.
- Part of SSA's strategic vision and a guiding principle of the IPM is a safe, engaged, well prepared professional workforce. Included in this is workforce wellness and a reduction of secondary traumatic stress for child welfare workers, a theme that also emerged from the Maryland PIP convening that should be addressed to support improving outcomes for children and families. In 2018, SSA supported the implementation of a Secondary Traumatic Stress (STS) Breakthrough Collaborative Series Pilot in seven jurisdictions (Allegany, Baltimore, Calvert, Carroll, Frederick, Prince George's and Talbot Counties) that was informed by the work of the National Child Traumatic Stress Network (NCTSN) and aimed to help LDSS strengthen their policies and practices to respond to staff trauma. LDSS completed pre and post assessments to assess the impact of the pilot. All seven jurisdictions indicated higher levels of STS Informed policies and practices, lower levels of STS, and similar levels of staff burnout.

County	STSI-OA Baseline	STSI-OA at LS 3	STSS at Baseline	STSS at LS 3	BO at Baseline	BO at LS 3
Allegany	77.62	116.34	37.21	33.11	21.84	21.10
Baltimore	71.64	85.66	37.73	35.71	23.21	22.08
Calvert	94.89	110.39	34.65	34.06	22.84	22.02
Carroll	71.21	91.54	37.52	37.15	23.87	22.15
Frederick	71.46	90.08	35.41	33.5	22.54	22.06
Prince George's	51.70	66.57	39.46	38.22	23.74	23.28
Talbot	96.06	125.71	35.90	32.88	21.45	20.84

Secondary Traumatic Stress-Informed Organizational Assessment (STSI-OA) scores- 0-200 range. Higher scores indicate higher levels of STS Informed policies and practices
STSS scores – higher scores indicate higher levels of STS
Burnout (BO)- ProQOL Burnout scores: 22 or less= low burnout; 23-41= average; 42 or above= high

- Recommendations following the pilot included:
  - Continued administration and analysis of the Secondary Traumatic Stress Informed- Organizational Assessment (STSI-OA) on a bi-annual basis to track progress (measures organizational and workforce levels).
  - Informal collaborative meeting, in person with current cohort at least twice a year.

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

- Merge and align STS language, priorities, and training into IPM.
- Make funding available that can be used creatively to address STS in local departments.
- Make the STS-BSC available to other jurisdictions.

5-Year Measures of Progress:	Baseline CY2018	2021 APSR CY2019	2022 APSR CY2020	2023 APSR CY2021	2024 APSR CY2022	2024 APSR CY2023
~~All 24 jurisdictions will have completed the STS-BCS by the end of the CFSP period. *No longer applicable~~	~~7~~	~~3~~	~~N/A~~			
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.	47%					
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%			

Goal 4 Objective 4.1: ~~Explore expanding the existing Secondary Traumatic Stress Breakthrough Collaborative Series in additional jurisdictions, through which individualized local plans for reducing STS will be developed and put in place.~~ 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*:* ~~Number of locals participating in STS-BCS each year~~ **NEW MEASURE:** Percentage of new staff completing trainings on STS and safety culture within one year of joining the workforce.

Rationale for Objective Selection:

- On average 88% of caseworkers hired between SFY 2015-SFY2018 retained their employment within their first year. This percentage decreases over the length of employment dropping significantly after 5 years of employment.
- Part of SSA's strategic vision and a guiding principle of the IPM is a safe, engaged, well prepared professional workforce. Included in this is workforce wellness and a reduction of secondary traumatic stress for child welfare workers, a theme that also emerged from the Maryland PIP convening that should be addressed to support improving outcomes for children and families. In 2018, SSA supported the implementation of a Secondary Traumatic Stress (STS) Breakthrough Collaborative Series Pilot in seven jurisdictions (Allegany, Baltimore, Calvert, Carroll, Frederick, Prince George's and Talbot Counties) that was informed by the work of the National Child Traumatic Stress Network (NCTSN) and aimed to help LDSS strengthen their policies and practices to respond to staff trauma. LDSS completed pre and post assessments to assess the impact of the pilot. All seven jurisdictions indicated higher levels of STS Informed policies and practices, lower levels of STS, and similar levels of staff burnout.

County	STSI-OA Baseline	STSI-OA at LS 3	STSS at Baseline	STSS at LS 3	BO at Baseline	BO at LS 3
Allegany	77.62	116.34	37.21	33.11	21.84	21.10
Baltimore	71.64	85.66	37.73	35.71	23.21	22.08
Calvert	94.89	110.39	34.65	34.06	22.84	22.02
Carroll	71.21	91.54	37.52	37.15	23.87	22.15
Frederick	71.46	90.08	35.41	33.5	22.54	22.06
Prince Georges	51.70	66.57	39.46	38.22	23.74	23.28
Talbot	96.06	125.71	35.90	32.88	21.45	20.84

Secondary Traumatic Stress-Informed Organizational Assessment (STSI-OA) scores- 0-200 range. Higher scores indicate higher levels of STS Informed policies and practices
STSS scores – higher scores indicate higher levels of STS
Burnout (BO)- Professional Quality of Life Measure (ProQOL) Burnout scores: 22 or less= low burnout; 23-41= average; 42 or above= high

- Recommendations following the pilot included:
  - Continued administration and analysis of the Secondary Traumatic Stress Informed- Organizational Assessment (STSI-OA) on a bi-annual basis to track progress (measures organizational and workforce levels).
  - Informal collaborative meeting, in person with current cohort at least twice a year.
  - Merge and align STS language, priorities, and training into IPM.
  - Make funding available that can be used creatively to address STS in local departments.
  - Make the STS-BSC available to other jurisdictions.

Key Activities	Benchmarks for Completion
Understand the lessons learned from the pilot of 7 jurisdictions and explore a proposal for expansion to additional jurisdictions.	2019

2019 Progress: ***Completed***

- Progress and data findings representing the 7 LDSS that participated in the initial Secondary Traumatic Stress Breakthrough Collaborative Series were reported by the UMB Institute for Innovation and Implementation and JA Consulting Services to the OISC in July 2019with recommendations to extend the series to the remaining Maryland jurisdictions.
- Participants in the original training cohort (2-3 staff members from the participating jurisdictions) completed internal analysis of worker safety, satisfaction, well-being, resilience and knowledge of trauma and trauma symptoms within their work site starting in September 2018.
- Participants in collaboration with their colleagues identified strengths and challenges regarding worker - wellness and secondary traumatic stress and developed strategies to make improvements. This included but not limited to changes in staff composition and work assignments, supervision and management support and expectations, team building rituals, organizational policy and procedures and enhancing the actual work environment. Participants also developed sustainability plans to ensure on-going positive change. All jurisdictions reported increased knowledge of secondary traumatic stress at the end of the collaborative training series. Participants began working on their sustainability plans from September 2018 to May 2019.

<table>
<tr><th>Key Activities</th><th>Benchmarks for Completion</th></tr>
<tr><td colspan="2">

- The STS Breakthrough Collaborative Series was officially discontinued in September 2019. A final presentation of lessons learned from this initiative were presented to the OISC in July 2019 with recommendations to expand the work into additional jurisdictions. SSA and The University of Maryland Institute for Innovation were unable to negotiate the continuation of services.

</td></tr>
<tr><td>Integrate safety culture concepts into Integrated Practice Model rollout.</td><td>2020</td></tr>
<tr><td colspan="2">

2019 Progress: ***In progress***

- November - December 2019: Training in the Safety Culture Model for local agency leadership was offered to all LDSS. All but two jurisdictions participated.
- Customized coaching and consultation followed this training and will continue through 2020 and the activities of the model which best align with local agency interest, capacity, and need are being built into the Integrated Practice Model curriculum.
- Learning collaboratives are being planned to continue transfer of learning and maximize coaching opportunities of the model.

2020 Progress: ***Completed***

- January-April: Concepts and practices of psychological safety built into the IPM training curriculum.
- July-December: IPM training implemented
- March 2020: Training on Safety Culture was provided by Chapin Hall designed to define Safety Culture, demonstrate alignment with the IPM, and discuss strategies for managing human error with a Safety Culture.

</td></tr>
<tr><td>Incorporate Safety Culture principles into pre-service and ongoing training.</td><td>2020</td></tr>
<tr><td colspan="2">

2020 Progress: ***In Progress***

- January-December 2020
  - New child welfare staff are introduced to safety culture in Module I-Foundations of Child Welfare Practice of the pre-service training as part of the DHS Welcome, Overview of Strategic Vision, and Worker Wellness and Safety Culture.
  - Safety Culture is also emphasized in Module II-Factors Impacting Child Abuse and Neglect of pre-service as there is a specific section on Secondary Traumatic Stress.
  - Safety Culture is more pronounced in Module VI-Planning, Intervening, Monitoring and Adapting of pre-service. There is a half day of training devoted to worker safety including: Self-Awareness, Safety Culture, Psychological Safety, Compassion Fatigue, Environmental Safety and Staff-Burnout.
  - Courses on Safety Culture have also been added to the in-service series: Secondary Traumatic Stress, Elements of Safety Culture, and Safety Awareness for Child welfare Professionals. These courses are offered several times throughout the year to accommodate the large number of child welfare staff statewide.

</td></tr>
<tr><td>Provide TA and coaching to state and local leadership on the implementation of Safety Culture approach.</td><td>2020-2024</td></tr>
<tr><td colspan="2">2020 Progress: ***In Progress***
January - April 2020: Safety Culture consultations continued throughout the state for 11 jurisdictions.</td></tr>
<tr><td>NEW ACTIVITY: Incorporate STS content and learning activities into the pre-service and in-service series.</td><td>2020-2024</td></tr>
<tr><td colspan="2">2020 Progress: ***In Progress***</td></tr>
</table>

Key Activities	Benchmarks for Completion
• With the discontinuation of the STS Breakthrough Series, increased attention was given to infuse more training on STS into the pre-service and in-service series. STS content and learning activities were included in the redesigned training series for new child welfare workers. Specifically, STS is covered in Module II of the Series: Indicators and Factors of Abuse and Neglect. There is an activity in this module that requires participants to reflect on matters of self-care and to complete a self-care resiliency plan. • March-December-2020: Specific in-service trainings offered with a focus on STS and/or worker wellness to include: o Indicators and signs of STS o Role of the Supervisor in Trauma Informed Practice o Addressing Issues of STS in a Safe Environment o Practicing Balance during Teleworking and Social Distancing (webinar) o Practicing Boundaries during Teleworking and Social Distancing (webinar) • June 2020: Additional Child Welfare on-line trainings pertaining to worker wellness made available to staff to include: o How Will You Practice Safety and Well-Being in Your Work? o Supporting Virtual Workforce Well-Being o What About You...Self-care for Those who care for Others December 2020: Worker Wellness Activity and Morale Booster Plan developed to include various team and morale building activities and building a Worker Wellness Committee to promote wellness activities statewide.	
~~Implement 2nd cohort for STS-BCS for 3-4 jurisdictions~~	2020
~~2020 Progress:~~ ~~The STS-BCS work has been discontinued. The WFD Network will continue to collect and review retention data and develop a retention plan to be approved SSA Executive Leadership by 12/30/2021~~	
~~Implement 3rd cohort of STS-BCS for 3-4 jurisdictions~~	~~2021~~
~~Implement 4th cohort of STS-BCS for 3-4 jurisdictions~~	~~2022~~
~~Implement 5th cohort of STS-BCS for remaining jurisdictions~~	~~2023~~
Provide technical assistance and support to locals as they participate in and complete STS-BCS, monitor and track data related to turnover, STS, Burnout, and Safety Culture.	2020-2024
2020 Progress: ***In Progress*** The STS-BCS has been discontinued. DHS/SSA will improve efforts to provide technical assistance to the local departments regarding STS, Burnout and Safety Culture. An implementation plan will be developed by 1/2022. DHS/SSA continues to monitor and report annually on retention rates and trends at all locals and provides technical assistance and analysis via the Workforce Development Network, which includes local leadership and stakeholders.	

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.

Assessment of Performance:

The agency has made progress towards strengthening 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. In calendar year 2020 (CY20), CFSR data shows improvements in the percentage of cases rated as a strength for children being

safely maintained safely in their homes whenever possible. This measure was 76% for CY 20 progressing the state towards the target of 79% or higher. Additionally, the agency has also seen improvement to Well-Being Outcome 1, the percentage of cases rated as a strength for families having enhanced capacity to provide for their children's needs. For CY 20, the percentage was 39%, an increase from 2019 progressing the state towards the target of 41% or higher. In addition, entry and reentry rates into foster care both showed decreases in CY 2020.

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.

Rationale for Goal Selection:

- Maryland CFSR Final Report results indicated that the State was not in substantial conformity in Systemic Factor Agency Responsiveness to the Community, Items 31 (State Engagement and Consultation with Stakeholders Pursuant to CFSP and APSR) and 32 (Coordination of CFSP with other Federal Programs)
- Maryland's PIP convening revealed that:
    - 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 resulting in a limited understanding of what other agencies can offer a family.
    - Families too often receive basic referrals versus facilitated and warm-handoffs and coordinated services.
    - Families report going through multiple systems in search of the support they need, becoming increasingly more 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 needed as a foundational element for bringing together system partners to form partnerships and work collaboratively to share resources and remove barriers in support of families.
- FFPSA implementation will require the development of and/or expansion of prevention evidence-based practices to address child and family needs in their homes and communities.

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 safely in their homes whenever possible will increase to 79% or higher by the conclusion of the CFSP period. (S2)	69%	63%	76%			
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	31%	22%	39%			

5-Year Measures of Progress:	Baseline CY2018	2021 APSR CY2019	2022 APSR CY2020	2023 APSR CY2021	2024 APSR CY2022	2024 APSR CY2023
increase to 41% or higher by the conclusion of the CFSP period. (WB1)						
Entry rates will decrease to 1.5 or lower by the conclusion of the CFSP period (Permanency Headline Indicator)	1.8	1.5	1.1			
Reentry rate will decrease to 8% or lower by the conclusion of the CFSP period	11.8%	10.1%	7.8%			

Goal 5 Objective 5.1: Develop and capitalize on community partnerships to strengthen the full array of services, including prevention services.

Measure for Objective 5.1: Number of community partnerships in place by fiscal year and service type
# of LDSS reporting Strong or Very Strong partnerships in the essential services category of the Community partnership - establish a baseline for year one and develop measure in subsequent years

Rationale for Objective Selection:

- Maryland CFSR Final Report results indicated that the State was not in substantial conformity in:
  - Systemic Factor Service Array and Resource Development, Items 29 (Array of Services) and 30 (Individualizing Services)
  - Systemic Factor Agency Responsiveness to the Community, Items 31 (State Engagement and Consultation with Stakeholders Pursuant to CFSP and APSR) and 32 (Coordination of CFSP with other Federal Programs)
- Maryland's PIP convening revealed that
  - 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 resulting in a limited understanding of what other agencies can offer a family.
  - Families too often receive basic referrals versus facilitated and warm-handoffs and coordinated services.
  - Families report going through multiple systems in search of the support they need, becoming increasingly more 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 needed as a foundational element for bringing together system partners to form partnerships and work collaboratively to share resources and remove barriers in support of families
- FFPSA implementation will require the development of and/or expansion of prevention evidence-based practices to address child and family needs in their homes and communities.

<table>
<tr><th>Key Activities</th><th>Benchmarks for Completion</th></tr>
<tr><td>Identify elements and lessons learned from existing local entity teaming projects and models to inform the development of a statewide strategy that structures and operationalizes local teaming on family/child specific cases, e.g., (PIP Activity)
Local care teams
Multidisciplinary teams
Partnering for Success in Baltimore County
Sobriety Treatment and Recovery Teams (START)</td><td>2019</td></tr>
<tr><td colspan="2">2020 Progress: Complete
January 2020 Service Array Implementation Team reviewed elements of success and lessons learned in local teaming models (local care teams, multidisciplinary team, Partnership for Success [local county model], START [national model implemented in thirteen MD jurisdictions]) and received input on further areas of inquiry regarding teaming that should inform model development.</td></tr>
<tr><td>Develop approach and policy for local teaming on work with families/youth that may include: (PIP Activity)
Local agencies who are suggested to be partners in the range of service types across the child welfare continuum (e.g., prevention, in-home services, out of home)
Approaches to aligning family/child assessment, plans, and monitoring efforts to create shared responsibility and reduce conflicts and redundancy in family/youth expectations and services (“one family, one plan”).
Mapping a family’s services to communicate with professionals about the challenges of multiple demands on families.
Template for memoranda of understanding to create infrastructure for local teams.</td><td>2020</td></tr>
<tr><td colspan="2">2020 Progress: Complete
July 2020: SSA has disseminated a Structured Teaming Model Survey targeted to participants to identify Successful Teaming Models.
August 2020: Analysis of data to create best practice documents was conducted.
May and July 2020: SSA garnered feedback and input from Service Array Implementation Team members around ideas for what an approach and process for implementing best practice teaming strategies at the local level can look like.
July 2020: Further developed the planned for the teaming approach to include:
Alignment with Implementation of Integrated Practice Model (IPM) teaming module efforts, develop a Structured Teaming model for Partnership framework to offer to LDSS
Structure teaming model guidance into established Integrated Practice
Model Training and Coaching Series for LDSS supervisors and Leadership
October - December 2020: Developed a Teaming with Partners Module that was included with the IPM training. Each LDSS program received the module via webinar training and supplemental materials providing guidance around best practices and tools to support enhanced teaming with partners to better support families. Through the submission of Integrated Practice Model coaching plans by the LDSS, an analysis of qualitative data patterns from the coaching plans submission related to teaming with partners was conducted.
November 2020: DHS/SSA began the Strategic Service Array Assessment and Planning Process focused on bringing together system partners to support an enhanced approach to teaming aimed to improve collaboration and communication in the development of local service arrays. Initial effort was well attended by partners.</td></tr>
<tr><td>Engage in exploration related to readiness to implement local teams; select LDSS to receive in depth technical assistance to implement local teams. (PIP Activity)</td><td>2020</td></tr>
</table>

Key Activities	Benchmarks for Completion
2020 Progress: ***In progress*** ● December 2020: Through the submission of Integrated Practice Model coaching plans by the LDSS, an analysis of qualitative data patterns from the coaching plans submission related to teaming with partners was conducted. As a result, identification of LDSS to receive TA around teaming will be provided. The activities within each strategy are sequential. Due to the initial delays with developing the teaming approach, this activity was also delayed. The new target date for this activity was moved to April 2021.	
Develop measures of progress and performance focused on more effective and comprehensive assessment and facilitation of services to meet family needs (PIP Activity).	2020
2020 Progress: ***Delayed*** The activities within each strategy are sequential. Due to the initial delays with developing the teaming approach, the subsequent activities were also delayed. We reconfigured the remaining key activities and proposed updated dates of completion for this strategy. The new target date for this activity was moved to April 2021.	
Conduct ongoing CQI using performance measures; share results and adjust local teaming approaches or policy as needed. (PIP Activity)	2021-2024

Implementation & Program Supports

During the reporting period, DHS/SSA continued to provide an array of implementation and program support to promote successful implementation of all goals and objectives outlined in the state's CFSP and CFSR PIP as well as to advance the strategic vision for child welfare transformation. In response to the COVID-19 pandemic, DHS/SSA spent the initial part of 2020 shifting its training and implementation supports to a virtual platform as well as developing guidance and support to assist LDSS staff in shifting their in-person practice to a virtual approach. Between March and April 2020, training was offered to LDSS related to utilizing virtual platforms to host virtual meetings and strategies for conducting effective virtual caseworker visits and visitation between children and their families. In addition to providing support to LDSS staff, DHS/SSA secured state and federal funds to provide technology (i.e., laptops, hotspots, etc.) to children, youth, and families to ensure their ability to participate in virtual learning, visitation, and court hearings. DHS/SSA will continue to provide support to LDSS staff in effectively using virtual platforms to ensure youth and family partnership and engagement in learning, training, visitation, and court hearings.

Training and Technical Assistance

Integrated Practice Model

In March of 2020, the State piloted a redesigned version of technical assistance around collaborative assessment and the use of the CANS and CANS-F in the process. This shift was designed to give more context to the universal core practices of teaming, assessing, and planning while incorporating the CANS and CANS-F as important tools in the process. This technical assistance to LDSS incorporated both the process in face-to-face contact as well as virtual visits due to the current public health emergencies. This version also highlighted other assessment tools used in child welfare as well. During April, May, and June of 2020, additional technical assistance sessions around collaborative assessment were held virtually with three additional counties after the pilot was held in person in early March.

In July and August of 2020, the State rolled out the first two modules (Authentic Partnership and Engagement as well as Teaming) of its Integrated Practice Model through statewide virtual training and accompanied by a learning collaborative for supervisors to promote transfer of learning and practice change support.

In September of 2020, a pilot session of the revised pre-service training which incorporated the Integrated Practice Model was rolled out to its initial cohort.

In October of 2020, Module 3: Assessing, Planning, Adapting and Transitioning of the Integrated Practice Model was launched and incorporated the technical assistance that was launched in March of 2020 but with more in-depth skill building around these core practices and building on the foundations of engagement and teaming that were rolled out in the first two modules of the Integrated Practice Model.

As CJAMS was implemented Statewide in 2020, further TA was offered around assessment and planning in relation to the new electronic record keeping system, highlighting the use of these functions in the system while also supporting the connection of CJAMS functionality to the core practices and principles of the Integrated Practice Model. These sessions were held in the fall of 2020.

While the rollout of the Integrated Practice Model was still taking place at the end of 2020, feedback evaluations indicate that the training represents a different approach to practice. Participants were asked to respond to the question "How different is the approach presented in the training from how you are currently practicing?" Participants were asked to give a rating between 0 (not different at all) to 10 (extremely different). The average response for Module 1 was 5.5 (representing a little above median = different); 6.5 for Module 2; 6 for Module 3. While it is too soon to see the impact of this change, it is expected that as further coaching is rolled out in 2021, we will start to see the impact on outcome measures.

In the next reporting period, DHS/SSA will continue training and technical assistance around the IPM through the implementation of standardized coaching approaches for DHS/SSA and LDSS Supervisory staff.

Capacity Building
DHS/SSA continued its partnership with the Capacity Building Center for States to advance three capacity building initiatives related to strengthening partnerships with families of origin, youth, and resource families.

Intensive Project #1: Authentic Family Partnership (AFP)
In the first half of the year, the team disseminated readiness findings to leadership and local jurisdictions through presentations and Infographics and solicited input from families with lived experience for the IPM Family Engagement module. In the second half of this year when the pandemic limited in-person contact, the Authentic Family Partnership (AFP)/IPM curriculum was converted to a virtual format and trainings began in July 2020. The team used the readiness results to identify two potential sites for implementation of a Parent Partner Model, one of which will serve as the pilot site. A subset of the project team joined LDSS pilot staff, families with lived experience, and community partners to serve as a local parent partner model implementation team. Overall, the team focused almost exclusively on a comprehensive review

of local and national parent partner models, an in-depth examination of the Iowa Model, hiring a vendor for implementation, establishing tasks and timelines, and developing implementation and evaluation plans. Further capacity building work with the Capacity Building Center for States is being requested for FY2022 to continue our implementation work, evaluation plan, and model fidelity.

Over the course of the project year, several key outcomes were achieved:

- Increased the understanding of local jurisdiction readiness to implement a parent partner model.
- Engaged a diverse group of stakeholders, garnered stakeholder support, and communicated the team's vision.
- Enhanced the knowledge and skills needed for authentic family engagement.
- Developed appropriate job descriptions for family engagement personnel.

Intensive Project #2: Resource Parent Engagement (RPE)

In FY20 Maryland received the Center for Excellence grant. The grant activities duplicated two major action steps in the Capacity Building Center for States' (the Center) FY20 RPE work plan. As a result, these action steps were removed from the work plan, and the RPE team reached consensus on several alternate strategies. Despite the need to pivot and identify new action steps as well as address the challenges encountered due to the COVID-19 pandemic, the RPE team was able to accomplish much over the past year. This success can be attributed to the expertise, commitment, and persistence of the team members, and the team's decision to use subcommittees to work on specific policies, practices, and trainings. The intensive work done by the subcommittees and presented at the monthly meetings enabled the RPE team to focus on higher level tasks, report outs, and strategic planning. Another potent factor in the project's success was the strong collaborative relationship between SSA and the Maryland Resource Parent Association (MRPA). This was accomplished through regular communication, transparency, mutual trust, and consensus on goals, objectives, and strategies. The team is continuing its work to build local capacity for resource parent associations; strengthen MRPA's ability to advocate, communicate, and support resource parents; and develop strategies for the recruitment of diverse resource parents who are representative of the children being served.

Several key outcomes were achieved over the course of the project year, including:

- Increased operationalization of teaming best practices in the Teaming Practice Profiles for resource parents, families of origin, and DSS staff.
- Increased capacity to facilitate feedback loops and assess data on practice profiles for purposes of refinement.
- Increased capacity to conduct assessment of local jurisdictional readiness, strength of local partnerships, and outreach/communication with resource parents.
- Increased understanding of the needs of resource parents and of issues impacting relationships with families of origin and DSS staff.
- Increased ability to develop policy that successfully navigates the SSA approval process
- Increased coordination of effort between MRPA and SSA.
- Increased understanding of the role of subcommittees in accomplishing project objectives.
- Increased understanding of the need for integrated training on Teaming Practice Profiles for resource parents, families of origin, and DSS staff.

Further capacity building work with the Capacity Building Center for States is being requested for FY2022 to continue the implementation of our current activities and continuing work with the statewide recruitment and retention system.

Intensive Project #3: Youth Advisory Board (YAB)
In the first half of year, the YAB project reconstituted its team with new members and updated the team charter; completed a readiness assessment with the state YAB project team; researched and compiled information for development of a toolkit to support local YABs; created job descriptions for ILCs and a youth consultant; clarified the legislative intent of the Code of Maryland Regulations (COMAR); drafted a YAB readiness survey for Local Department of Social Services (LDSS); and drafted a PowerPoint presentation about YABs for use with leadership and LDSS. In the second half of the project year, the YAB team conducted the LDSS readiness assessment, completed the YAB toolkit, drafted implementation and evaluation plans for piloting the toolkit, completed the YAB PowerPoint presentation to build awareness and support for YABs, secured funding for youth participation on the committee, conducted trainings on strategic sharing, and developed virtual engagement strategies to accommodate the need for remote meetings due to the COVID-19 pandemic.

Over the course of the project year, several key outcomes were achieved:

- Increased understanding of factors that contribute to starting, restarting, and strengthening YABs in Maryland.
- Increased knowledge of effective youth engagement strategies.
- Increased understanding of materials that engage LGBTQ and pregnant and parenting youth.
- Increased number of qualified ILCs that understand their responsibilities.
- Increased knowledge and skill in strategic sharing.

DHS/SSA expects to continue its partnership with the Capacity Buildings Center as each project moves into full implementation.

Research, Evaluation, and Management Information Systems Support
As of July 27, 2020, all jurisdictions in Maryland moved from the SACWIS (MD CHESSIE) to the new CCWIS (CJAMS) Child Welfare and Provider Modules. This transition started slowly with Child Welfare migrations in October 2019, January 2020, April 2020, May 2020, June 2020, and the last one in July 2020, which also included the Provider Module. This process included verification of migrated data to ensure the accuracy and quality of the data from MD CHESSIE.

Initial jurisdictions received face-to-face instruction on the new system, however by March 2020 training and on-site support was converted to a virtual format. To support this shift, several learning support tools were developed including E-Learning videos and How-To- Guides. Virtual learning sessions were provided in two tracks: Intake/CPS/Family Preservation and Placement and Permanency, which included Adoption and GAP. A new virtual assessment was also created for both these tracks to cover the track Program Areas. The total number of those trained via these methods of Adult Learning equaled 2900 staff. Using virtual training, DHS/SSA has seen a larger number of attendees participating in training and greater access through E-learning materials, such as recorded CJAMS Child Welfare Program Area modules,

that have been posted to the DHS intranet. DHS/SSA also established CJAMS Coordinator groups, made up of representatives from across various jurisdictions, to provide local feedback on areas of the system that may need further enhancements. Child Welfare staff now have iPads which they can take out into the field in order to more effectively work with their clients, rather than having to return to a Brick and Mortar location to record their work.

As DHS/SSA moved to CJAMS, workers reported being better able to document work in a system that was not "folder" driven, like MD CHESSIE, but rather a seamless flow that allowed more of a "One Family/One Plan" mindset by having broader view of the continuum of a care from the start of the services all the way through to end of the agency's partnership with the child and family. Child Welfare users have also reported that the system is much easier to navigate and has also greatly reduced redundancy and duplication of having to add data in multiple areas, as was the case with MD CHESSIE. As DHS/SSA continues to enhance and strengthen CJAMS, venues for ongoing training and implementation support will continue to be provided.

Quality Assurance System

Maryland remains committed to implementing planned enhancements to the current QA/CQI system, as outlined in the 2020-2024 Child and Family Services Plan. The state acknowledges the importance of a strong QA/CQI system to monitor performance, assess strengths, and identify opportunities for growth across safety, permanency, and well-being outcomes. To continue this progress and commitment to a robust QA/CQI system, Maryland will continue to implement and refine its statewide QA/CQI system and ensure that it is aligned with the federal standards outlined in IM 12-07.

The CQI Unit has continuously led CQI support for all jurisdictions by conducting ongoing case reviews using the federal On-site Review Instrument (OSRI). Maryland utilizes a three-year cycle to review cases from every jurisdiction with some jurisdictions reviewed more than once in this cycle. Maryland's CQI process also encompasses and compliments the federally required Child and Family Services Reviews (CFSR), which Maryland has been approved to conduct as a state led process. Maryland's CFSR includes two phases: (1) State's self-assessment and (2) State's onsite review. The onsite review includes: (1) a case record review and (2) interviews with key case participants including, case workers, parents/caregivers, children, and resource parents. An onsite review can last from five to fifteen business days during the review month depending on the jurisdiction size. As the pandemic and associated stay-at-home orders interrupted normal CFSR case review processes over the last year, Maryland was able to quickly shift all operations to accommodate a remote workforce. These efforts included adapting the CFSR case review process to function virtually, thus preventing interruption to PIP measurement. To further support this modification to the CFSR process, the CQI Unit developed new CFSR interview questions designed specifically to capture practice during the pandemic. These questions have allowed Maryland to monitor and improve practice in light of the myriad service delivery challenges posed by the pandemic.

The CQI Unit has also continued to provide technical assistance to local departments to support developing CIPs informed by their CFSR performance and feedback. The CQI Unit's assistance to local departments has enhanced their understanding of Maryland's overall CQI process as well as their individual performance on headline indicators for safety, permanency, and well-being.

Additionally, the state is continuing to collaborate with LDSS to create or further strengthen localized QA/CQI systems to monitor compliance and quality of the department's work with children and families. This has included developing a strategy for biannual (twice a year) focus groups with LDSS staff and families. In partnership with the University of Maryland School of Social Work, DHS/SSA began focus groups in the fall of 2020 with internal and external stakeholders with a focus on systemic factors and the IPM. While this was later than anticipated due to the pandemic, the focus groups have been a successful feedback loop for gathering qualitative insights from key stakeholders to understand systemic factors, inform program improvement initiatives and further contextualize headline indicator data. Feedback from stakeholders and the Implementation Teams within the DHS/SSA Implementation Structure has further refined these focus group questions, which will be instrumental in DHS/SSA's ongoing improvement efforts and IPM implementation. The SSA CQI unit has received technical assistance from the Children's Bureau, the Capacity Building Center for States, and Chapin Hall to enhance skills. CJAMS was implemented in calendar year 2020, and no enhancements are needed at this time to support CQI/QA processes.

To further support strong implementation of the IPM, the QA/CQI system has been actively involved in designing and implementing an IPM evaluation and CQI plan. The CQI Unit, in partnership with Chapin Hall and DHS/SSA's Integrated Practice Implementation Team, developed performance measures for the IPM that will be operationalized over the next year. SSA/DHS is still in the process of designing implementation measures in addition to tools to support tracking and monitoring implementation progress. These appropriate measures align with the QA/CQI system's efforts to monitor fidelity and impact of the IPM on practice in addition to child and family outcomes throughout the phases of the IPM's implementation.

Feedback Loops

Maryland's State CQI cycle enables regular review and discussion of outcomes data to identify performance improvement opportunities, prioritize performance issues, conduct root cause analysis, and develop strategies to address the priority performance areas needing improvement. CFSR and headline performance data are regularly shared and reviewed with key internal and external stakeholders through the DHS/SSA Implementation Structure, SSA Advisory Committee, and FCCIP. DHS/SSA Implementation Structure groups actively participate 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 further analyze to address through small tests of change and improvement strategies.

This process has strengthened collaboration between SSA, LDSS, and external partners to critically assess data together and co-design improvements that are tailored to jurisdiction-specific contexts. One key example from last year involved the Service Array Implementation Team's Health Workgroup, which is charged with enhancing well-being outcomes for children in foster care through collaboration and education. Members of this workgroup include stakeholders from across the state as well as LDSS staff and representatives from Maryland's Managed Care Organizations and dental insurance providers. After reviewing the headline indicators and CFSR outcomes related to well-being, the Health Workgroup identified timeliness of initial and comprehensive health and dental assessments as key improvement areas to explore. The CQI Unit with Chapin Hall facilitated root cause analysis of these improvement

opportunities to understand barriers to quality service delivery. As a next step to this root cause analysis, the workgroup is holding focus groups and administering a survey with key stakeholders to better understand the identified root causes and has already identified workforce development, cross-systems training, and practice considerations as areas to target improvement strategies.

Additionally, the State's CQI Cycle has created opportunities to engage with the Children's Bureau to review CFSR performance. Over the last year, DHS/SSA in partnership with the Children's Bureau reviewed a high-level analysis of specific items related to safety and permanency (items 1, 5, and 6 of the OSRI). The CQI Unit targeted its additional trend analysis of these areas and other outcomes to one jurisdiction, Baltimore City, due to its high population and multiple on-site reviews during periods 3 and 4 (spanning April 2018 through May 2020). Through this trend analysis, DHS/SSA found that Baltimore City's safety and well-being item ratings aligned with statewide trends but struggled with permanency items. This trend analysis was shared with Baltimore City leadership to inform locally driven decision-making and improvement strategies to address performance concerns related to well-being and permanency. The CQI Unit is also leveraging the qualitative data collected through its CFSR process for improvement initiatives by conducting analyses of the narrative case review summaries from the OSRI. Analysis of case review narratives has provided SSA implementation teams with actionable insights as to the root causes of key practice issues, thus equipping them to develop targeted strategies for improvement. Analyzing the narratives has allowed local jurisdictions and SSA to focus on barriers to quality practice as well as illuminating gaps in program knowledge and understanding that targeted training and additional job aides can address. In addition, the narrative analyses conducted over the last year have elevated opportunities for enhanced partnership between the agency and the court to improve permanency planning as well as improved teaming between the agency and families to ensure needs are assessed and appropriately met.

Sustaining the ability to conduct a State Case Review Process for CFSR Purposes
To sustain the ability to conduct a State Case Review Process for CFSR Purposes, the State will continue to conduct qualitative case reviews (MD CFSRs) monthly in a small, medium, or large jurisdiction including Baltimore City (metro), which is reviewed biannually. This process is aligned with the Children's Bureau Round 3 process and uses the federal Onsite Review Instrument (OSRI) for case reviews and reviews at least 65 cases each 6-month cycle. The ongoing CFSR Onsite Review allows each jurisdiction being reviewed on a three-year cycle. The case review schedule spans through March 2024 and includes six 6-month review periods. A randomized sample, that includes CPS, Family Preservation and Foster Cases, is utilized. The reviews use a random sampling methodology to ensure comparability between each 6-month period.

Update on the Service Descriptions

Stephanie Tubbs Jones Child Welfare Services Program
Below is a list of all services currently provided by DHS/SSA which have not changed since the submission of DHS/SSA's CFSP. For a full description of services please refer to DHS/SSA's CFSP.

- Child Protective Services

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

Services for Children adopted from Other Countries
There were zero (0) disruptions and (0) dissolutions for FFY2020 for Inter-Country Adoptions that were reported by the LDSS.

Maryland does not provide any specific programs targeted to children adopted from other countries. If these 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. At the time of removal, families are eligible to receive post adoption support which include entering into a Voluntary Placement Agreement (VPA) with the Local Departments of Social Services. These VPA services also include assistance with the placement of youth who have special treatment needs that require specialized placements such as reactive attachment disorder or other emotional and/or physical challenges. Parents may also receive post adoption counseling support services under the VPA.

Maryland has continued to implement a tracking system that identifies children who were adopted from other countries and entered into State custody as a result of the disruption of a placement for adoption or the dissolution of adoption. The tracking system also includes information on the agencies who handled the placement or the adoption, plans for the child, and the reasons for the disruption or dissolution of the adoption. Each LDSS is responsible for tracking and reporting the number of children who were adopted from other countries and who have entered into State custody as a result of the disruption of a placement for adoption or the dissolution of an adoption, the agencies who handled the placement or the adoption, the plans for the child, and the reasons for the disruption or dissolution. DHS/SSA plans to integrate a tracking system within the new child welfare data system to track the LDSS adoption disruptions to ensure the self-reporting data is accurate.

Services for Children Under the Age of Five
DHS/SSA has continued to monitor the length of stay for children under the age of five in care. In reviewing the data in the Table 34 below when comparing the last three calendar years, the number of children who have been in care less than 12 months has continued to decline each year. There was a slight decrease of 1.5% as the number of children in care from 7 to 11 months from 2019 to 2020. The number of children under the age of 5 that were in care 6 months or less has decreased by 8.1% from 2019 to 2020.

The number of children 5 and under who are in care over 12 months continues to increase each year. There was a 9.4% increase in stay of 12 months or more from 2019 to 2020. The trend continues to indicate that while there are children under age five who come into care and exit

within 12 months, many more remain in care longer than 12 months. Preliminary review of factors contributing to this trend revealed that children who have longer length of stays in care tend to be more complex in nature and from high need families which compound the interventions and supports needed to achieve permanency. In order to better understand and explore this issue, the agency plans to conduct a root cause analysis which includes reviewing data to understand the specific characteristics of these children (i.e., what are the needs of this population, what are their permanency plans, what factors are contributing to their entry into foster care) who exit within 12 months and those who remain in care over 12 months.

That agency will continue to provide and collaborate with partners to ensure the following services are offered to support the agency in reaching goals of 80% of the children 0-5 having a length of stay 11 months or less by 2024.

Table 34: Children Under Age Five Length of Stay CY2020

Social Services Administration: Children Under Age Five in Out-of-Home, Length of Stay (LOS)				
LOS in Care (In Months) of Children Under Five in Out-of-Home				
Calendar Year	**6 or less**	**7-11 months**	**12 or more**	**Total**
2020	259	252	763	1,274
Percentage of population	20.3%	19.8%	59.9%	100%
Percentage Point Change: 2019 to 2020	-8.1%	-1.5%	9.4%	
2019*	353	264	627	1,241
Percentage of population	28.4%	21.3%	50.5%	100%
Percentage Point Change: 2018 to 2019	0.2%	-3.0%	2.9%	
2018**	351	302	592	1,245
Percentage of population	28.2%	24.3%	47.6%	100%
The goal is for 80% of the children 0-5 will have length of stay 11 months or less by 2024.				
Source: CJAMS				
*2019 has been updated to include Washington County which was missing last year due to CJAMS transition **2018 has been updated				

Maryland has continued to support and monitor various activities implemented by LDSS to support children under five designed to prevent their entry into care and/or shorten their length of stay in care. As parental substance use disorder continues to be a factor in placement and reentry rates, Maryland has a number of 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 are:

- 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 (13 jurisdictions)

In addition, the agency continuously strives to expand the services array to meet the needs of our most vulnerable population. The agency currently supports and collaborates to implement a number of evidence-based or promising practice interventions for young children and their families. These interventions include:

- Parent Child Interactive Therapy (PCIT) 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 County. This intervention is included in Maryland's Family First Prevention Plan, allowing for expansion to other jurisdictions in coming years.
- Nurturing Parenting Program (NPP) is a promising parent-education program that is being implemented in two jurisdictions.
- Healthy Families 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 five jurisdictions. This intervention is included in Maryland's Family First Prevention Plan allowing for expansion to other jurisdictions in coming years

Additionally, during this reporting period, the agency worked towards improvement of permanency goals and reducing lengths of stays through activities such as:

- Improving coordination between LDSS and court and legal staff. In an effort to increase education to all judicial parties, DHS/SSA conducted a webinar in Winter of 2020 at the annual LDSS legal attorneys conference around TPR filings. The webinar consisted of information sharing regarding the Adoption Call to Action, Maryland's adoption data, and adoption case vignettes.
- Workforce Development Training: Training to LDSS workforce through the IPM was tailored to build skills that support successful partnership, engagement and teaming in Modules 1 and 2. These trainings focused on engaging with families, building teams that support protective factors and emphasizing these skills in a universal manner instead of in specific interventions such as family team decision meetings. IPM Module 3 focused specifically on collaborative assessment with families, identifying useful strengths, using family-identified teams to enhance protective factors, and prioritizing needs through the lens of the families, youth, children or vulnerable adults with whom the LDSS is working. Strengthening these skills in the workforce should improve diversion, reunification, and concurrent planning needed to support the needs of children between 0-5 and their families.
- Increase consistent and frequent visiting between parents and their children in foster care. The LDSS initiated Family Visitation Centers prior to the pandemic in an effort to facilitate and monitor frequent visitation between parents and their children, however due to COVID in-person visitation was stopped. DHS/SSA will need to assess if the LDSS has re-instituted the visitation centers since in-person visitation has resumed.

- Development of process for case-level reviews to identify barriers to permanency for each child. DHS/SSA is in the process of developing a permanency staffing survey centered around LDSS permanency case staffings. Data and activities will be available during the next reporting period.

Lastly, as previously reported, DHS/SSA restructured to create a Child Welfare 0-5 specialist position. 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 agency was preparing to hire for the specialist position at the on-set of the COVID-19 pandemic; however, a hiring freeze has delayed the efforts.

Efforts to Track and Prevent Child Maltreatment Deaths
Process for reporting fatality data to NCANDS
Maryland developed a partnership with Maryland's Office of the Chief Medical Examiner (OCME) who has shared the OCME database of all deaths with DHS/SSA on a monthly basis during the latter part of 2020. This allows DHS/SSA to obtain more detailed findings about a fatality that may not be available until several months following a fatality and the closure of a CPS investigation. With this additional information, Maryland has been able to update information provided by the LDSS that was not available to the LDSS at the time of case closure leading to more accurate data. DHS/SSA is working on developing an MOU with the OCME to ensure consistent sharing of information moving forward.

Currently, SSA receives information about fatalities or new fatalities from LDSS at the time of the fatality. To ensure DHS/SSA is receiving timely reports of child fatalities, enhancements will be made to CJAMS to capture data elements directly from the system. This will improve Maryland's ability to monitor trends and provide any necessary policy or training to staff.

Steps to develop and implement a statewide plan
Maryland's Child Maltreatment Fatality Review plan (https://dhs.maryland.gov/documents/Child%20Protective%20Services/Maryland%E2%80%99s-Child-Maltreatment-Fatality-Review-Plan.pdf) remains the same as cited in the CFSP. DHS/SSA has compiled a set of objectives to encompass the methodology, implementation and necessary policy and practice changes related to the plan These objectives include processing and learning from staff experiences working within the entire child and family-serving system. Front line staff are a direct source of information as to what was happening; what was needed versus what was provided or available; and what barriers or supports existed during casework practice. The information shared by the staff has assisted DHS/SSA in understanding how to best increase a culture promoting staff well-being and promotional growth. Their valuable insights also contributed to the revision of the CMFR policy and accompanying forms.

While Maryland's plan is in the process of being finalized, the current criteria for triaging fatalities has been determined. Fatalities that may result in a State-led review are:

- All youth in out of home placement
- Children aged 4 years and under with an undetermined cause of death
- All deaths for children active with LDSS or within last 12 months

- Administrative requests

DHS/SSA is revising the SSA Policy Directive #10-5 Child Fatality Serious Physical Injury Critical Incident Protocol and the related reporting forms after receiving feedback from stakeholders to streamline guidance and to include new provisions to address sleep-related incidents which is the number one reason a child death occurs in Maryland. In line with the Integrated Practice Model and the commitment to safety culture, the Child Maltreatment Fatality Review (CMFR) review team was trained to use the Safe Systems Improvement Tool. Using data from previous years, the initial pilot jurisdictions were chosen, and the pilot began in the first jurisdiction. The updated policy is expected to be released no later than June 30, 2021.

Engaging public and private agency partners
DHS/SSA is working with Chapin Hall to develop a comprehensive child fatality review process based on the success of those implemented at the national level. Throughout 2020, Chapin Hall assisted with updating the CMFR policy and accompanying forms, which are currently in the SSA approval process. Chapin Hall also partnered in defining Maryland's Integrated Practice Model, which incorporates Safety Culture, a fundamental attribute of the CMFR which also has broader impact on the continuum of child welfare services. Chapin Hall provided training on the Safe System Improvement Tool (SSIT) including follow up and ongoing discussion and case reviews.

DHS/SSA was able to connect with OCME and Vital Statistics to improve communication and limited review of child fatality data inconsistencies. Access to these databases help identify potential cases of maltreatment that are not reported to the LDSS and are therefore not included in the DHS/SSA data. Gaining access has also been beneficial as it relates to the official cause and manner of death, which may alter the CPS disposition findings.

Supplemental funding to prevent, prepare for, or respond to, Coronavirus Disease 2019 (COVID-19)
DHS/SSA utilized the supplemental funding allocated in 2020 to provide an array of services to respond to, prepare for, and/or prevent child welfare needs arising from the coronavirus pandemic. Specific uses of these funds included the purchase of:

- Purchasing personal protective equipment (PPE) including face masks, sneeze barriers, disposable masks, medical gowns, digital thermometers, hand sanitizer for child welfare staff, youth, and families
- Securing Non-IV-E eligible placements for youth/family to quarantine
- Laptops, Webcams and Hotspots
- Rent/Mortgage Assistance
- Therapeutic Services to include specialized therapy and behavioral health treatment for youth and families to address social isolation, support wellness, and maintain placement stability
- Staff training on impact of pandemic and wellness
- Air filters for Visitation Rooms
- Educational supports and supplies to include books, tutoring, and mentoring
- Transportation Support
- Child Abuse prevention outreach

DHS/SSA allocated funds to LDSS using a methodology based on child population, to ensure equitable distribution of funds across jurisdictions. Each LDSS provided guidance on the approved uses of these and submitted a proposal for the use of the funds received. Allocations were provided to LDDS in July 2020. In 2020 DHS/SSA has expended approximately $258,000 and served approximately 470 children, 250 youth, 700 families, 710 parents/caregivers, and 600 staff.

Mary Lee Allen Promoting Safe and Stable Families (PSSF)
Please refer to the CFSP and previous APSRs for background information on the PSSF grant. In 2022, Maryland will utilize 20 percent of the PSSF grant in each of the following service categories: family preservation, family support, family reunification, and adoption promotion and support services. Ten percent of the grant will be administration and discretionary spending**.** These funds are allocated to the Local Departments of Social Services (LDSS) for contracting with local community-based organizations to provide services to families and children within their local jurisdiction. There were no changes or additions in services or program design during this reporting period.

DHS/SSA also received emergency funding for the Mary Lee Allen Promoting Safe and Stable Families (PSSF). These funds will be allocated to local departments to be utilized in the following manner: to support families by facilitating reunification of youth who are placed in out of home care, to support and prevent entry into care and promote and support adoption finalization and remove barriers for those youth who have a goal of adoption.
Family Reunification Services
Approximately 1,041 families and 1,540 children were served in SFY2020. (unduplicated count) 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
- Inpatient, residential, or outpatient substance abuse treatment services
- Mental health services
- Assistance to address domestic violence
- Temporary childcare and therapeutic services for families, including:
    - Crisis nurseries
    - Transportation
    - Visitation centers

Adoption Promotion and Support Services
Approximately 815 families and 547 children were served in SFY2020. The 24 LDSS offer adoption promotion and support services to remove barriers to a finalized adoption, expedite the

adoption process, and encourage more adoptions from the foster care population, which promote the best interests of the children. For the SFY2020 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 recruitment events
- Life book supplies for adopted children
- Recruitment through matching events, radio, television, newspapers; journals, mass mailings; adoption calendars and outdoor billboards
- Picture gallery matching event, child specific ads, and video filming of available children
- Promotional materials for informational meetings
- Pre-service and in-service training for foster/adoptive families
- National adoption conference attendance for adoptive families
- Materials, equipment and supplies for training
- Foster/Adoptive home studies
- Consultation and counseling services to include individual and family therapy and evaluations to help families and children working towards adoption in making a commitment.

In CY2020, DHS/SSA also utilized the Adoption Promotion funds in the following ways to promote adoption finalization. The LDSS were able to achieve their individual adoption goals developed in conjunction with the Children's Bureau's All-In Foster Adoption Challenge/Adoption Call to Action:

- Fire, Health, Lead Paint, and Environmental inspections for potential foster care homes-required to license adoptive homes;
- Training for CPR and resource parent PRIDE training for potential foster/adoptive parents;
- Medical care of youth for services such as braces;
- Personal care items to support pre-adoptive placement such as toiletries, diapers, etc.;
- Marketing and advertising to recruit families for Foster Care and Adoption;
- Targeted services to remove barriers for foster youth for goals of adoption;
- Payment to trainer/facilitator for the adoption support and education groups;
- Food and supplies for adults and children for the adoption support and education groups;
- Payment for TPR mediation and attorney fees for children with permanency plans of adoption;
- Adoption education/counseling for pre-adoptive parents and children;
- Deposit for adoption celebration.

Family Preservation and Family Support Services

In SFY2020, family preservation and family support funds through PSSF were allocated to all twenty-four (24) LDSS in Maryland resulting in approximately 1,041 families and 1,540 children being served. Most of the LDSS operate a specific program with these funds that provide family visiting, counseling, evidenced based services. The local departments 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. In SFY2020, the following jurisdictions continued to receive "flex funds": Baltimore City, Anne Arundel, Caroline, Charles, Frederick, Harford, Howard, Prince George's, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, and Wicomico County. Community based parent education programs and structured parenting classes were offered as an integral part of child welfare services, offering parenting development opportunities. 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.

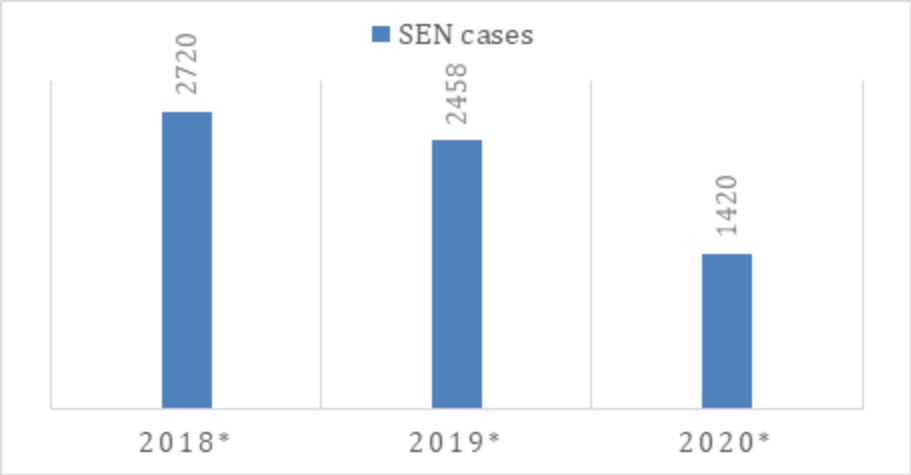
In addition, Maryland was awarded $1 million of additional PSSF Pandemic Relief funds to support local departments. In July 2021, funds were released to the twenty-four LDSS to utilize in the three areas mentioned above (Family Reunification, Family Preservation/Family Support, and Adoption Support/Promotion activities). The LDSS were provided with a tip sheet and guidance for use of the funds and tracking expenditures on a quarterly basis. The state will be able to report on the utilization of funding and specific activities during the next reporting period.

Populations at Greatest Risk of Maltreatment

SENs

Maryland's decline in substance exposed newborn (SEN) cases continues to be a trend examined along with the agency's ability to effectively identify services to meet the unique needs of Substance Exposed Newborns (SENs) and parents impacted by substance use. Since the passage of Maryland's Family Law Article § 5-704.2 that went in effect on June 1, 2018, that removed a mother's positive toxicology from the SEN definition, and included a SEN reporting exception for health care practitioners (HCPs) a decline of at least 10% or slightly greater has continued (Table35). The mother's positive toxicology result for a SEN notification being removed appears to be a contributing factor. Additionally, a mother being prescribed a controlled substance by a health care practitioner allows medical personnel to determine if prenatal substance exposure resulted in the newborn displaying the effects of withdrawal, effects of fetal alcohol spectrum disorder, or the newborn affected by substance abuse. With the agency's implementation of CJAMS, we expect improvements in SEN data reports to support a good data analysis that will better inform the agency on the SEN population, positive outcomes, and programmatic needs.

Table 35: SENs cases CY 2018-2020



Calendar year (Data Source: CJAMS)

Ensuring SENs as well as parents and families impacted by substance use receive unique and individualized services are a shared goal and responsibility across agencies. When caseworkers assess the safety, risks, and needs of the SEN and family members, service referrals are initiated by the caseworker. However, the LDSS and caseworkers are not responsible or often aware of the availability of services needed for the family. During 2020, the agency's efforts to strengthen state and local partnerships with substance treatment providers, maternal and child health providers, and key service providers (behavioral health, peer recovery specialists) has been a primary focus. Formal partnerships at the state and local level brings together key stakeholders involved in the service delivery and continuum of care for SENs and parents to be in agreement on areas of focus identifying targeted services needs that will support positive outcomes and enhance service delivery.

Through continued TA with the LDSS', key stakeholders, and community providers, SSA's SEN policy was revised to address gaps in preceding policies and implementation of the agency's standardized Plan of Safe Care (POSC) to improve practice. SSA collaborated with Maryland's Department of Health Behavioral Health Administration and Maternal and Child Health to develop a two-day SEN policy training in early 2021. Target audience for the training included birthing hospital staff (HCPs, mandated reporters), community health providers serving SEN or parents with a substance use disorder, and LDSS staff. The training will serve to inform these internal and external stakeholders on the SEN policy changes, SEN resources, and resources for parents to ensure effective implementation of the policy and adherence to Maryland's SEN statute. The agency also worked with University of Maryland School of Social Work, Ruth Young Center for Families and Children Child Welfare Academy to enhance the current training curriculum for child welfare staff. The enhancements will support implementation of the new SEN policy and advanced skills in key areas such as medical cannabis, effective partnerships (for families affected by substance use disorders), and pharmacotherapy for pregnant women and fathers.

COVID-19 restrictions required the state to prioritize the agency's program needs to ensure continuity of care and access to services for SENs and families. This included working with state partners and key stakeholders to inform staff on changes in service delivery (home visiting, substance use treatment) to telehealth due to COVID-19 regulations and implementing COVID-

19 screening for residential treatment services. Several SEN and substance use disorder activities scheduled for 2020 are tentatively planned for 2021.

SSA will issue a new statewide SEN policy. The policy will provide guidance and direction on cross-system collaboration and clarification on the newly developed, standardized POSC necessary for completing a timely and comprehensive SEN assessment. SSA's Well-Being (WB) Unit, with technical assistance (TA) from The Institute for Innovation and Implementation (The Institute) and Chapin Hall along with sister agencies, will facilitate a policy webinar to support development and implementation of the POSC with ongoing TA to LDSS' staff on the use of the POSC.

A SEN policy survey will be developed for local program staff. The purpose of the survey will be to gain information and assess policy comprehension to support statewide development and implementation plans for the new SEN policy, and any provisions needed to support effective implementation of the POSC. Based on survey results, the WB Unit will coordinate SEN TA meetings with all 24 LDSS program staff to provide targeted support on the implementation of the SEN policy. SSA will utilize the information from the TA meetings to determine needed programmatic changes to ensure effective implementation of the POSC.

Currently, the agency utilizes its CQI structure to monitor POSC. The agency utilizes Standard Operating Procedures (SOP) for the oversight and monitoring of SEN cases. In that process, a sample of SEN cases are reviewed. This includes reviewing POSC that have been developed for each SEN. The agency utilizes the information found in the review to establish or refine strategies related to improvement of practice for SENs and related service delivery.

As a result of the review and information obtained from technical assistance provided to the LDSS, the agency developed a SEN Collaborative Toolkit. The toolkit is designed to build and enhance current cross-system collaboration teams and improve positive outcomes for SENs, parents with substance use disorders (SUDs), and support development and implementation of the Plan of Safe Care. The Well-Being Unit continues to provide technical assistance to the Local Department of Social Services (LDSS) to enhance and build local SEN Collaborative Teams that will address local programmatic challenges related to implementation of the POSC and serve as a feed-up loop to SSA for statewide program enhancements for the SENs population.

Currently, the POSC is a fillable PDF document. For ongoing monitoring and to further strengthen the oversight of POSC, the agency plans to embed the POSC document into the current child welfare system, CJAMS. This will allow the agency to extract data related to referrals and service delivery, as well as to inform practice and program changes.

In the agency's efforts to implement POSCs, there are continued challenges that exist around effective implementation of POSC. This includes quick access to appropriate substance use disorder services, and quality of those services to meet the needs of the affected caregivers and address risk factors. The state can benefit from national technical assistance focused on assessing the Maryland SUD service array, quality of treatment, and service matching.

Several webinars are planned for Fall 2021 to support and improve coordination and delivery of services for SENs and parents with SUDs, as well as, enhance collaboration at the state and local level between child welfare and substance use providers involved in implementing or supporting the POSC.

Kinship Navigator Funding

Maryland used FFY20 Kinship Navigator funding to support training, planning and program development of an enhanced kinship navigator program that is soon to be launched in three regions of the State and in 8 pilot jurisdictions. Funding in 2020 was specifically used to further planning and the development of the evaluation plan for the enhanced model. In addition, outreach materials were purchased, and formalized training was designed and offered to navigators to support effective facilitation of peer support groups as well as understanding kinship family dynamics. An on-line kinship navigator retreat was held in 2020 featuring kinship specific training including training around the connection between outcomes improvement and data collection related to kinship navigation through Maryland's electronic record keeping system. FFY20 funds were also used to support stability of kinship families as needed throughout the pandemic. As part of Maryland's ongoing program development that began in CY2019, efforts continued in CY2020 to develop the essential components of an enhanced program model as well as design the evaluation. DHS/SSA and the evaluation team also began discussions with the pilot sites in preparation for implementation of the enhanced model in 2021. In CY2021 DHS/SSA plans to develop a menu of trainings to be offered in 2021. In addition, funding will be used in 2021 to increase service coordination with 2-1-1 Maryland as an access and referral service to Maryland's kinship navigator program.

Monthly Caseworker Visit Formula Grants and Standards for Caseworkers

Caseworker Visitation Summary

DHS/SSA has continued to ensure that children in foster care receive monthly visits from their caseworker as outlined in policy. During CY 2020, 97.5% of children in foster care received a monthly visit from their caseworker. DHS/SSA did experience some impact on caseworker visitation as a result of COVID-19 due to the suspension of in-person visitation that occurred in March 2020 which caused a delay in visitation for some youth especially those in residential facilities where teleconferencing may have failed and within the private provider community where caseworker's visits were also restricted.

Improving the quality of caseworker visits

DHS/SSA continued to allocate funds to the LDSS for the caseworker visitation grant with the goal based on proposals submitted by watch jurisdiction. LDSS were asked to prioritize activities that support and guide staff in aligning caseworker visitation practice with the new Integrated Practice Model and improving permanency outcomes for youth. In CY2020, LDSS utilized funds to support a number of workforce development activities to include specialized training for their staff, consultation and clinical supervision support, and trauma-informed training. The LDSS also utilized funds to purchase supplies and support services to ensure quality for caseworkers to include the following activities: supplies needed to facilitate worker/youth visitation, COVID-19 supplies for staff, nursing/educational consultant, educational liaison, clinical supervision, and trauma informed training.

Supporting quality virtual caseworker visits
Maryland, like many states around the country, adjusted its in-person visitation policies in light of the COVID-19 pandemic to meet CDC requirements and the State of Maryland Emergency Plan. For a portion of CY2020, in person visits were suspended and virtual visitation options were provided to allow for caseworker visitation to occur. To support caseworker staff in successfully conducting virtual visits a number of learning opportunities were provided. The DHS Learning Office provided a series of trainings to orient and teach staff to utilize the array of virtual platforms available to DHS staff. In addition, DHS/SSA technical assistance partners provided training to LDSS caseworkers on conducting quality virtual visits to include discussions around how to prepare for, conduct, and document visits effectively while ensuring privacy and safety.

Adoption and Legal Guardianship Incentive Payments
Analysis of the Data:
In SFY 20, 26% of the past fiscal year expenditures were spent on providing an array of direct services to children and families including medical, therapeutic, and educational services. Between October 2020 - December 2020, 100% of the 2017 and 2018 were utilized to cover foster care rate increases ($600,961) and guardian subsidy increases ($422,209) on behalf of IV-E ineligible children. Table 36 below outlines the total amount spent from January 2020-December 2020. These expenditures provided additional supportive services to help incentivize adoption/guardianship finalizations, however the finalization numbers will not be reflected until the next reporting period due to COVID-19 jurisdictional court closures.

Table 36: Adoption and Legal Guardianship Incentive Expenditures CY2020

Grant Year	Amount Expended
2017	$467,320
2018	$555,850
Total SFY 2020	$1,023,170

DHS/SSA continues to issue the LDSS Adoption Incentive Goals on a quarterly basis which is proving to be an effective supervision tool for the LDSS regarding knowledge of the funding however the state is still challenged with the LDSS expending the funding. In 2020, an Adoption/Guardianship Fact Sheet was distributed to the LDSS as a desk guide to assist the LDSS adoption/guardianship casework staff with highlights about the COMAR, SSA Policy Directives, and SSA available funding. These funds were used to provide adoption incentive funding to local departments to incentivize adoptions. Services provided were counseling and medical services, sibling visitation, and other specialized services. Over the next reporting period, the state plans to assist the LDSS in increasing funds to pay for the services mentioned above as well as counseling, educational, and visitation services to pre-adoptive families to increase the number of adoption/guardianship finalization.

Plan for timely expenditure of the funds within the 36-month expenditure period
During the reporting period, DHS/SSA continued to be challenged with the expenditures of the funding. DHS/SSA has conducted webinars, distributed fact sheets, disseminated adoption

permanency data over the last several years; however, the LDSS still appears to be challenged in requesting funding assistance from the state office. DHS/SSA plans to administer a survey to the LDSS to determine if the lack of funding requests is due to barriers to permanency planning. As indicated by the performance measures, Maryland is not in substantial conformity in providing permanency to youth via adoption/guardianship finalizations. It is suspected that this is why there is a lack of funding requests from the LDSS. It is anticipated that we will have the results of the survey, an analysis as well as an implementation plan to improve adoption/guardianship permanency by the next reporting period.

Adoption Savings
The state calculates adoptions savings based on the number of finalized Title IV-E adoptions per fiscal year. For CY20, DHS/SSA spent a total of $72,325 on Adoption Savings funds with $67,825 supporting the renewal of the PRIDE Hybrid resource parent training contract and $4500 supporting the provision of additional funding to a local department for recruitment and retention activities. 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.

During this reporting period DHS/SSA initiated several activities to procure services to address the desired outcomes, however a number of challenges were experienced. Between July and October 2020 DHS/SSA began discussions with its state adoption partners regarding the implementation of Post Adoption Support Services throughout the state to adoptive families referred by the LDSS. The procurement of the two State Post Adoption Support Services contracts is anticipated to be implemented in SFY21.

In addition, DHS/SSA believes that the impact of COVID-19 resulted in delays in local spending as many of the recruitment/retention events were cancelled due to social distancing requirements and the closure of venues. The state will need to provide more monitoring/oversight on how the funds are to be expended during the next reporting period.

DHS/SSA has identified the following timetable for spending unused adoption savings funds calculated from previous years: (The following additional services are projected to be procured by the next reporting period)

- Statewide Recruitment Campaign (Resource Homes)-$15,000 to increase resource parent recruitment by the end of FY22.
- Statewide Recruitment Campaign (Adoption/Guardianship)-$15,000 to increase adoptive parent recruitment by the end of FY22.
- Adoption Competency Training (2-day tailored post implementation training)-$5,000 to provide post technical assistance training to local department adoption staff who received the Adoption Competency training by the end of FY22

Family First Prevention Services Act Transition Grants
The Family First Transition Act provided flexible one-time grants to states to support the successful implementation of the Family First Prevention Services Act. During the reporting

period DHS/SSA utilized $3.5 million of its allocation to fund Child Welfare caseworker costs to serve in-home children and their families including referral to non-medical services and case management. These services were provided to families whose children reside at home that are not candidates for foster care or Prevention Services. While services to In-Home non-candidates are not IV-E allowable, DHS/SSA has continued Waiver projects serving this population and plans to expand claiming title IV-E Prevention Services Program for allowable In-Home activities that are performed on behalf of candidates for IV-E Prevention Services.

For the remaining funds Maryland obtained feedback from DHS/SSA Implementation Teams, local department directors, representatives from Maryland Association of Resources for Families and Youth (MARFY), and families to compile a list of strategies to be supported by the Transition Act funds. The strategies below were selected as they will position Maryland for successful and sustainable implementation of Family First.

- ***Support residential placement providers to improve quality and better meet the needs of child welfare-involved families***
  Most residential placement facilities must meet federal criteria for a qualified residential treatment provider (QRTP) in order for the state to claim for title IV-E foster care maintenance payments for eligible children placed in those facilities. While many Maryland residential placement providers already meet several of the QRTP criteria, meeting all of the new federal standards requires careful planning and financial investments on the part of the providers. Funds will be used to support up front and ongoing costs to meet accreditation requirements and to develop capacity to offer family-based aftercare support for at least 6 months post-discharge.

  Excepted from the QRTP requirements are certain non-family based residential settings - including facilities specifically designed for youth at risk of or who are victims of trafficking, pregnant and parenting youth, supervised independent living facilities for youth age 18 or older and licensed residential family-based treatment facility for substance abuse. In particular, Maryland's data suggests that parental substance use is a driver of entry into care. However, there are few in-patient residential facilities that provide treatment services to parents and allow children to remain with them and those that exist may need additional support to manage care coordination for or provide tailored services for child welfare-involved clients. Transition funds will be used to build the capacity of residential substance use treatment facilities or other residential placements to serve child welfare-involved families or youth, in alignment with population needs.

- ***Develop a rigorous evaluation strategy for certain evidence-based programs***
  Family First requires that any evidence-based program funded by Family First must have a rigorous evaluation plan, with the exception of interventions that are rated as well-supported by the federal Clearinghouse. Maryland's Prevention Plan is approved currently for five programs at the well-supported level, however, in the plan DHS/SSA signaled an intention to iterate the plan to include two programs that are not yet rated at that level. SSA identified Family-Centered treatment (FCT) and Sobriety Treatment and Recovery Teams (START) for future inclusion because they are well-suited to the needs of children who are at risk of entering foster care and are already implemented with the

support of DJS and SSA. During the reporting period FCT was rated as not meeting the evidence criteria outlined by the FFPSA Clearinghouse. DHS/SSA must detail the rigorous evaluation strategy for START in order to include this Intervention in its Prevention Plan to include these interventions. Transition Act funding will support DHS/SSA working with partners (i.e., contractor/university partner and sister/local agencies), to develop and describe an evaluation strategy for inclusion in the plan.

- ***Support building the evidence for certain interventions previously funded under Families Blossom (title IV-E waiver)***
  Several evidence-based programs that were funded under Families Blossom, Maryland's title IV-E Waiver, have become valuable and lauded programs within their communities and are experiencing positive service and outcomes for Maryland children and families. As a result, Maryland has committed to continuing state level funding for many of these programs. Only some of these programs, however, are viable contenders to be sustained via Family First prevention federal reimbursement, given the federal parameters for types of programs (parenting, mental health or substance use disorder) and the required levels of demonstrable evidence. If Maryland invests in such programs to provide additional implementation support (e.g., to manualized programs, set clear fidelity criteria) and increase the rigor of evaluation, it is possible that they will be eligible for federal funding in the future; creating more opportunity to scale or expand the scope of programs that work for Maryland's population.

- ***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. Using existing infrastructure allowed Maryland to be ready to build on existing capacity quickly, since installation of the program had already occurred, including necessary training of staff and building of other infrastructure. However, for Maryland to increase the reach of these interventions, either by expanding in the current jurisdictions and with existing providers, or by installing in new sites, new capacity is likely needed. For example, staff training and certification costs related to delivering the EBP can be expensive, so supporting these costs may speed our ability to extend services to more children and families. Also, some interventions require licensing fees and ongoing consultation fees with the proprietor. Also, there are expenses associated with providers developing appropriate infrastructure (e.g., meetings with DHS/SSA and LDSS, developing data collection and CQI procedures) which cannot be covered in typical treatment rate structures. Covering some of these infrastructure related costs up front may improve Maryland's ability to support existing providers and scale up.

- ***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. While Maryland currently collaborates with providers/local departments to collect some data (e.g., via School of Social Work and Department of Health) there is not a singular data system or portal that houses all

necessary data for Family First purposes and facilitates CQI at the state level. The need to have a centralized data system or portal will help Maryland better determine the outcomes related to EBP interventions and monitor fidelity as Maryland expands and scales up. Funding could support determining: the viability of a provider portal build-out into CJAMS or other appropriate interface, and/or determining initial specifications for such infrastructure.

- ***Rebrand child welfare services as family support services***
  During the development of our CFSR PIP, DHS/SSA heard clearly from external partners, family members, and the courts that there is a stigma associated with receiving DHS/SSA services and that families and the community generally do not see it as a support to their families. As a result, partnership and community engagement suffers. Foster care prevention services may be more easily facilitated and effective, if families and communities learn about the agency's evolved mission and vision to support the entire family and primarily keep families intact. Funding could support external messaging and community engagement about relevant aspects of the integrated practice model that highlight how DHS/SSA and LDSS are working with families at the center of their services. These efforts could also feature prevention related systems and ways in which the agency works to support families without deepening system involvement, to reset the image and brand of the agency.

DHS/SSA has outlined a budget to each of the strategies and is continuing the additional work planning through the DHS/SSA implementation structure to support successful implementation. See Appendix A for the proposed budget.

John H. Chafee

Feedback from youth and young adults on service needs and outcomes

Maryland has used several platforms to solicit feedback from youth and young adults about their service needs and desired outcomes within the Chafee program. Maryland youth elevate their voice and advocate for desired outcomes through their participation in youth focus groups, virtual gatherings promoting peer to peer support and engaging local youth and state advisory boards. In August 2020, several youth advisory board leaders participated in a two-day virtual Jim Casey Youth Opportunity Initiative Activating Youth Engagement Summit. During this emergent learning opportunity, youth provided feedback in collaboration with SSA Executive Leadership on how it would look to authentically partner and share power with young people in order to dismantle system racism.

As Maryland continues to embrace youth voice and youth driven plans and transition, the state has been deliberate and responsive to feedback received from youth and young adults on Ready By 21 benchmarks and youth transition plans. Information retrieved from youth focus groups and key informative interviews was used to enhance and incorporate edits on the form documents for visual appeal, color and space to record and reflect on goals, tasks, and overall progress. Regarding content, youth recommendations were made to enhance the Education post high school and Employment section to reflect the needs of youth post high school, internship and summer employment opportunities. Although DHS/SSA did not have an opportunity to circle

back with the youth within the calendar year, there are plans to convene a focus group with youth in the first quarter of 2021 to review recommended changes.

The Maryland Youth Launching Initiatives for Empowerment (MYLIFE) revised website was created by youth for youth. The website is intended to be used as a conduit to engage youth, support advocacy and serve as an informational catalyst for easy access to transitional aged resources and services for youth in care and alumni. Through the collaborative effort between youth and the DHS Communications department, youth elevated their design themes to include a final product that encompass youth user friendliness, visual appeal and mobile capacity.

Youth who contribute and provide feedback on transitional aged youth programming and initiatives are provided with opportunities to discuss and review enhancements prior to implementation or given an explanation on why specific recommendations were not implemented. DHS/SSA held focus groups when obtaining input and feedback with the planning of the revised MYLife website, RB21 benchmarks and the Youth Transition Plan. Youth Advisory Board (YAB), State Youth Advisory Board (SYAB) and virtual check ins have also been used as a platform for this purpose.

Services provided in CY2020
DHS/SSA created and finalized a readiness assessment survey for workforce (ILCs, RB21 caseworkers, LDSS supervisors, administrators) to obtain feedback on their knowledge and preparedness to support youth in their participation and facilitation of a youth advisory board. As we continue to engage youth voices and incorporate their feedback through the process of transition planning, DHS/SSA anticipates seeing improvement in areas of enhanced authentic partnership and youth engagement. The outcomes most likely to be impacted are increased youth participation in YAB and consistent inclusion of youth voice on overall child welfare service delivery practices and training for resource providers. The desired outcomes support Goal 1 of the CFSP to increase families of origin and youth voice in their child welfare experience to improve safety, permanence and well-being outcomes.

DHS/SSA continues to partner with the Center for States to build YABs and SYAB. Concentrated efforts have been made to advance on a toolkit to assist ILCs on acquiring resources to create, implement and sustain YABs and the SYABs. A draft of a presentation will be given to DHS/SSA and LDSS leadership. The presentation is data informed and provides an overview of the work of YAB steering committee and CFSP and efforts being made to provide support and guidance to ILCs to be successful and supportive of youth members of the board. SSA is creating a youth consultant panel consisting of current youth in care and alumni to incorporate youth voice within various work groups and committees.

Progression towards training and the implementation is underway following the finalization of the toolkit. Independent Living Coordinators (ILC) from six jurisdictions (Baltimore, Charles, Carroll, Cecil, Prince George's and Washington Counties) will pilot the toolkit which will include inclusion of youth voice and resource providers which specifically aligns with Goal 1 of the CFSP: Increase families of origin and youth voice in their child welfare experiences to improve safety, permanence and well-being outcomes and Goal 2 of strengthen workforce

knowledge and skills to in support of the full implementation of Maryland's Integrated Practice Model (IPM).

NYTD Data Collection

DHS/SSA relies on data derived from NYTD, CQI analysis, CRBC, feedback from stakeholders and youth to address gaps in the quality and quantity of services for youth to enhance programming, increase resources and improve outcomes. There are ongoing efforts to enhance and strengthen the collection of reliable and high-quality data through youth and workforce engagement of the NYTD data collection process. SYAB members, Independent Living Coordinators (ILC), Emerging Adults workgroups (EA) which include stakeholders and providers have participated in presentations that support the purpose of the NYTD survey to encourage improved data collection efforts and an analysis of data to inform service delivery, needed community partnerships and enhanced life skills training for youth. Efforts are being made to include NYTD data and analysis on the MYLife website for public access.

Opportunities for training and skills building for workforce and stakeholders have been identified to support collaborative data collection efforts. In its efforts to inform youth about NYTD, Maryland continues to have a dedicated page on the mdconnectmylife.org website which provides youth information through three simple questions: What is NYTD? Why is it important? and Why should I complete NYTD? These themes are revisited with youth to emphasize the importance of receiving feedback and input from youth throughout focus groups and youth engagement projects.

Engagement of Public and Private Sectors and Coordination with Other Federal and State Programs

Maryland involves the public and private sectors in helping youth in foster care achieve independence through collaborative teaming, work groups and partnerships. These efforts are supported through the Emerging Adults workgroup, Youth Advisory Steering Committee, Court Appointed Special Advocates (CASA), Cash Campaign of Maryland, Foster Club, and Fostering Change Network LLC (FCN).

Coordinating services with other federal and state programs is paramount to the success of youth independence positive outcomes. Maryland partners with the Maryland Department of Health, the Ruth Young Center for families and children and subject matter experts at the Prevention of Adolescent Risk Initiative (PARI) for the Personal Responsibility and Education Program (PREP) to provide youth reproductive health curricula workshops. Power through choices topics for youth include building healthier relationships, reproductive health basics, making choices good choices about sex, understanding sexually transmitted infections (STI) and HIV and how to reduce your risks, and increasing contractive knowledge.

Housing is one of the most sought-after resources for youth and young adults transitioning from care. Efforts to secure safe and stable housing include expanding partnerships with the National Center for Housing and Child Welfare to provide statewide guidance and training to over 200 LDSS leadership, ILCs and case managers on HUD's Foster to Independence Initiative, New Future Subsidy and Family Unification Program. The Maryland Department of Disabilities (MDOD) and SSA initiated plans to explore and analyze specific needs of youth with

disabilities. Promoting and connecting youth to sustainable independence housing resources is a shared goal aimed to ensure youth in this population have a better quality of life and youth driven desired outcomes.

DHS, in partnership with other state agencies, encourages the use of hiring agreements via the Hiring Agreement Program (HAP) as a mechanism for providing Family Investment Program recipients and Foster Care Youth/Alumni (18-25-year-olds) with employment opportunities with companies doing business with the state as vendors. Based on the needs of the target population, DHS leveraged partnerships with state agencies (including Department of Budget and Management (DBM), Department of General Services (DGS), Maryland Department of Transportation (MDOT), and the Department of Information Technology (DoIT) In addition to the State Contractors, HAP is also supported by local governments through an agreement with the Maryland Association of Counties (MACo). HAP outcomes vary for youth in foster care and alumni in comparison to other populations HAP serves i.e., current temporary cash assistance recipients (TCA), former TCA recipients (less than or equal to 5 years), children of former TCA recipients (ages 14 and older) and child support obligors. State contractor job placements for youth in foster care and alumni are slightly higher at a 57% retention rate in comparison to the overall population served which is at 55%. Local government contractor job placements for youth in foster care and alumni have significantly lower retention rates at 20% in comparison to 40 % of the geriatric population served. While state agency retention rates for youth in foster care and alumni are consistent with the general population served at 57%. Overall retention rates are higher for state agencies at 59% followed by state contractors at 55% and local government agencies at 40%. There were a total of 3,343 HAP contracts statewide in 2019 in comparison to 3,107 in 2020 indicating an 8% decrease in HAP contracts. Further exploratory monitoring and analysis may uncover why this has occurred. Although no factors have been identified, it is plausible that the COVID 19 public health emergency may have decreased participation due to a decrease in available employment opportunities.

CHAFFE Consolidated Appropriations Act:
Maryland received a $3.1 million allocation from the Supporting Foster Youth and Families Pandemic Act Division X of the Consolidated Appropriations Act 2021. Funds were distributed to the LDSS for the purpose of continuing to engage and support youth who are at-risk for experiencing negative outcomes during the pandemic. Emphasis and focus on allowing youth to remain in care, re-entry into care and providing wraparound supportive services to youth and young adults who had lived experiences from the ages of 14-26. Those eligible through Division X provisions will receive services consistent with:

- Crisis and case management
- Housing and related household management needs
- Transportation Assistance
- Technology and internet connectivity supports
- Employment services and Internship opportunities as youth consultants
- Cash grants
- Food Insecurities
- Connections to support social and well-being to include physical and mental health services

In addition, DHS/LDSS plan to continue to support youth and young adults by prioritizing engagement efforts through a SYAB and alumni listening session to obtain feedback on specific needs of older youth and alumni. Information learned will guide strategies used to inform youth of the services available and how to access them. DHS workforce has partnered with community stakeholders and Check for Us to share these resources through social media and other avenues to reach eligible youth and young adults.

Since Maryland's last submission of the APSR, SSA continues to support transitioning youth and young adults by engaging and actively supporting these youth with transitional living services necessary to transition youth from the foster care system to successful adulthood. Experiential learning opportunities connected youth to transitional services to ensure they have employment and educational opportunities, stable housing, access to health care, financial stability, and permanent supportive connections. Learning objectives and services encompass five key preparedness domains that ensure the progression of successful outcomes as youth transition to adulthood. The five key preparedness domains are: Education & Employment; Financial Empowerment; Permanent & Supportive Connections; Well Being & Civic Engagement; and Safe & Stable Housing.

Through lessons learned through the pandemic and extreme hardships experienced by our transitioning youth and young adults, it is apparent even through their resilience that they need additional support and guidance as they navigate into adulthood. As a result, SSA plans to expand services to transitioning young adults up to the age of 23 in FY2022. In doing so, SSA is also planning to recruit and engage youth consultants with lived experiences to participate in the planning process and partner with other workgroups and committees to ensure youth voice is incorporated in the design of service delivery.

Education and Training Vouchers (ETV)
The services provided through the ETV program support the goal of assisting eligible youth in successfully completing their education, training and services needed to become independent and secure employment. Services included providing direct financial resources to cover post-secondary education related expenses as well as 1:1 coaching, financial literacy and budgeting provided by the ETV coordinator. The individualized 1:1 coaching and support, as well as the education and information provided to each applicant, increased the likelihood that youth will be successful in completing their education goals. Students are making educational and personal strides with the support of ETV funding and this is evident by yearly graduation rates and credits obtained by applicants. For the 2019-2020 school year, 28 youth graduated from a 4-year college or earned a certificate and 74% had a grade point average of 2.4 or higher. The largest percentage of ETV funds support youth living expenses, transportation and childcare to support youth while attending school. While much of the service delivery and administering for the ETV program remained the same since the submission of the state's plan, services were enhanced and targeted to mitigate needs and barriers related to the impact of the COVID-19 pandemic.

Standard services provided through the ETV program are:
ETV Awards: Direct payments made to students up to $5,000.00 for college and vocational training for full time students. Part time students may be eligible for up to $2,500 annually. Funding is provided to cover the cost of Tuition, Childcare, Living Expenses, Housing, School Supplies, and Transportation. 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. FC2S helps students develop budgets based on each semester's combined funding and explains how MD ETV students can pay for school without incurring excessive debt.

Mentoring/Coaching: MD 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.

Senior Year Coaching: All MD ETV students who met the expanded criteria were recruited for this coaching program, which was developed to match students who will be looking for a job after graduation with a professional coach who is either a certified life/career coach or a Human Resources (HR) professional. The goal of this program is to encourage students to plan ahead, avail themselves of opportunities, and identify gaps or weaknesses in their resume before they graduate.

Coaches encourage students to focus on tangibles and tasks such as:

- Making an appointment with advisors on campus to do a degree audit,
- Identifying internships, fellowships and student abroad opportunities early,
- Understanding how volunteer work or part-time employment should be presented on a resume,
- Developing a plan to collect and keep important documentation such as letters of reference, and
- Identifying opportunities to work on projects with a professor or in the community on a report or publication.

During this reporting period, FC2S enhanced their youth outreach and engagement through social Media. The enhancements made were a direct result of the success FC2S was having in connecting with youth via social media. To better meet students where they are, FC2S maintains several social media platforms: Facebook, Twitter, Instagram, YouTube, and Pinterest, as well as a private Facebook group for FC2S students and alumni. FC2S uses social media to deliver information and answer questions and the goal is to offer youth the information and support they

need using every tool available and to stay relevant in their eyes. Building on the social media messaging, more detailed information is posted on Fosteru.org, an FC2S student information website. Through social media, FC2S engages youth and provides information on topics such as Academics & Careers, AmeriCorps, Contests, Discussions & Polls, Budgeting and Financial aid Health and wellness, Internships, Job opportunities, Motivation, News, Parenting, Reminders, Resources, Scholarships and Volunteer opportunities. This service was particularly important during the pandemic.

COVID-19 Response

Due to the pandemic and onset of COVID-19, there were some amendments made to ETV program services during 2020. Students experienced a range of emotions and reactions in response to COVID-19. At the onset and as the pandemic continued, many students found themselves unable to focus on school, shifting their focus to meeting basic needs and day-to-day survival. For young people already struggling with mental health conditions such as anxiety and depression, the daily onslaught of news about increasing infection and death rates threatened their already precarious ability to cope and manage their daily lives. Students had to leave the dorms and secure alternative housing arrangements, were laid off or had their work hours dramatically reduced. Additionally, the transition to online classes proved challenging due to the abrupt shift in course delivery methods, the lack of or slow/intermittent internet access, or the lack of a living space that facilitated their ability to complete their course work.

As a result, the agency was in close collaboration with the Foster Care 2 Success, the SSA Older Youth Team and the LDSS to ensure that all students who were housed on campus prior to the pandemic were contacted and connected to receive support. This included a reassessment of their financial need in order to provide additional funds that can help you in avoiding disruption to education and transitioning to virtual platforms.

Additionally, the agency waived the “making satisfactory progress” requirement for students affected by the pandemic in March 2020. This waiver allows youth whose academic progress was hindered and impacted by the pandemic to access ETV funding to cover costs associated with the disruption of education. This waiver was intended for youth who may have moved to virtual classrooms and were unable to maintain success in academics or youth who were unable to complete their learning path due to the pandemic and may have failed or withdrew from classes.

FC2S administered a COVID-19 survey in May 2020 to current and former ETV awardees. Students were asked to respond to a survey regarding the impact of COVID-19 on their overall well-being. Students were asked to respond to questions around the current living arrangements, rent obligation, housing stability, enrollment and experiences in online classes, advice and information topics they need, if they are parenting, and their current concerns. This survey allowed FC2S to assess which areas they may need to prioritize to help students meet the challenges created by the pandemic.

Based on their survey responses, current ETV awardees were contacted with the goal of talking them through their unique situation and concerns. Outreach efforts were made to contact youth who did not complete the survey. Many students contacted were distressed at the disruption of

their day-to-day lives, frustrated with the abrupt shift to online classes, and struggling to deal with uncertainty about their futures. Youth who expressed feelings or behaviors synonymous with depression or anxiety were provided with resources on wellness and were encouraged and supported in seeking out services and or reconnecting with community support including their county worker, a primary physician or behavioral health professional. Youth who were parenting were sent information via emails and texts encouraging them to utilize online resources available to support them in homeschooling, parenting and information such as visiting online museums and zoo tours and learning websites.

Additionally, all ETV awardees were sent information on the following areas: How to access Wi-Fi (library parking lots and hot spots), Ideas to safely maintain health and wellness i.e., tips on safely exercising outdoors, simple healthy meals and positive messages about finding inner strength and developing good sleep habits, How to collect stimulus money; IRS rules for filers & non-filers, including a link to the IRS portal for non-filers to register, Information on how and why to complete a PO change of address form, Banking rules; why having an overdrawn account must be resolved, building a financial safety net, and the difference between not attending online classes and officially withdrawing from classes and the impact on their grade point average. FC2S provided personalized guidance to ETV awardees designed to address challenges, connect students with resources and supports, and help them move forward based on their level of maturity and life circumstances. FC2S also utilized social media platforms to engage youth around the COVID-19 pandemic and offer information, support, resources and guidance to help with navigating the various changes that occurred throughout the year.

ETV funding allocation is made after reviewing students' financial aid information, the school's Cost of Attendance (COA) to determine unmet need, as per the Higher Education Act. FC2S attempts to help each student develop a realistic budget for the semester that includes all forms of financial aid, other income, and non-monetary supports (ex: rental assistance) minus expenses.

Unduplicated number of ETVs awarded in 2019-2020 (academic year)
In the academic year 2019-2020 (July 1, 2019 to June 30, 2020), 155 eligible youth attending 45 colleges received ETV funding. Sixty (60) were new applicants and 95 were returning ETV recipients. Of the 155 youth, 18 were females and 37 were males. There were a total of 155 youth funded with a total award amount of $374,360.80 awarded. A total of 140 applicants were not funded for ETV. The reasons for not being funded were as follows: some students were not enrolled in approved education settings; not progressing academically (prior to pandemic), some students did not provide necessary documentation for enrollment, incomplete ETV application, some were not actually enrolled in school, not graduated high school or obtained GED and some were over the age of 26. During the 2019-2020 school year, 28 ETV recipients graduated from college or earned a certificate; 2 students received a Certificate; 12 students earned a Bachelor's Degree.

For the 2020-2021 School Year (July 1, 2020 to June 30, 2021) as of March 2021, there were 120 youth who received ETV awards. Thirty-Eight (38) were new applicants and 43 were returning ETV recipients.

ETV Pandemic Act Funding

MD was awarded $449,718 in Division X additional ETV funding. The agency plans to utilize the funds awarded through the Pandemic Act 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. The additional funding will be provided to Foster Care 2 Success (FC2S); the agency that facilitates the Maryland ETV program to be used for the purpose of providing direct financial support to and engagement with youth around how they can reconnect or maintain with their educational goals.
The agency plans to utilize the funding to provide direct payments and services to various categories of youth. This includes:

- Previously ETV-funded youth who have received the prior maximum benefit however have demonstrated a need for additional financial support to reconnect with or maintain their education goals.
- Students who can demonstrate otherwise satisfactory academic progress that was disrupted solely due to COVID-19.
- Youth who due to the pandemic, had their education interrupted and had to discontinue their post-secondary education path, resulting in needing additional time to complete.
- Eligible youth who are 27 years of age for the period from October 1, 2020, through September 30, 2021. This includes youth who were enrolled in an academic or training program but failed or withdrew, had their education plans disrupted by institutional changes due to the pandemic, wanted or intended to enroll but could not due to COVID-19-related challenges.

The agency plans to prioritize a portion of funding for the following populations:

- Older youth who are aging out of eligibility for other educational funding supports.
- Undocumented youth you may not have access to other funding sources
- Applicants who are pregnant or parenting or serving as caregivers
- Applicants experiencing housing instability
- Applicants who have experienced loss of employment during the pandemic
- Applicants experiencing mental health concerns

The agency plans to use Pandemic Act ETV funds to help support youth in accessing academic related and cost of living expenditures such as expenses that are not part of the cost of attendance. Funding will also support FC2S in enhancing their existing online portal to accept and review new pandemic act ETV applications and track funding and applications separately. Funding will support FC2S to provide additional education and coaching to students related to online education and how students can succeed in virtual learning, developing a communications and outreach plan as well as communication materials aimed to inform foster parents, service providers, schools, colleges and the broader community of the additional support available.

Chafee Training
Building worker capacity was an overarching goal that was supported during the COVID- 19 pandemic through incorporating a virtual speaker series to enhance workforce engagement with youth and supporting transitional services for youth. The series of speakers included topics on life skill courses, housing resources, strategic sharing, financial empowerment, and effective strategies for youth engagement. In addition, exploratory discussions within the Youth Advisory Steering Committee, Emerging Adults workgroup, workforce development and Practice Innovation at DHS/SSA began to ensure continued support of Maryland's Chafee plan and

training needs to assist youth in the transition to adulthood. Training curriculum and implementation of the YTP will occur in 2021. While Chafee training efforts have focused on staff skill building, DHS/SSA is currently exploring training opportunities to enhance trainings offered to resource parents and workers in group homes to include the healthy development of racial and ethnic identity for youth and children in foster care.

Consultation with Tribes
See Section 8 Consultation and Coordination Between States and Tribes

Consultation and Coordination Between States and Tribes

There are no Federally recognized tribes in Maryland; however, DHS/SSA maintains contact with Mr. Keith Colston, Director, Ethnic Commissions, Governor's Office of Community Initiatives, on an annual basis to discuss issues, updates, upcoming trainings and changes in policy related to Native American children in Out-of-Home Placement as well as several key strategies identified in DHS/SSA CFSP and annual reports. Specific discussions include issues related to the recruitment of Native American families as foster parents and feedback on addressing DHS/SSA's IPM in the area of cultural responsiveness and partnering with the Native American population. Mr. Colston participated in the SSA Advisory Council that met quarterly in 2020 and is a standing member. DHS/SSA will continue to collaborate with Mr. Colston to obtain his input on child welfare issues as it pertains to tribes and solicit his input on developing the APSR.

Process used to gather input from Tribes
The only three Maryland recognized tribes, the Piscataway Indian Nation, the Piscataway Conoy, and the Accohannock, are an integral part of the Maryland Commission on Indian Affairs. There are no federally recognized tribes in the State.

Measures taken to comply with ICWA
In 2015, a draft policy directive was shared with Mr. Colston that clarified services and policies related to children in Foster Care who identified as Native American. To date, there have been no changes to the policy and procedures regarding working with Native American children and their families. DHS/SSA plans to review the SSA-CW 16-5 Policy Directive within the next 6 months to ensure it is in alignment with the Bureau of Indian Affairs, Department of Interior ICWA guidelines and update it as needed.

There is less than 1% of youth in care that identify as American Indian. From 2019 - 2020, there was a decrease in the number of American Indian youth in care from 0.25% to 0.18%. This decrease may be indicative of the ICWA law being adhered to thereby allowing youth who identify as American Indian to be placed within their respective tribes.

CAPTA State Plan Requirements and Updates

There have been no significant changes to Maryland's previously approved CAPTA plan. The State successfully negotiated 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 $199,363.00. The vendor for the service will remain the same for this year (SEC. 106 #11).

The second contract, with The Family Tree offers a 24-hour parenting hotline, home visits, as well as complete pre and post services assessments with caregivers. The awarded contract amount is $101,770.

In SFY2020, the Family Connections Program (FCP) provided services to a total of 89 families including 236 children. During this time frame, 88 referrals were received, and 69 new cases were opened. Services included assessment, planning, and referrals to services and/or resources; individual, conjoint, family and group counseling; case management; 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.

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: The Positive Schools Center, Homeless Social Work Council, Financial Social work Initiatives, Family Support Group, Wellness Committee, Grief and Loss Groups, Girls Symposium at Wildwood Elementary Middle School, Fatherhood Group at Catholic Charities, Infant & Early Childhood Mental Health Certificate Program, and Restorative Practices.

Due to the needs of Baltimore City residents, FCP clinicians apply a lens of mental health equity and systemic disparities to the work. FCP's 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, 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, as well as 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.

The second contract supported with CAPTA funds is for an array of services including a 24-hour hotline (or stress line) for parents to call when having a parenting crisis, positive parenting classes, home visiting and parents' anonymous support groups. The award from CAPTA is $101,770 annually and was awarded to the Family Tree, Maryland's chapter of the Prevent Child Abuse America and Parents Anonymous. 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 following data reflects activities and families served October 1, 2019 through September 30, 2020 by The Family Tree. The parenting HelpLine responded to 2,763 calls (this includes 659 website requests). The Parent Support Groups had 49 participants, while the Parenting Classes served 447 parent participants, and there were 54 families that participated in the Family Connects Maryland Home Visiting program. A total of 339 home visits were conducted. As a result, 106 children in Baltimore City and Baltimore County were serviced. 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.

The Parenting Education program surpassed its goal, and a total of 382 parents completed the program. Three hundred seventy-three (373) completed the satisfaction survey, and 84% of those completers strongly agreed that the program met or exceeded their expectations. The program served Marylanders from Baltimore City, Baltimore County, Prince George's County, and Harford County. The 10-week parent support groups served 49 participants, reaching 82% of its goal to serve 60 participants. Forty-one attendees completed the satisfaction survey, and 68% strongly agreed that the group met or exceeded their expectations.

Currently, there is a portion of CAPTA funding utilized to support the implementation of the Sobriety Treatment and Recovery Team (START) model. 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 Local Department of Social Services (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).

For more information on the development, implementation, and monitoring of the POSC, view the SEN section under Populations at Greatest Risk of Maltreatment.

DHS/SSA has not utilized 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.

American Rescue Plan Act of 2021 CAPTA State Grant:
DHS/SSA has identified the following activities to be supported be the American Rescue Plan Act of 2021CAPTA State Grant:

1. Enhance 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.
2. Improve the use of multidisciplinary teams and interagency, intra-agency, interstate, and intrastate protocols to enhance investigations.
3. Enhance systems of technology that support the program and track reports of child abuse and neglect from intake through final disposition and allow interstate and intrastate information exchange.
4. Develop public education resources relating to utilizing Maryland's CPS Hotline to reporting suspected incidents of child abuse and neglect, including the use of differential response.

State's response to the annual citizen review panel report(s)
See Appendix B and C for DHS/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 Section

State CAPTA coordinator:
Maryland's State Liaison Officer:
Stephanie Cooke
Director, Child Protective Services/Family Preservation Services
311 W. Saratoga St.
Baltimore, MD 21201
(410) 767-7778 or stephanie.cooke@maryland.gov

Targeted Plans

Health Plan
In CY 2020, the DHS/SSA sought to build upon the progress of the previous year in its implementation of the 2020-2024 Health Care Oversight and Coordination Plan (HCOP); subsequent to CY 2020's activities, there are no significant additions or changes thought necessary to the HCOP.

Progress and Accomplishments:
Child Welfare Information System

DHS completed the phased introduction of the Child Juvenile & Adult Management System (CJAMS) to all local jurisdictions in July 2020. The Maryland Children's Electronic Social Services Exchange (MD CHESSIE) continued to be the electronic system of record for DHS and LDSS prior to the dates of jurisdictional CJAMS roll-out, with documentation of health care services in both systems, but MD CHESSIE was fully decommissioned and became archival only in December 2020. Throughout SFY 2020, prior to and during system rollout, the SSA Child and Family Well-Being Unit (Well-Being Unit), along with the child welfare medical director, provided input to the content and design (mandatory data fields, specific metrics and reporting functions, etc.) of the health section of the CJAMS's Child Welfare module, which is designed with checks and features for oversight, such as dashboards, ticklers and alerts. The health section of CJAMS incorporates a more granular collection of data with standardized diagnoses and categorization, allowing for reporting by various metrics, including chronic diseases, conditions and examination types. During latter CY 2020, as LDSS continued to acclimate to the new software and mobile hardware, the Well-Being Unit worked with SSA Systems Development to assess and respond to challenges that arose, specific to health and education data entry, planning and case management. One specific project was the improvement of out-of-home milestone reports, including an assessment of compliance with the state periodicity schedule for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) preventive health care services. The child welfare medical director utilized the monthly out-of-home milestone reports to initiate quarterly and annual reporting in CY 2019, to address local health care monitoring and case management quality assurance and quality improvement efforts. It is anticipated that the improved jurisdictional reports will be delivered to the local directors in CY 2021, as the reporting capabilities of CJAMS continue refinement. In 2021, DHS/SSA will undertake an evaluation of CJAMS operability after a full year of state usage; however, improvements in data entry, case management performance and quality are projected. For example, the child welfare medical director was able to utilize CJAMS data to complete the state-mandated annual assessment of the status of health care services for children in foster care. While there are challenges around data entry consistency and completeness in the new system, the medical director was able to examine performance to the level of not only race and ethnicity but also the type of out-of-home placement. Certain racial disproportionalities were noted, with White children and youth keeping a higher proportion of appointments (93.7%) than African American children and youth (91.9%) and the underrepresentation of White children and youth with reported disabilities and conditions was greater than the overrepresentation of African American children and youth with disabilities and conditions. Such findings will inform administration policy and workforce efforts on equity. When looking at placement type, children and youth with regular and restricted foster care placements had the highest percentage of kept health appointments; formal kinship care had the lowest; this level of granularity will assist with quality improvement around local case management.

State Regulation and Policies

In CY 2020, the Well-Being Unit continued work on updating its policies concerning health care service oversight and monitoring, with the goal of improved alignment with the Child Welfare League of America and American Academy of Pediatrics guidelines, in order to improve care planning and health care outcomes. The foundation for this effort was the construction of recommended revisions to the Code of Maryland Regulations (COMAR) within the purview of the Department of Human Services relating to medical care, in collaboration with the state's

attorney general office and LDSS. The revised regulatory language was submitted for incorporation into the state's regulatory code in late 2020, with approval anticipated in CY 2021. However, it was determined that certain desired regulatory changes, such as those related to health screening content and timing, impact COMAR that is under the purview of the state department of health. Therefore, discussion has been initiated with staff from the Maryland Department of Health's Health Care Financing to explore possible cooperation. In the meantime, DHS/SSA will adjust current policy based on the regulatory changes approved in CY 2021, and develop desk guides, checklists and training for LDSS as previously indicated.

Centralized Health Care Monitoring and Coordination

According to state statute, the child welfare medical director is to assess DHS/SSA staffing needs and develop a centralized comprehensive health care monitoring and coordination program, in collaboration with the LDSS. The legislation specifically refers to the centralized health care monitoring and management program utilized by the Baltimore City DSS (BCDSS). The Making All the Children Healthy (MATCH) program provides its medical case management services through a contractual relationship with Health Care Access Maryland (HCAM), a non-profit agency; the five-year interagency agreement (IAA) was renewed in 2020. The MATCH program model employs a variety of professional and clinical personnel organized into health risk-based teams to effectively track and coordinate somatic and mental health care, including a consultant child psychiatrist for cases with complex psychiatric health needs, and is managed by a medical director, who also provides consultation with medically complex cases. In CY 2020, the child welfare medical director was made a member of the Baltimore City Department of Social Services Health Care Advisory Council, which supports the work of the BCDSS and HCAM, and was able to review the 2020 IAA. Based on an assessment of emergence MATCH scope of work and staffing, the child welfare medical director proposed a staffing model for a SSA Health and Medical Oversight Team (HMOT) which would provide statewide nurse case management through a regional approach. In early CY 2020, the DHS/SSA approved a reclassification of three existing agency FTEs to initiate work towards a nascent team, including a nurse supervisor, a consultative nurse, and a medical social worker. The nurse supervisor will provide expertise and analysis of health care issues affecting out-of-home children and youth, assist in developing and accessing agency health care policies, identify opportunities for improvement and associated interventions, and provide LDSS consultation on a variety of health care topics. This position will also provide training to new social workers, supervisors and other SSA/LDSS staff; and assess the medical needs of children and recommend policy changes/improvements and solutions to the child welfare medical director and participate in their development. The consultative nurse is to be assigned regionally and help implement healthcare-related agency policy, assess the medical needs of children, and provide consultation to internal SSA staff, LDSS, and to foster/adoptive parents and guardians. The medical social worker will perform a variety of functions including physical and behavioral health advocacy and interventions designed to promote health, prevent disease, and address barriers to access healthcare needs and services of youth in care or custody. Unfortunately, vacancies were unable to be filled, due to the COVID-19 public health emergency in conjunction with a hiring freeze that was in place and remained, with few exceptions, through the end of CY 2020. In 2021, DHS/SSA is employing a tiered approach to seeking hiring freeze exceptions for existing vacancies and reclassified positions. The Well-Being Unit will work within the agency process to implement the HMOT in CY 2021.

Health Information Access
In CY 2020, DHS/SSA continued discussions with the state's health information exchange, Chesapeake Regional Information System for our Patients (CRISP), which connects health care providers by allowing medical information to move among electronic health information systems. At the present, DHS and CRISP have an agreement in place that allows for the use of certain hospital encounter data and personally identifiable information for limited state emergency operations such as family reunification. Building on that relationship, DHS/SSA and CRISP began work on a memorandum of understanding which would allow the child welfare medical director to have access to CRISP data in order to fulfill the office's statutory duties. It is hoped that beginning in CY2021 this work, by identifying current statutory and regulatory data sharing barriers and proposing solutions, will lay the groundwork for possible future LDSS timely access to past and current medical information (diagnoses, medications, health care episodes, etc.) and the use of CRISP's encounter notification service for alerts to DHS/SSA of health care service, which will provide real-time notice of health care provision and allow improved caseworker follow-up and care management. CRISP and DHS data sharing rules and regulatory barriers continue to be challenges to progress on electronic health passport adoption, but discussions about possible avenues for data use agreements or COMAR revision will continue in CY 2021.

Use and Monitoring of Psychotropic Medications
Currently, SSA Policy Directive # 15-8 governs the oversight and monitoring of psychotropic medication and includes procedures for obtaining informed consent and local worker monitoring. Over the past year, the University of Maryland School of Pharmacy continued to provide regular reports on its monitoring of patterns of psychotropic use of youth in foster care to the DHS/SSA. According to the latest data, attention-deficit/hyperactivity disorder (ADHD), adjustment disorder, and anxiety disorder were reported to be the predominant diagnoses; approximately 10% of youth in foster care were reported to have complex comorbid conditions, with ADHD diagnosed with adjustment disorder, bipolar disorder, conduct disorder most frequently. The primary classes of psychotropic medication were ADHD medications, antidepressants, and antipsychotics. In general, though there has been a decrease in the proportion of youth without any psychiatric diagnoses, the proportion of youth with no psychotropic medication use has shown an increasing trend over the past several years, along with a decreasing trend in the number receiving one or more psychotropic medication. The state Medicaid Peer Review Program, which requires pre-authorization and ongoing clinical review of pediatric antipsychotic medication treatment for Medicaid-insured children less than 18 years of age, has been linked to decreases in the use of antipsychotics in youth in foster care.

In CY 2020, LDSS reported few public health emergency issues with their processes for receiving and reviewing requests and compliance with the policy directive. Beyond the directive, several jurisdictions utilize a psychiatric consultant, either through their county health department or on a contractual basis, as part of their outpatient medication approval process. Medical information was reportedly shared with bio-parents and resource parents and they were included in conversations (e.g., the past effectiveness of proposed meds and side effects). However, there are challenges that remain. LDSS report training is needed for the resource parents to understand their roles in monitoring medication use and what symptoms can appear

with various psychiatric diagnoses and medication complications. Psychiatric treatment providers additionally may change medications without LDSS or the parent's consent. Lastly, youth involvement, as well as bio-parent input, in medication decision-making is not consistent. These challenges will inform DHS/SSA training and procedural discussions in CY 2021. Additionally, the DHS/SSA will continue to engage with MDH and the University of Maryland School of Pharmacy on needs assessment activity regarding the expansion of the Peer Review Program to include all psychotropic medications.

Impact of and Response to COVID-19 Public Health Emergency

In relation to the global pandemic, from the time of the Governor's declaration of the COVID-19 public health emergency on March 5, 2020, DHS has worked with sister governmental agencies and providers to mitigate the risk of infection with SARS-CoV-2, the virus responsible for COVID-19, among staff, providers and ultimately the children and youth in out-of-home care. After the initial general quarantine measures of the early stages of the pandemic, SSA provided guidance on visitation procedures and implemented risk-based processes for out-of-state travel. The State Health Secretary's March 23 Order to suspend all elective and non-urgent medical procedures until after the state of emergency allowed for a health care provider's clinical judgment as to what procedures were "critically necessary for the maintenance of health for a patient," with subsequent guidance from the Maryland Department of Health's clinical team and Medicaid clarifying that there was provider discretion to determine what preventive care was necessary. During the initial stage of the pandemic, health care providers were prioritizing the identification and treatment of ill individuals and altering practice procedures, reducing primary care access and leveraging telehealth technology; this allowed for the assurance of only clinically necessary visits during the time of extensive community viral transmission. Due to both the challenge of reduced access and the benefit of limiting youth and resource family possible community exposure, DHS temporarily modified time frames for the initial health screening and comprehensive health assessments, while prioritizing EPSDT health care services for the younger out-of-home children and the administration of immunizations required for schooling and child care. LDSS were responsible for monitoring health care delays and maintaining lists of those out-of-home children and youth waiting for preventive services. As the state moved through the phases of recovery, the LDSS were surveyed regarding health care and mental health services. In latter CY2020, the local directors reported the resumption of entry assessment and preventive health services, both in-person and via telehealth; the scheduling of routine dental services was progressing as well, but backlogs and reductions in operatory use continued to impact timeliness. Most mental health services were reported to be occurring virtually, but a number of LDSS indicated that there remain standing issues with the number of community-based mental health providers in their jurisdiction and virtual mental health services have been a challenge for some children (those who do better with interpersonal interaction). Additionally, pre-placement COVID-19 testing requirements instituted by several congregate care providers led to delays of days to weeks and the occasional loss of placement due to provider deadlines. DHS/SSA collaborated with the Maryland Department of Health in attempts to arrange timely rapid point-of-care testing with appropriate reflex diagnostic follow-up for congregate care pre-placement needs. The state health department provided rapid testing supplies for use in potential partnerships with local health departments and federally qualified health centers. At the close of CY 2020, DHS/SSA was negotiating memoranda of understanding with two Baltimore City federally qualified health centers to provide on-demand testing services.

Foster and Adoptive Parent Diligent Recruitment Plan
Data analysis on Maryland's progress on diligent foster and adoptive parent recruitment is described in Systemic Factor Item #33 while the progress and accomplishments in implementing the state plan, including the Assistant Secretary's ALL-IN Foster Adoption Challenge/ Adoption Call to Action, can be found in Section 7: Update on the Service Descriptions Adoption and Legal Guardianship Incentive Payments. See Appendix D for updates to the Foster and Adoptive Parent Diligent Recruitment Plan.

DHS/SSA continues to partner with local adoption agencies to provide supportive services such as post adoption services to resource parents. The partnership with the Child Welfare Academy has increased resource parent training and retention due to the alteration of training from in-person to virtual. The Pandemic allowed for more conversation around ways to ensure resource home compliance requirements and parents' needs were still met. In addition, DHS/SSA's partnership with the Maryland Resource Parent Association has continued to be our most valuable resources as they are a part of our Resource Parent Engagement Workgroup, assisting in the development of monthly educational webinars, as well as promoting the increase of the LDSS foster parent associations in obtaining their 501(c)3 status.

Disaster Plan
No updates were made to DHS's current Emergency Operations Plans. The state utilized Emergency Operations Plans to respond to two disasters since the last APSR:

- COVID-19 Pandemic
  The state used the Emergency Operation Plan during COVID-19 response to convene a multi-agency COVID-19 Feeding Task Force committee. This committee is regularly convened in Maryland during larger-scale disasters, per the Emergency Operations Plan. The COVID-19 Feeding Task Force was led by the Maryland Department of Human Services, per the State plan, and coordinated resources between governmental and non-governmental agencies to ensure provisions were made for potential and actual gaps within vulnerable population feeding systems. These coordinated efforts ensured resources were available to public and non-profit agencies who provide feeding services to vulnerable populations. Beginning March 2020, the committee meets regularly to discuss and coordinate the provision of resources to meet any identified gaps. Since March of 2020, resource requests have been made by local government and non-profit agency partners. The committee supported operational feeding needs by providing staff and systems to support feeding requirements and analyzed funding requests by local and non-profit feeding agencies to make funding recommendations to the State COVID-19 spending committee. This structure worked very effectively to share critical information and provide points of contact for non-governmental agencies to make resource requests. This structure also allowed for local governments to have clear points of contact to make requests of the state, via the Maryland Emergency Management Agency.
- Hurricane Isaias
  The state activated the Emergency Operations Plan in response to Hurricane Isaias. The Maryland Department of Human Services led the mass care services response and provided guidance for non-congregate disaster sheltering due to the on-going pandemic. The storm passed over the state quickly, and no shelters were needed. The State

Emergency Operations Plans worked effectively to provide structure for local jurisdictions to make any necessary requests of the state, and the plan's State Coordinating Function Human Services group worked effectively to provide necessary and appropriate guidance in mass care services.

Training Plan

To meet the growing and diverse professional development needs of staff, DHS/SSA in partnership with the CWA continues to add new courses to its training series. There were 39 new trainings added in 2020 that covered a variety of content areas including but not limited to: Secondary Traumatic Stress, Ethics, and Resiliency during the Pandemic. A major accomplishment for CY2020 was the conversion of the entire training system, pre-service, Foundations, in-service and CJAMS into a virtual format to enable training to continue uninterrupted during the COVID-19 crisis. Other milestones include the integration of IPM content into the pre-service curriculum and the statewide launches of the CJAMS, IPM and revised pre-service training series. A comprehensive matrix of new training is updated quarterly and compiled into an annual report for inclusion in the APSR. The matrix includes the following information: Course Title and Overview, Duration, Provider/Venue, Audience and Title IV-E Cost Allocation. See Appendix E for a listing of the trainings added in CY2020.

Statistical Reports

CAPTA Annual State Data Report Items

Demographic Information

Table 37 below outlines the number of CPS staff, education level, gender, and race and ethnicity by calendar year. In CY2020 the total CPS Staff increased by 34 positions although the overall staff percent change is -7.67 from last year. In terms of education, the majority of caseworkers continue to hold a Master's degree or higher with the remainder holding a Bachelor's degree. Overall, in CY2020 there continued to be more females (71%) than males (28%) in CPS positions however the number of males increased by 18 percentage points. Finally, when looking at race and ethnicity, the majority of staff continued to be African American (50%) or White (43.53%).

Table 37: CPS Staff Demographics by Calendar Year

Child Protective Services (CPS) Staff	CY2019	CY2020
Case worker Staff (FTE)	340	83% (369)
Supervisor Staff (FTE)	69.5	17% (74.5)
TOTAL	409.5	443.5
Education Levels		
Bachelor's degree	32.50% (110.5)	32% (117.5)
Master's or above degree	67.50% (229.5)	68% (251.5)
Gender		
Males	10% (33)	28% (105)

Females	90% (307)	72% (264)
Race/Ethnicity		
American Indian	0% (0)	0% (0)
Asian	1.18% (4)	1% (4)
Black/African American	49.71% (169)	50% (183)
Hispanic	4.41% (15)	5% (18)
Native Hawaiian	0% (0)	0% (0)
White	43.53% (148)	43% (160)
2 or more Races	0.88% (3)	1% (4)
Unknown	0.29% (1)	0% (0)

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 Pre-Service and Inservice Training System.

Maryland Caseload Standards

Maryland continues to strive to maintain an average worker caseload at the standards established by the Child Welfare League of America. For CPS investigations the caseload standard is 1:12. As of December 2020, the average CPS caseload per caseworker was 10.7 which represents a slight decrease from last year. During that same month, the supervisor/worker ratio averaged 1 supervisor to 5.0 workers which is on par with last year's report. CPS supervisors do not carry a caseload.

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. 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 Out-of-Home Placement.

ETV Vouchers
Please see Appendix F for the number of youth who were new voucher recipients in each of the school years.

Inter-Country Adoptions
There were no youth reported that were adopted from other countries or who entered state custody in FY2019 as a result of the disruption of a placement for adoption or the dissolution of an adoption as reported by the LDSS. DHS/SSA continues to offer post-adoption services to families with children adopted from other countries who enter care as a result of the disruption of a placement for adoption or the dissolution of an adoption. With the implementation of a new data system DHS/SS will explore opportunities to enhance the system to support continued tracking of disruptions or dissolutions of intercountry adoptions.

Monthly Caseworker Visit Data
Data for FY 2021 will be submitted by December 15, 2021.

Financial Information

Financial Limitations:
Payment Limitations: Title IV-B, Subpart I: The amount Maryland expended for childcare, foster care maintenance and adoption assistance payments for FY 2005 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 FY 2005 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 20 percent of the grant with state funds.

Payment Limitations: Title IV-B, Subpart II:
The FY 2019 state and local share expenditures amount for the purpose of Title IV-B, subpart II is $73,702,881. The 1992 base year is $31.7 million.

See Appendix G for required financial reports.

FF Transition Act Funding Estimates - DRAFT 8/10/2020
MD Allocation = $7,175,450 (October 1, 2019 – September 30, 2025)

Use of Funds	Reporting Category	Year 2 (10/1/20 - 9/30/21)	Year 3 (10/1/21 - 9/30/22)	Year 4 (10/1/22 - 9/30/23)	Year 5 (10/1/23 - 9/30/24)	Total
Support capacity building for residential placement providers (1)	Family First: Part IV - Ensuring the Necessity of a Placement that is not in a Foster Family	$ -	$ 135,000	$ 40,000	$ 40,000	**$ 215,000**
Develop a rigorous evaluation strategy for certain evidence-based programs (2)	Family First: Part I - Prevention Activities Under Title IV-E	$ -	$ 165,000			**$ 165,000**
Support building the evidence for certain interventions previously funded under Families Blossom (3)	Waiver Continuation	$ -	$ 700,000	$ 700,000	$ 700,000	**$ 2,100,000**
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 (4)	Family First: Part I - Prevention Activities Under Title IV-E	$ -	$ 263,400	$ 158,795	$ 155,750	**$ 577,945**
Support infrastructure for EBP CQI efforts (5)	Part I - Prevention Activities Under Title IV-E	$ -	$ 259,753	$ 259,752	$ 68,000	**$ 587,505**
Rebrand child welfare services as family support services (6)	Part I - Prevention Activities Under Title IV-E	$ -	$ 10,000	$ 10,000	$ 10,000	**$ 30,000**
Child Welfare caseworker costs to serve in-home children and their families including referral to non-medical services and case management		$ 3,500,000	$ -	$ -	$ -	**$ 3,500,000**
		$ 3,500,000	**$ 1,533,153**	**$ 1,168,547**	**$ 973,750**	**$ 7,175,450**

FF Transition Act Funding Estimates - DRAFT 8/10/2020
MD Allocation = $7,175,450 (October 1, 2019 – September 30, 2025)

Budget Assumptions:

1. Residential Assumptions. Assumes that each residential provider who is not yet accredited will receive up to $5,000 to support initial accreditation (n=25; $125,000 costs vary from approximately $8,000-12,000, typically based on size/revenue). Providers who need to maintain accreditation status will receive up to $1,000 in support one time during the five year period (n=40 and $40,000, including newly accredited, assumed to be fairly distributed across years). Items of cost for building capacity of SUD parent/child facilities are estimated to be $30,000 in each year inclusive of all facilities, beginning in year 2

2. Evaluation Assumptions. Estimate based on additional costs to begin funding a rigorous evaluation of FCT and START in year one with no costs due to shifting to the title IV-E Prevention Program in the later years.

3. Building Evidence assumptions. Estimate based on paying for partial program operational/implementation costs for the Bester Community of Hope and Partnering for Success ($500,000 total per year) plus evaluation costs for each program ($200,000 per year per program).

4. Expansion assumptions. Based on per program estimates of expanding capacity for existing programs or installing new programs, including costs such as startup, developer fees, training and infrastructure. Assumed priority for capacity building is NFP, PCIT and MST and those costs would start in year 1, remaining program capacity expansion would begin in year 2: PCIT (Yr 1 - 158,400), MST (Yr 1: $105,000, yrs 2-5: $55,750), FFT (Yr 2: $238,865, yr 4: $100,000, yr 5: $40,000), HFA (Yr 2: $6,760). Does not cover all fees that may be necessary for program fidelity and operation.

5. Provider CQI Assumptions. Assumption is that these costs will cover 40% of UMB's TA agreement for year 1 and 2 (apporximately $650,000 over 2 year agreement) and the remainder will be be spread between headquarter operations for a portal that interfaces with CJAMS and local provider costs to interface with the portal.

6. Rebranding Assumptions. Based on similar costs for communications for the waiver demonstration program and material items that demonstrate an agency support approach.

MARYLAND DEPARTMENT OF HUMAN SERVICES

MARYLAND STATE COUNCIL ON CHILD ABUSE & NEGLECT ANNUAL REPORT

JANUARY 1, 2019 – DECEMBER 31, 2019

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 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.

- Maryland Essential for Childhood Workgroup Chairs: Pat Cronin, Claudia Remington, Kay Connors, D'Lisa Worthy, Joan Stine, Melissa Rock, Rachel White, Cathy Costa, and Wendy Lane.

- 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 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-Informed State; and, for testifying on behalf of HB 486, S.E.S.A.M.E. (Stop Educator Sexual Abuse Misconduct & Exploitation) legislation. Pat Cronin and the staff of The Family Tree for their co-backbone support of Maryland Essentials for Childhood Initiative, particularly Ruby Parker, Naketta Lowery, and Jennifer Roberts for their leadership and support of the ACE Interface Project.

- ACE Interface Master Trainer Cohort for their continued commitment to ensuring Maryland becomes a N.E.A.R. Science-Informed State: Dorinda Adams, MSW, LGSW; M. Saida Agostini, Ulysses Archie, Jr.; Delegate Vanessa Atterbeary; Christina Bethell, PhD; Wendy C. Blackwell; Pamela M. Brown, PhD; Kay Connors, LCSW-C; Patricia Cronin, LCSW-C; Robin Davenport; Amber Guthrie; Joyce Harrison, MD; David Humphries; Lauren Jenkins; Frank Kros, MSW, JD; Naketta Lowery, CFLE, COS; Sarah Manekin; Lt. Veto Mentzell; Cathy Meyers, LCPC; Deborah Nelson, PhD, NCSP; Ruby Parker; Kathy Powderly; Claudia Remington, JD; Steve Rohde; Diane Shannon, LCSW-C; Teresa Simmons, MSW, LCSW-C; Joan Stine, MHS, MS; Honorable William Tucker; D'Lisa Worthy, M.Ed; and Steven Youngblood, LCSW-C.

- ACE Interface Master Presenters for joining the ACE Interface Project and dedicating their valuable time and skills to the efforts to ensuring Maryland becomes a N.E.A.R. Science-Informed State: Alexandra Podolny, Alisha Saulsbury, Amie Myrick, Andrea Butler, Andrew Bell, Angela Gray, Angela Holocker, Beth Anne Langrell, Beth Schmidtt, Candace Hawkins, Cara Calloway, Carmen Getty, Carol Auerbach, Catherine Abrams, Chari Jones, Charlene Creese, Charles Gammons, Denise Garman, Denise Messineo, Desiree Shantai Smith, Dillon McManus, Donna Jacobs, Doria Fleisher, Elizabeth Garcia, Emily Moody, Eric Rollins, Guli Fager, Harold Young, Harriet Smith, Heather Hanline, Jamie Shepard, Jan Brewer, Jay Hessler, Jen Thomas, Jennifer Redding, Jennifer Roberts, Jenny Howard, Jessica Oterson, Jim Raley, Jonathan Williams, Joseph Windsor, Joy Ashcraft, Kawana Webb, Kelly Hutter, Kelly Reynolds, Kim Dumas, Kimberly Buckheit, Kimberly Repass, Kip Castner, Kristy Conklin, Lacey Tsonis, Latrice Gray, Lauren Williams, Laurie Galloway,

Laverne Cray, Leah Bentfield, Leslie Follum, Ligia Teodorovici, Lori Hauser, Lucane LaFortune, Marie Statton, Martha Ruiz, Matila Jones, Megan Pinder, Melissa King, Melita Friend, Meredith Miller, Michelle Gilliam, Michelle Lancaster, Miera Corey, Myra Sturgis Glover, Nana Ama Adom-Boakye Kanyi, Nicole Conner, Nicole Fisher, Pat Mosby, Patricia Barger, Paul Griffin, Robert Zellner, Rose Zollinger, Sadie Liller, Sandra Gammons, Sara Haina, Scott Showalter, Sean Robinson, Shannon Cassidy, Shantay McKinily, Staci Aperance, Stephanie Scharmen, Stirling Ward, Tarik Harris, Tasha Jamison, Terrell Sample, Tonya Green- Pyles, Tracey Cottman, Victoria Rentz, Vonda Colson, and William Jernigan.

- Maryland ACEs Connection Community Managers, Jamie Shepard, Ruby Parker, Claudia Remington and Erik Weber.

- Vanessa Milio, Executive Director of No More Stolen Childhoods (NMSC), and the Board of NMSC for lending their expertise to efforts to pass S.E.S.A.M.E. legislation and HB 687 and HB 974 (Child Sexual Abuse Civil Statute of Limitations Reform) through testimony, and media, and social media advocacy. Special thanks go to Founder, Wayne Coffey; Board Presidents, Michael Fitz-Patrick and Pamela Piro; and Secretary, Brooks Patternotte for their bill testimony and/or support of the ACEs Roundtable for Members of the General Assembly; and, Vice President, Christian Mester, for sharing his legal expertise. Additionally, thanks go to Sondheim Nonprofit Leadership Fellow, Olivia Morse (with the support of NMSC E.D. and Board) for her assistance in the researching and drafting of Maryland Essentials for Childhood's ***Toward A More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient Communities.***

- Delegate Vanessa Atterbeary and Senator Antonio Hayes for sponsoring the ACEs Roundtable for Members of the Maryland General Assembly (MGA).

- Delegates Alice Cain, Michelle Guyton, Susan McComas, Stephanie Smith, and C.T. Wilson and Senators Malcolm Augustine, Susan Lee, and Chris West for participating in the ACEs Roundtable.

- ACEs Roundtable national speakers: The First Lady of Delaware Tracey Quillen Carney, Kate Blackman and Kate Bradford (National Conference of State Legislators), Michael Castagnola (staff to the late Congressman Elijah Cummings), Joan Gillece (NASMHPD), Frank Kros (Kros Learning Group), Melissa Merrick, PhD (Prevent Child Abuse America), and Mary Rolando (Building Strong Brains Tennessee)

- ACEs Roundtable national, state, and local experts: Andrea Butler (Aetna), Cathy Costa (BCHD), Karen Kreisberg and Brooke Hisle (Krieger Fund), Anne Hoyer (MD Safe at Home Program), Stacey Jefferson (BHSB), Wendy Lane (SCCAN, MDAAP), Sarah Manekin (Abell Foundation), Lt. Veto Mentzell (Harford County ACE Initiative), Pilar Olivo (Frederick County ACEs Workgroup), Dan Press (Campaign for Trauma Informed Policy & Practice), Laurie Anne Spagnola (Board of Child Care), Terry Staudenmaier (Abell Foundation), Jimmy Venza (The Lourie Center), and Ellen Volpe (HRSA, Division of State & Community Health, Maternal and Child Health Bureau).

- Maryland Essentials for Childhood partners for their volunteerism and support of the Roundtable: Ulysses Archie for providing photography services, Pat Cronin, Stacey Jefferson, Eileen King, Wendy Lane, Brittany Lore, Denise Messineo, Olivia Morse, Ruby Parker, Pam Piro, Claudia Remington, Melissa Rock, Jamie Shepard, and Joan Stine.

- Sarah Manekin and The Abell Foundation for their generous support of facilitation services and graphic recording of the ACEs Roundtable for Members of the MGA.

- Sue Borchardt for her assistance in planning and facilitating the ACEs Roundtable; and, Lucinda Levine of Inkquiry Visuals for her graphic recordings of the ACEs Roundtable.

- Delegate C.T. Wilson for sponsoring and tirelessly advocating for HB 486 (S.E.S.A.M.E. legislation) and HB 687 (2019) HB 974 (2020) (The Hidden Predator Act of 2019 and 2020 - 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 687 and HB 974 (The Hidden Predator Act of 2019 and 2020).

- Senator Clarence Lam for sponsoring SB 541 (S.E.S.A.M.E. legislation) to prevent child sexual abuse in school settings *before it occurs*.

- The Members of the Maryland General Assembly for unanimously passing the S.E.S.A.M.E. Act HB 486 (2019) and the House of Delegates for passing HB687 (2019) and HB974 (2020) legislation to prevent child sexual abuse in school settings *before it occurs*.

- Vanessa Milio and Becca Lestner for the design of legislative talking points for HB 486/SB 541, social media images, and S.E.S.A.M.E. Social Media Toolkit.

- Nicole Atkinson, Owner of Push to Start, for her pro bono publications and communications services on behalf of Maryland's S.E.S.A.M.E bill.

- Shannon Sollenberger, Legislative Counsel to the Senate of the Commonwealth of Pennsylvania for sharing her expertise and experience and important lessons learned in passing S.E.S.A.M.E. legislation in Pennsylvania.

- S.E.S.A.M.E. President, Teri Miller for sharing her time, expertise and national S.E.S.A.M.E. organization resources in support of passage of Maryland's HB 486/SB 541.

- Dr. Chester Kent for sharing his time and expertise to inform Maryland's S.E.S.A.M.E. legislation and for traveling to Maryland to testify on behalf of the bill.

- Jetta Bernier, Executive Director of Mass Kids, and Rush Russell, Executive Director of Prevent Child Abuse New Jersey, for sharing their time, expertise, and lessons learned from efforts in their states to pass S.E.S.A.M.E. legislation.

- 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 Kevin Redden, Lauren Fash, Ariel Neumann, Felicia Langel and Brooke Kasoff for their legal expertise, testimony, and support of efforts to pass S.E.S.A.M.E. legislation and the Hidden Predator Act of 2020.

- The following organizations for their support and advocacy on behalf of passing S.E.S.A.M.E: Maryland Association of Boards of Education (MABE); No More Stolen Childhoods; The Moore Center for the Prevention of Child Sexual Abuse; Maryland PTA; American Academy of Pediatrics, Maryland Chapter; Prevent Child Abuse, Maryland, The Family Tree; Advocates for Children and Youth (ACY); Parents' Coalition of Montgomery County; Child Justice; Maryland Children's Alliance; Baltimore Child Abuse Center; Citizens' Review Board for Children; Maryland Family Network; Maryland Catholic Conference; CASA; Parents' Anonymous of Maryland; Center for Children; Council for American Private Education (CAPE); and National Association of Social Workers, Maryland Chapter (NASW);

- The Maryland State Education Association, particularly Sean Johnson, and the Maryland Association of Nonpublic Special Education Facilities, particularly Dorie Flynn, for their good faith negotiations on HB 486/ SB 541 in order to find solutions to their concerns about the bill, while ensuring the protection of the students in their care.

- 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 2019 and 2020.

- 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 687 and HB 974 The Hidden Predator Acts of 2019 and 2020. 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***.

- Maryland Child Abuse & Neglect Fatality (MCANF) Workgroup: Rich Lichenstein, Wendy Lane, Cathy Costa, Joan Stine, Melissa Rock, Rachel White, Denise Wheeler, Pam Dorsey, Linda Ramsey, Erica LeMon, Corine Mullings, Cathy Meyers, Veto Mentzell, Sheree Keitt, Maura Dwyer, and Claudia Remington.

- Nicholle Cross, Capstone Project master's in public health candidate at University of Maryland, for her analysis and drafting of the initial MCANF Workgroup Report.

- Sara Manetta, Medical and master's in public health student at the University of Maryland, for her assistance with developing the SCCAN-MD EFC Education, Advocacy, and Awards Day at the General Assembly.

- The many other partners, stakeholders, and citizens who contribute to moving SCCAN recommendations and Maryland Essentials for Childhood 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

November 9, 2020

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 your continued support of State Council on Child Abuse and Neglect (SCCAN) legislative initiatives. During the 2019 Maryland General Assembly session, HB 486/SB 541 passed both Houses unanimously and was signed by the Governor. Building upon the foundation of 2018's HB 1072, which required education on preventing and identifying child sexual abuse, HB 486/SB 541 will prevent school employees with a track record of disregarding laws, policies, and codes of conduct related to sexual abuse and sexual misconduct from being passed from one school to another without consequence or question. Specific elements of this bill include:

1) Requiring anyone applying for a position in a school—public or private—involving direct contact with minors to provide a written release and a statement disclosing whether s/he has been the subject of a child sexual abuse or sexual misconduct investigation by any employer, and whether s/he has ever resigned or separated from a position amid pending allegations of child sexual abuse or misconduct.
2) Requiring the school considering the applicant to contact each of the applicant's former employers and inquire whether the applicant has been investigated for child sexual abuse or sexual misconduct, and whether the applicant resigned or separated from a position amid pending allegations of child sexual abuse or sexual misconduct.
3) Requiring all contacted former employers to furnish the requested information.
4) Banning non-disclosure agreements in cases involving child sexual abuse or child sexual misconduct;
5) Prohibiting schools from expunging data from personnel files in cases of employee sexual abuse or misconduct;
6) Providing immunity from civil and criminal liability to former and current employers for providing information or records, including personnel records, in good faith.

This bill will help ensure the health, safety, and well-being of Maryland children. Though the 2020 legislative session was cut short because of the coronavirus pandemic, we look forward to continuing our legislative partnerships to protect children.

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:

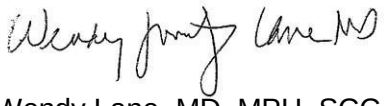
1) *to "evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities;"*
2) *to "report and make recommendations annually to the Governor and the General Assembly on matters relating to the prevention, detection, prosecution, and treatment of 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 2019, we have chosen to continue our focus on the primary prevention of child maltreatment, health care for children involved in the child welfare system, and child abuse and neglect fatalities. On pages 59-69, the Council 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, prevent child abuse and neglect fatalities, 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 Robert R. Neall
DJS Secretary Sam Abed
MSDE State Superintendent of Schools, Dr. Karen B. Salmon, PhD
MDD Secretary Carol A. Beatty
DBM Secretary David R. Brinkley
DPSCS Secretary Stephen T. Moyer
DLLR Acting Secretary James Rzepkowski
Governor's Office of Crime Prevention, Youth, and Victim Services, V. Glenn Fueston, Jr., Executive Director
SCCAN Members

EXECUTIVE SUMMARY

As a result of the COVID-19 pandemic, the ensuing stay-at-home orders, economic downturn, unemployment, food and housing insecurity, and other financial difficulties, day care and school closing, and the death of family members, experts are seeing a significant increase in parental stress. That stress is known to create 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.

SCCAN's 2019 Annual Report to the Governor and General Assembly continues to provide a framework for a seismic shift in how we as a state address child abuse and neglect, along with related adverse childhood experiences (ACEs) or childhood trauma. Child physical, sexual, and emotional abuse and child neglect are traditional foci; to these more obvious forms of abuse, we now add other adverse events shown to disrupt the healthy development of children, including but not limited to 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, and bullying, and historical and intergenerational trauma. Individually and particularly when experienced in combination, these ACEs lead to poor child health and educational outcomes and also reduce public safety and economic productivity at an immense cost to children and taxpayers. We support Governor Hogan's vision of economic opportunity for all of Maryland's children, youth, and families and urge him and the General Assembly to develop and refine policy in ways that leverage the exciting advances in the N.E.A.R. (Neurobiology, Epigenetics, ACE Study, and Resilience) science to reach that vision. SCCAN's recommendations for more than ten years have set out specific policies, strategies, and training that build the individual and collective knowledge and skills of Marylanders in our child and family serving agencies and communities to provide the safe, stable and nurturing relationships and environments that children need to grow into healthy and productive citizens. In responding to feedback on prior SCCAN reports, some recommendations are addressed specifically to the Governor, the General Assembly, or one or multiple child and family serving agencies. At the same time, implementation of many of these recommendations will require leadership support and the hard but attainable work of collaboration and coordination across child and adult serving agencies that strive now more than ever to integrate themselves and their missions toward this shared vision.

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's 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 U.S. Centers for Disease Control. 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 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. Over the past year, SCCAN and MD EFC have been the catalyst for the following achievements toward making Maryland a trauma-informed and resilient state:

- Raising awareness of N.E.A.R. Science and continuing to build commitment and political will to put the science into action to reduce and mitigate ACEs by:
    - Increasing the breadth and reach of the ACE Interface Project:
        - ACE Interface Master Trainers trained 97 Master Trainers representing all 24 Maryland jurisdictions; including two specialized cohorts:
            - Opioid Epidemic – MDH's Regrounding Our Response to the Opioid Crisis (31 Master Presenters statewide)
            - Education- MSDE (36 Master Presenters statewide)
        - Since its inception in December 2017 and March 2019, volunteer ACE Interface Master Trainers and Presenters have given 255 ACE Interface presentations to over 8000 attendees across all 24 jurisdictions.
    - Consulting with Congressman Elijah Cummings Office on development of the first Congressional Hearing on Childhood Trauma which took place on July 11, 2019.
    - Meeting with staffers of the Maryland Members of the House Committee on Oversight and Reform and Leader Hoyer to brief them on Maryland's efforts to reduce and mitigate childhood trauma.
    - SCCAN's E.D. serving on Congressman Cummings' fourteen member Baltimore City Childhood Trauma Roundtable to share SCCAN and MD EFC statewide efforts to prevent and mitigate childhood trauma and build resilience.
    - Consulting with Councilman Zeke Cohen on the Elijah Cummings Healing City Act (Trauma-Responsive Baltimore).
    - Holding the 1st full day ACEs Roundtable for Members of the Maryland General Assembly on December 13, 2019 sponsored by Delegate Vanessa Atterbeary and Senator Antonio Hayes, including presentations on the N.E.A.R. Science, The CDC's Best Available Evidence Research: ACE Data (MD & US) & Implications for Government Policy, the Economy, & Business, State Legislative Strategies to Prevent & Mitigate the Effects of ACEs, Translating the Science into Federal and State Policies Panel, Translating the Science Maryland's State and Local Efforts, and the "So What Now? World Café": Designing the Future MGA Working Groups with "Call an expert" lifeline. By the end of the day, the group of legislators who attended committed to developing a Maryland Legislative Caucus to Prevent and Heal Childhood Trauma, arranging for a joint ACEs hearing for the Senate Judicial Proceedings and House Judiciary Committee, working with MD EFC to develop an ACE-informed platform of bills through the newly formed caucus, and encouraging their colleagues to attend the SCCAN-MD EFC ACEs Education & Advocacy Day at the General Assembly on Thursday, February 7th.
    - Hosting SCCAN-MD EFC Education, Advocacy, and Awards Days at the General Assembly in February 2019 and 2020.
    - Continuing to develop and expand Maryland ACEs Action blog page on ACEs Connection:
        - Recruited a lead Community Manager to recruit additional members.
        - Doubled Membership, making Maryland ACEs Connection Community the 43rd largest of 285 Communities on ACEs Connection and the 6th largest statewide community after California, Washington, Arizona, Michigan, and Oklahoma.
        - 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.
    - Developing a Maryland Essentials for Childhood webpage: https://mdessentialsforchildhood.org/.
- Educating and Advocating for ACE-Informed Policy & Funding Priorities by:
    - Developing and publishing ***Toward a More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient***

Communities (See Appendix B).
    - Providing 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 C).
    - Sharing expertise with and participating in survivor and ally led efforts to pass the Hidden Predator Act of 2019 and 2020 (See Appendix D) and Justice4MDSurvivors.org.
- Leading efforts to create shared ACE and resilience data:
    - Successfully advocating for the inclusion of 4 ACE questions that were included in the Fall 2018 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 advocating for BRFSS and YRBS/YTS ACE data to be collected in 2015, 2018, and 2020.
    - Completing MCANF Reviews of child fatalities of children under the age of 5. Analysis of data and recommendations are forthcoming, as our volunteer reviewer time permits.

SCCAN's Annual Report includes the following:

- A brief background of SCCAN's mandate, focus, and efforts.
- An overview of the key concepts of neurodevelopmental science and the impact of adversity on the developing brain.
- A discussion of Maryland data on the magnitude of the problem.
- A description of the MD EFC and 2019 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.

Key Recommendations for the Governor, the General Assembly, and Agencies[1]:

1. Take meaningful action to raise awareness of brain science, adverse childhood experiences (ACEs), resilience, and build community commitment to prevent, reduce, and respond to ACEs by launching an ACEs Initiative similar to former Governor Bill Haslam's ACEs-Building Strong Brains Tennessee, former Wisconsin First Lady Tonette Walker's Fostering Futures[2], and Governor Carey's Executive Order Making Delaware a Trauma-Informed State. Maryland's Governor and/or the General Assembly should take the following actions, similar to sister states, to create a trauma-informed and resilient state through an executive order or legislation:
    - Establish a state lead coordinating body.
    - Develop and implement a State Plan for Preventing and Mitigating ACEs to
        - Incorporate 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.
        - Incorporate trauma-informed best practices across state child and family serving agencies.
        - Provide executive level awareness trainings and opportunities.
        - Enhance the State's ACEs surveillance system, data collection and analysis.

[1] A comprehensive list of SCCAN Recommendations by Agent/Agency can be found on pages 59-69.

[2] While Governors Haslam and Walker no longer hold office, their legacies live on in the communities and agencies across their states.

- Develop ACE awareness campaigns, employing science-based communication strategies.
- Make budgetary commitments to prevent and mitigate ACEs.
- Make use of the expertise and build upon the cross-sector and interdisciplinary partnerships and efforts of Maryland Essentials for Childhood.
- Recruit the support of private foundations, business, and faith-based communities in efforts to prevent and mitigate ACEs.

2. Review, analyze, publish, and effectively disseminate Maryland's 2015 and 2018 baseline state and local ACE Module Behavioral Risk Factor Surveillance System (BRFSS) data (pp. 29-43 below) and 2018 YRBS/YTS (Youth Risk Behavior Survey/Youth Tobacco Survey) (pp. 44-51 below).

3. Continue to collect BRFSS ACE data every three years.

4. Expand Maryland's YRBS/YTS ACE module to include all CDC YRBS ACE module questions and collect this data every two years.

5. Begin collecting resilience or positive childhood experiences (PCE) data in the BRFSS (as is being done in Wisconsin) and the YRBS/YTS in order to both understand the magnitude of this public health epidemic and to develop policy solutions to reduce the numbers and impact of ACEs.

6. Embed the science of the developing brain, ACEs, and resilience into the Children's Cabinet Three-Year Plan. Start by providing ACE training to all Children's Cabinet members. When creating future plans, consider how each recommendation might reduce ACEs or their impact, and improve child, family, organizational, and community resilience.

7. Offer free screenings and time to view the film *RESILIENCE: The Biology of Stress & The Science of Hope* to introduce staff from all state agencies to the brain science, ACEs and resilience, including the importance of trauma-informed systems. Provide opportunity for dialogue on how it might be used to provide better customer service within child and family serving agencies.

8. Fund free screenings of the film *RESILIENCE: The Biology of Stress & The Science of Hope* through Maryland Public Television (MPT). Provide virtual townhall opportunities for dialogue with local communities on how they might employ the science within their communities to improve outcomes for kids.

9. As the next level of the Governor's G.O.L.D. Standard Customer Service Training Initiative, offer ACEs Interface trainings (brain science, ACEs, resilience) to all state employees who work with the public; begin with leadership and supervisors.

10. Explore ways to increase awareness of the brain science and the impact of ACEs on the children and families each agency serves. Integrate the science into agency and cross agency work:

- Participate in developing a State Plan to Prevent and Mitigate ACEs
- Partner in Maryland Essentials for Childhood Initiative to ensure cross-agency coordination

- Consider the appropriateness of screening clients for ACEs and resilience factors.[3]
- Provide pre-service and in-service training to all staff on brain science, ACEs and resilience.
- Research and develop Maryland guidelines for becoming a trauma-informed agency similar to The Missouri Model: A Developmental Framework for Trauma-Informed Approaches.
- Ensure that state contracts require providers meet performance measures to become trauma-informed based on the above referenced Maryland guidelines.
- Embed- the science into agency 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.
- Ensure agency policies and regulations reflect the science.
- Ensure agency practice models reflect the science.
- Invest resources in evidence-based trauma prevention and treatment interventions and creating trauma-informed agencies.[4]
- Partner with the 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 brain development. A similar plan in Tennessee included:
    - Three scientific symposia: Neurobiology, the Science of Programmatic Innovations, and the Science of Policy Innovations.
    - Four three-day "FrameLabs" in which individuals from all sectors and professional disciplines learned values and metaphors that help even people who have no familiarity with child development.
    - A three-day "Train the Trainer" workshop for curriculum designers and agency training leaders.
    - Ongoing technical assistance and a review of materials.
    - Advisory services for the initiative steering group.
    - 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.).

11. Establish a robust Children's/ACEs Trust and Prevention Fund.

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

[3] 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*.

[4] See the National Child Traumatic Stress Network for resources on creating trauma-informed systems.

training, policies, and guidelines; similar to those required in public and nonpublic schools.

16. 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.

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[5] 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.[6]

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"[7] 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."[8] 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".[9]

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-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

[5] The other panels are the Citizens' Review Board for Children and the State Child Fatality Review Team.

[6] See Appendix D for current members.

[7] Section 5016a (c) (4) (A)

[8] Section 5016a (c) (4) (C)

[9] Section 5-7-09A (a)

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.

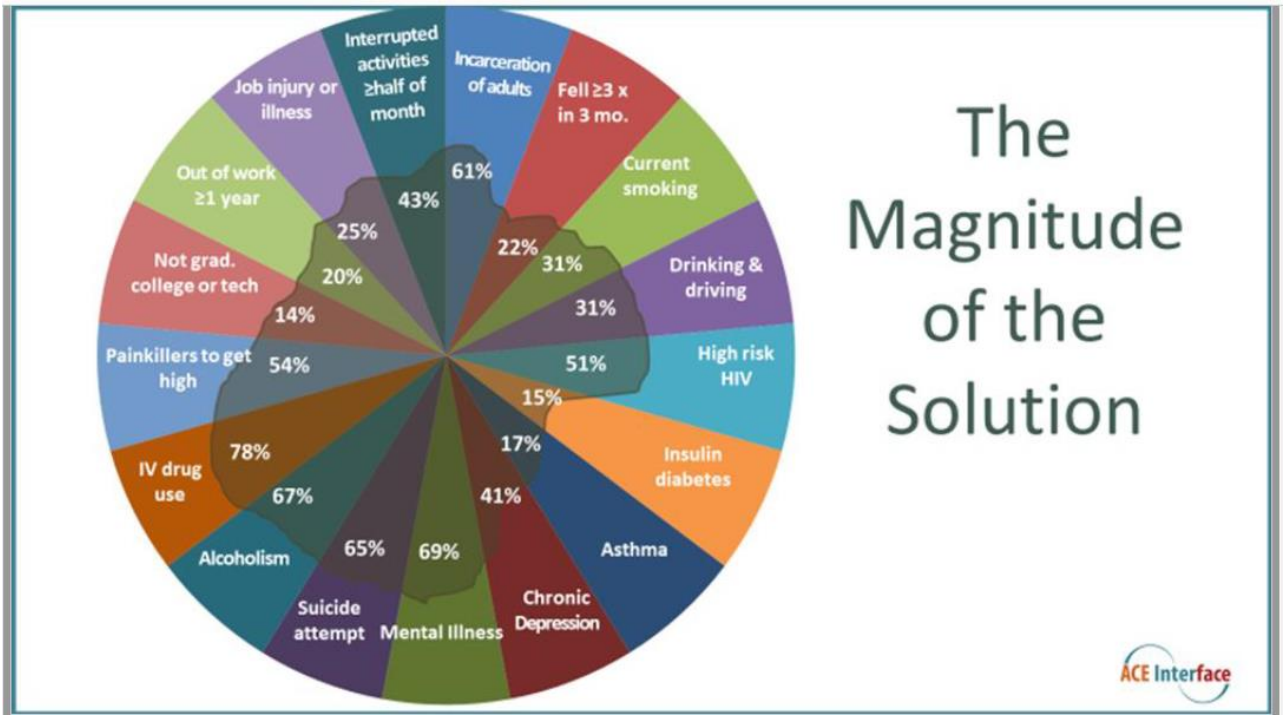
A broader public health approach is needed to prevent child maltreatment *before it occurs.* The public health approach extends our criminal justice and case-based approaches by fostering a better understanding of the complex causes of child maltreatment in order to more effectively and preemptively 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[10] initiative that promotes safe, stable, nurturing relationships and environments for children and prevents, mitigates ACEs, and builds resilience in children, families, and communities.

[10] Channeling Change: Making Collective Impact Work, Stanford Social Innovation Review, https://ssir.org/articles/entry/channeling_change_making_collective_impact_work

THE SCIENCE OF THE DEVELOPING BRAIN, ACES & RESILIENCE: A STRONG CASE FOR A PROSPEROUS MARYLAND[11]

As Marylanders understand the impact of Adverse Childhood Experiences, they realize that the future economic development and prosperity of the state depends on rethinking our policies in health, education, public safety, justice, public assistance, child welfare, and juvenile justice. Focusing on building healthy brain architecture for every child and coordinating our efforts across all our child and family serving systems will prove to be key. This shift in our focus will considerably *reduce childhood adversity at a population level* and stem the tide of ever-more-costly social problems. Understanding the implications of the ACE study and the developments in fields of neuroscience, epigenetics, trauma and resilience is a powerful pathway to health, well-being, and a more prosperous Maryland. Preventing ACEs and their intergenerational transmission is the greatest opportunity of our time…perhaps of all time…for improving the well-being of human populations.

The figure below from the ACE Interface training shows the percentage of various health and social problems that epidemiologists estimate is caused by ACEs. The calculation that is commonly used to do this in public health studies is called Population Attributable Risk (PAR). The PAR calculation is displayed as an "oil spill" on this slide. The percentage of a problem coated by the oil spill represents the percentage of each problem that is potentially preventable by preventing ACEs. The percentages are quite large. In fact the high percentages portrayed in the figure below are rarely seen in public health studies.



[11] The common language used in this section comes from a combination of sources: ACE Interface, Harvard Center for the Developing Child, Frameworks Institute, CDC Essentials for Childhood and Tennessee's Building Strong Brains: ACEs Initiative.

The cumulative effects of ACES reflect a powerful opportunity for prevention – no matter if you are working to prevent heart disease or cancer, end homelessness or hopelessness, or improve business profitability – as we align a portion of our work around a common goal of preventing the accumulation of ACEs and moderating their effects, we will reduce all of these problems, and many others, all at once!

Preventing and mitigating ACEs will require that our vision, policies, and practices as a state are guided by the following ten principles[12] from the neurodevelopmental science:

1. Healthy Development Builds a Strong Foundation – For Kids and For Society

2. Experiences Build Brain Architecture

3. Serve & Return Interactions Shape Brain Circuitry

4. Brains are Built from the Bottom Up, Skills Beget Skills

5. The Biology of Toxic Stress or Adverse Childhood Experiences (ACEs) Derails Healthy Development

6. Positive Stress Aids Healthy Development, Toxic Stress Impedes It

7. The Presence of Responsive Adults at Home & in the Community Lessens the Impact of Toxic Stress

8. Childhood Experiences Build the Foundation for a Skilled Workforce, a Responsible Community & a Thriving Economy: Executive Function & Self-Regulation Skills or "Air Traffic Control Skills" are Critical for Learning & for Life

9. These Essential "Air Traffic Control Skills" are Built in Relationships and the Places in which Children Live, Learn, and Play

10. Rethinking Our Policies

We should focus on preventing ACEs (the original 10 ACEs, urban and community ACEs), whenever possible and on providing trauma-informed services to children, families, and communities when trauma occurs. Preventing and mitigating ACEs will require strong collaboration across disciplines, departments, agencies, and communities with a focus on building state infrastructure (state agencies knowledgeable in the ACE science, data to measure the magnitude of the problem and the effectiveness of the solutions, effective funding mechanisms, and technical assistance) to support local community cross-sector action. The CDC's ***Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence*** lists 6 strategies that are effective in preventing ACEs. Maryland should develop a statewide plan

[12] For further discussion of the 10 neurodevelopmental principles see the 2018 SCCAN Report and Maryland Essentials for Childhood's ***Toward A More Prosperous Maryland: Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient Communities*** (Appendix B).

to prevent ACEs that include these six strategies and help build resilient communities:

- Strengthen Economic Supports for Families
- Promote Social Norms that Protect Against Violence and Adversity
- Ensure a Strong Start for Children
- Teach Skills (parenting, social emotional learning, safe dating and healthy relationships)
- Connect Youth to Caring Adults and Activities
- Intervene to Lessen Immediate and Long-term Harms

Maryland's future prosperity depends on how well we, as adults, foster the healthy development of our youngest generation. Raising happy, competent children who will lead our communities tomorrow requires smart and innovative thinking today. ACE science provides us with a blueprint for how to ensure children get what they need for healthy development. We now know that early experiences literally build the architecture of the brain, and that stable, responsive interactions with caring adults at home and in the community are the key ingredient in building a solid foundation for future growth. We also know that not all children have access to the kinds of experiences that will most benefit their development - some children are exposed to conditions or events that are so severe and persistent as to produce toxic stress responses that damage the brain's developing architecture. By passing policies that provide the kinds of experiences in early care, education and family support settings that help parents and provide sturdy foundations for children's development as outlined in the six strategies above, Maryland policy makers will promote the health and well-being of future generations and build the foundation for a more prosperous Maryland.

All children and parents (especially those with high ACE scores) need someone in their corner. The shift from "What is wrong with you, or why are you a problem?" to "What has happened to you, and how can we support you and help you heal from these experiences?" will result in more effective service delivery systems and a healthier, socially and economically stronger Maryland.

BRAIN SCIENCE SERVES AS A STRONG FOUNDATION FOR GOVERNOR HOGAN'S VISION OF ECONOMIC OPPORTUNITY & STRATEGIC GOALS[13]

While Governor Hogan's four strategic goals identified in Maryland Children's Cabinet Three-Year Plan (Reduce the Impact of Incarceration on Children, Families, and Communities; Improve Outcomes for Disconnected/Opportunity Youth; Reduce Childhood Hunger; and Reduce Youth Homelessness) are very important to youth well-being, they are not sufficient to realize the Governor's goal of greater economic stability and human capital formation to long-term self-sufficiency for children, youth, and families. Each of Governor Hogan's goals would be strengthened by purposeful dissemination and an understanding of the implications of the science of the developing brain, ACEs, and resilience. The Action Items laid out in the Three-Year Plan should each be grounded in this science. Policy makers should ensure that state agency policies, strategies, and technical assistance focus on strengthening caregiver, family, and community capacity to create safe, stable and nurturing relationships and environments that most importantly promote healthy child and youth development and, in turn, prevent a multitude of negative outcomes from substance abuse, mental illness, high school dropout, delinquency, youth suicide, bullying, youth homelessness, intimate partner violence, youth unemployment, and child maltreatment. The following core concepts should be infused into the Children's Cabinet Action Plan:

I. **A primary focus on Early Childhood Development is foundational to promotion and prevention efforts, i.e., Brains are built from the bottom up. Skills beget skills. The ability to change brains and behavior decreases over time (brain plasticity).**
II. **Prevention of Childhood Adversity and Early Intervention to Mitigate Trauma is a necessary precursor to effectively preventing many youth problems, including youth homelessness and disconnection.**
III. **Data systems should track the trajectory of children from one state system and/or service to the next.**
IV. **Brain Science should be used to Design Multi-Generation Paths Out of Violence, Poverty, Addiction and Mental Illness**
V. **Understanding brain science, ACEs and how trauma impacts executive function skills is critical to providing the best possible Customer Service in child and family service systems**.
VI. **Understanding neurobiology, epigenetics, ACEs, and resilience changes practice.**

Our failure to prevent children's maltreatment (CM) *before it occurs* is conservatively estimated to cost Maryland's economy, businesses and taxpayers over $1.5 billion each year. Investing in child well-being and preventing CM is not only *humane and just*, but *makes good economic sense*.[14]

[13] For further elaboration on this section, See SCCAN 2018 Annual Report.
[14] Why Early Investment Matters?, The Heckman Equation, James J. Heckman, PhD

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). The Council and partners are hopeful that this ground-breaking project, MD THINK, will bring needed accuracy, efficiency, data analysis capabilities, and tracking of critical outcomes for children across child and family serving agencies. Many key data points are either not regularly and systematically collected or are not readily accessible and therefore not analyzed (e.g., ACEs of children involved in child welfare: parental substance abuse, parental incarceration, parental mental illness within child welfare). *We hope that MD THINK will provide critical technology to give us 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 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.[15] 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).

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 2018, DHS SSA reports that it received 64,200 referrals of suspected child abuse or neglect, down from 67,467 referrals in 2017. Of those, 26,841 reports or 41.8% were screened in for a CPS response (either investigative or alternative response).
- During FFY 2018, 13,722 investigations were completed. Of this total, 5,922 were indicated for abuse or neglect (or 26.5%, a 15.7% decrease in indicated cases from 2017). The 5,831 indicated cases represent -9.2% of the total abuse and neglect reports. Once there is an indicated referral, children are considered victims of child abuse/neglect.[16]
- During FFY 2018, 8,253 screened-in reports (12.9% of total reports) received an alternative response (AR). Of those 8,253 cases, 465 (or 5.6% of AR cases) received services and 663 cases

[15] 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.

[16] 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.

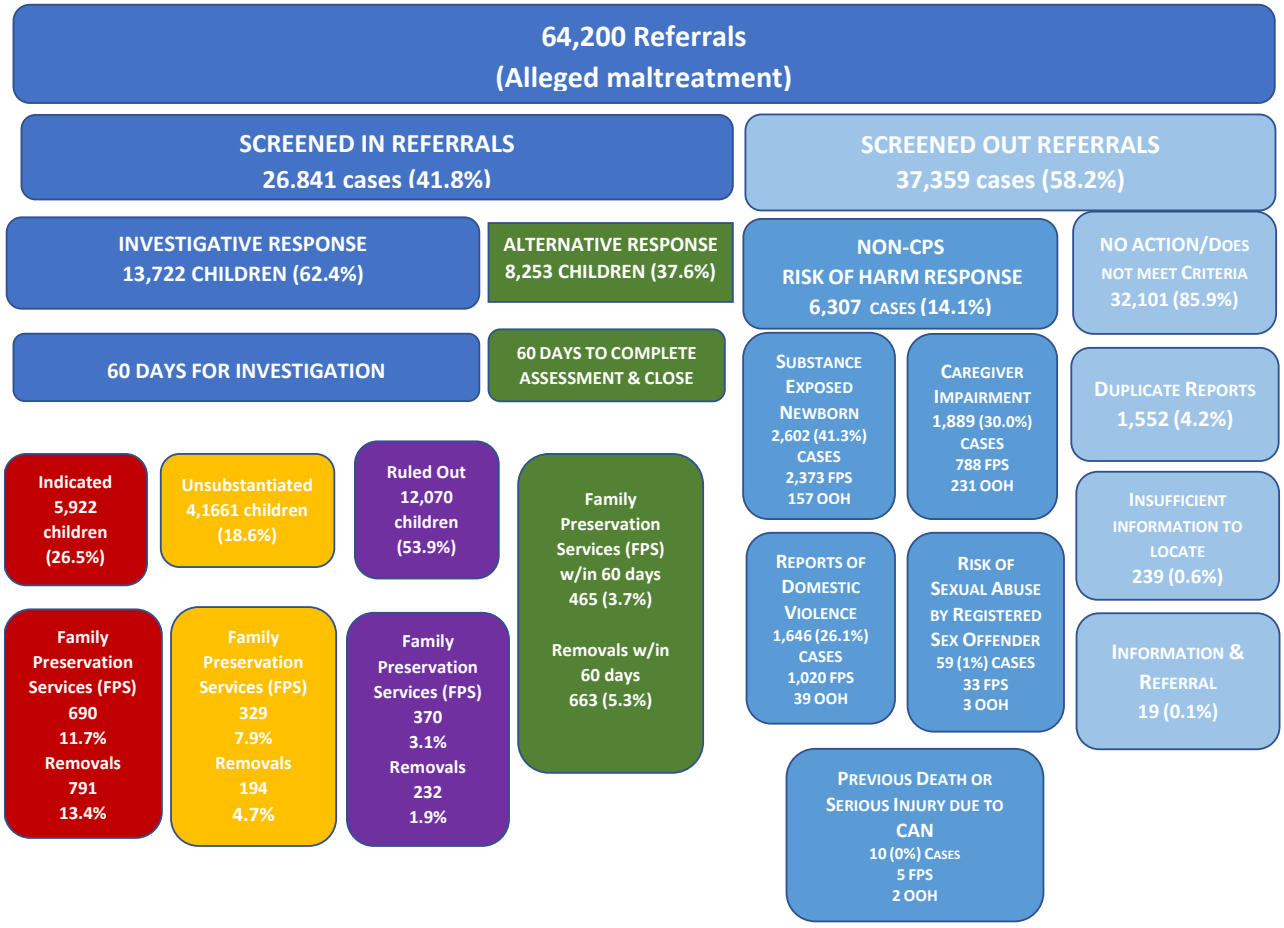
(or 8% of AR cases) ended up with a removal; and, the majority of AR cases (86.4%) received neither services nor ended up in a removal.

- 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 Citizen's 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 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[17].

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.**

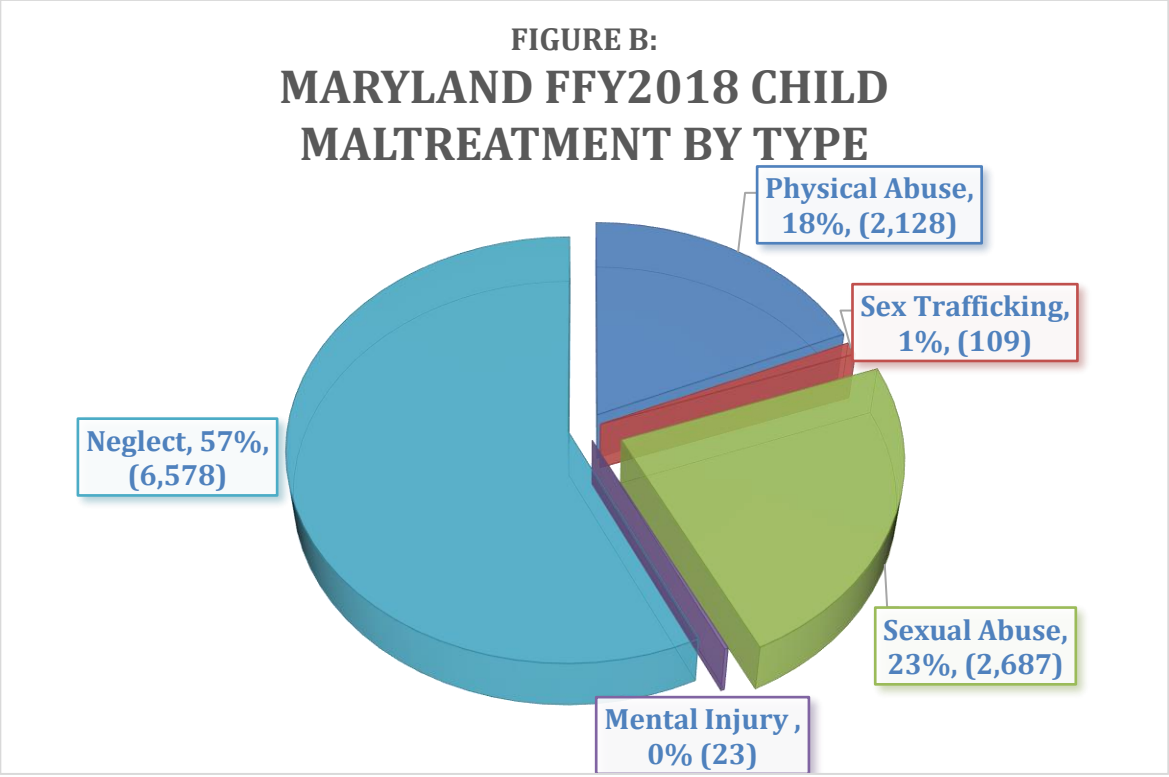
[17] Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities, p. 14.

Figure A: FFY2018 Child Maltreatment Referral, Pathways, and Services



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.[18]
- 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 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

[18] *In Brief, The Science of Neglect*, Harvard Center on the Developing Child.

Children and Families *Child Maltreatment 2018* 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 (caregiver): The compulsive use of alcohol that is not of a temporary nature.
- Drug abuse (caregiver): The compulsive use of drugs that is not of a temporary nature.

The Maryland Department of Human Services submitted data to NCANDS that 2.2% of child maltreatment victims (i.e. cases with an indicated finding) in Maryland had a caregiver risk factor of alcohol abuse and 5% had a caregiver risk factor of substance abuse.[19] 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 45.5% in Alaska to Maryland's 2%; victims with substance abuse caregiver factor varies from 66.1% in New Mexico to Maryland's 5% and Arkansas's 3.1%).

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 37.9% of all children removed from their homes in FY 2018.[20] 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 substance abuse disorder.[21] 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. As addressing caregiver risk factors are key to preventing and responding to child maltreatment, it is critical to have accurate data upon which to base policy and practice decisions.

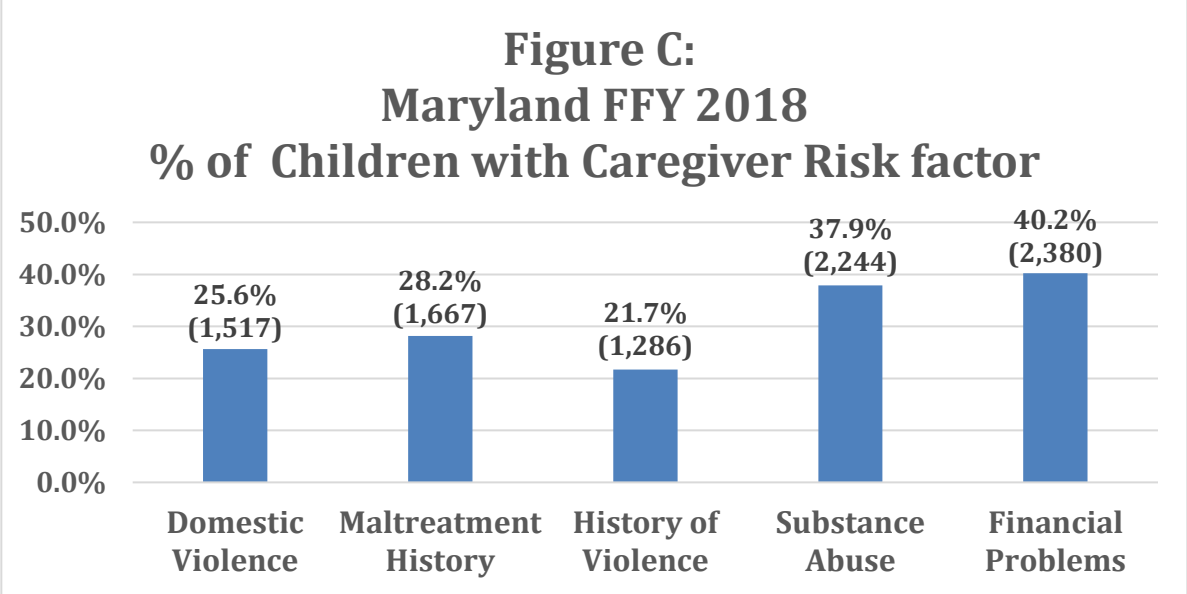
Parental **Risk Factors Among Maryland Children Who Receive an Investigative Response from DSS no matter the finding (as reported to SCCAN by DHS)**:

- 25.6% (down from a reported 38.1% in 2017) of child victims had a caregiver risk factor for domestic violence
- 37.9% (different from 2% and 5.1% with a caregiver risk factors for alcohol - and drug abuse, respectively, as reported to NCANDS) of child victims had a caregiver risk factor of substance abuse.
- 40.2% of child victims had a caregiver risk factor for financial problems
- 28.2% of child victims had a caregiver risk factor of maltreatment history.
- 21.7% of child victims had a caregiver risk factor of a history of exposure to violence.

[19] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2018), *Child Maltreatment 2017*; https://www.acf.hhs.gov/sites/default/files/cb/cm2017.pdf

[20] http://www.dhr.state.md.us/blog/wp-content/uploads/2015/01/MARYLAND-data-packet-3-6-15.pdf, p. 10.

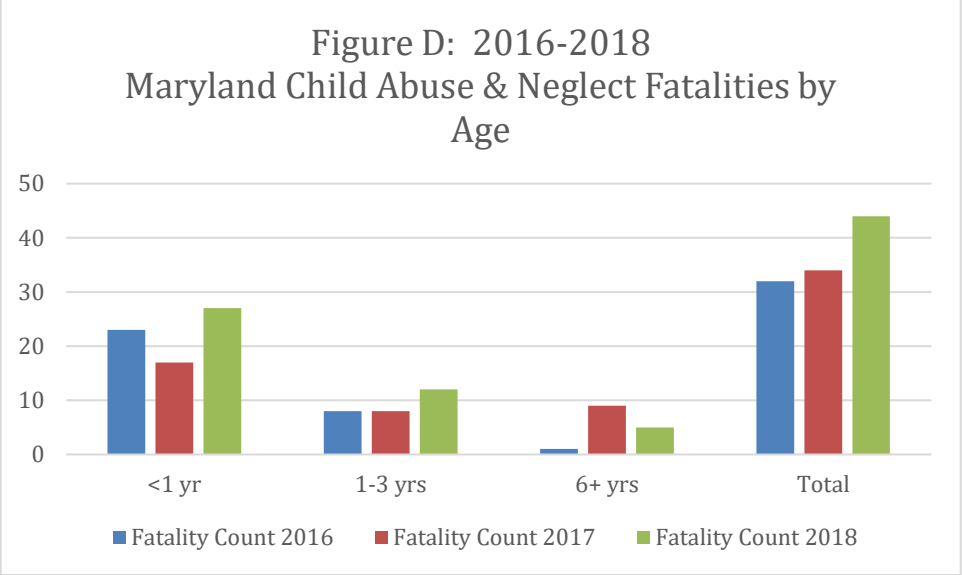
[21] https://www.samhsa.gov/data/sites/default/files/report_3223/ShortReport-3223.html



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 child welfare data systems, and 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 2018, DHS reported to NCANDs that at least 40 Maryland children had died with child maltreatment as a contributing factor. This data has increased each year over at least the last 3 years from 34 the prior year and 32 and 28 the two years before. It was reported that of those 40 children, none of the children's families had received Family Preservation Services within the previous 5 years and no child was removed from his/her family within the previous 5 years.
- SSA reported 44 child fatalities in FFY 2018 to SCCAN. Twenty-seven (61%) of child deaths were < 1 years old; 12 (27%) were 1-3 years old; and 5 (11%) were between 6-17 years old. Due to COVID-19 data requests, the SSA was unable to provide data on the race and ethnicity of the children.
- In FFY 2018, DHS reported that there were 49 serious physical injuries (SPIs) with child maltreatment as a contributing factor (up from 19 in FFY 2017). Thirty-three (or 67%) of the SPIs were of children <1-year-old; 12 (or 24%) were 1-3 years old; and 4 (or 8%) were 6-10 years old. No data was provided regarding the number of SPIs that had an active case or prior child welfare case which had been closed within the past 12 months.
- SSA was unable to provide data on the race and ethnicity of child fatalities and children with SPIs and this is of great concern to the Council. This data should be publicly available on a regular basis.



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. Maryland BRFSS surveyed 12,000 non-institutionalized adults aged 18+ in 2015. Six thousand of those surveyed were administered the ACE module. In the 2018 Maryland BRFSS, 12,000 participants out of 18,000 total were administered the ACE module.

The BRFSS ACE module collects data on eight of the original ten ACEs, excluding physical and emotional neglect from the questionnaire. The following questions were asked on the 2015 and 2018 BRFSS surveys:

Physical Abuse	"Before the age of 18, how often did a parent or adult in your home ever hit, beat, kick or physically hurt you in any way? Do not include spanking." Response options: Never, Once, More than once.
Emotional abuse	"Before age 18, how often did a parent or adult in your home ever swear at you, insult you, or put you down?" Response options: Never, Once, More than once.
Sexual abuse	"Before the age of 18, how often did anyone at least 5 years older than you or an adult ever touch you sexually?", "Before the age of 18, how often did anyone at least 5 years older than you or an adult ever try to make you touch them sexually?" or "Before the age of18, how often did anyone at least 5 years older than you or an adult ever force you to have sex." For analysis Maryland classified an adult to have been sexually abused if they answered once, or more than once to at least one of these questions Response options: Never, Once, More than once. Responses of "once" or "more than once" to one or more of these questions were classified as sexual abuse.
Household Mental Illness	"Now, looking back before you were 18 years of age, did you live with anyone who was depressed, mentally ill, or suicidal?"

Household Substance Abuse	"Before you were 18 years of age, did you live with anyone who was a problem drinker or alcoholic?" or "Before you were 18 years of age, did you live with anyone who used illegal street drugs or who abused prescription medications?
Divorce & Separation	"Were your parents separated or divorced?" Response options: Yes, No, Parents not married. Responses of "parents not married" were excluded from analysis due to small numbers (<2% of sample).
Household Incarceration	"Before you were 18 years of age, did you live with anyone who served time or was sentenced to serve time in a prison, jail or correctional facility?"
Witnessing Domestic Violence	"How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?" Response options: Never, Once, More than once.

Forty-two states and D.C. have collected at least one year of ACE data. While SCCAN and MD EFC are encouraged that Maryland is collecting ACEs prevalence data, effective analysis and publication of that data at both statewide and jurisdictional levels is essential to using the data to inform state and local action. From the 2015 and 2018 Maryland ACE BRFSS data, we hope to learn about the prevalence of ACEs in Maryland adults, populations most at risk by demographic characteristics, prevalence of risky health behaviors by the number or "dose" of ACEs, as well as the prevalence of health outcomes by the number or "dose" of ACEs.

YRBSS and the ACEs Module

The CDC's Youth Risk Behavior Surveillance System (YRBSS) monitors the prevalence of six types of health-related behaviors that contribute to the leading causes of death and disability among youth and adults:

- Behaviors that contribute to unintentional injuries and violence
- Sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection
- Alcohol and other drug use
- Tobacco use
- Unhealthy dietary behaviors
- Inadequate physical activity

YRBSS also measures the prevalence of obesity, asthma, and other health-related behaviors as well as sexual identity and sex of sexual contacts.

The YRBSS includes both a high school and middle school-based core survey conducted by CDC and additional state and local questions selected by individual states. The CDC provides the core YRBSS survey questions and approves each state's additional questionnaire. Maryland chooses two-thirds of its' questions from the core YRBSS and one-third from Youth Tobacco Survey (YTS) and stakeholder requests. Separate instruments are used in middle school and high school. The survey is conducted via paper and pencil during one class period (45 minutes) and is confidential and anonymous. State- and Jurisdiction-level YRBSS data is available on the Maryland Department of Health website. The CDC produces data tables and figures of all survey questions.

In 2018 at the urging of SCCAN and MD EFC, Maryland became one of two states (along with New Hampshire) to begin collecting ACEs data through the YRBSS. MDH together with MSDE decided to include a limited four of ten ACE questions on the 2018 YRBSS. They decided which four questions they would ask in part based on research by Christina Bethell, et. al.[22] which found the highest prevalence ACEs were parental incarceration, parental substance abuse, parental mental illness, and witnessing intimate partner violence (IPV); followed by physical abuse, sexual abuse, and emotional abuse respectively. In the 2018 YRBSS survey of high schoolers, MDH and MSDE asked four original ACE questions: emotional abuse, household substance abuse, household mental illness, and household incarceration. According to Bethell, et.al., those who experienced these most prevalent ACEs were more likely to have experienced other ACEs. Original ACE questions not asked included four of the five questions on child abuse and neglect (physical abuse, sexual abuse, physical neglect, emotional neglect), household domestic violence, and divorce or separation.

The following questions were asked of Maryland high school students:

Emotional abuse	"Does a parent or other adult in your home regularly swear at you, insult you, or put you down? Response options: Yes, No.
Household Substance Abuse	"Have you ever lived with anyone who was an alcoholic or problem drinker, used illegal street drugs, took prescription drugs to get high, or was a problem gambler?" Response options: Yes, No.
Household Mental Illness	"Have you ever lived with anyone who was depressed, mentally ill, or suicidal?" Response options: Yes, No.

[22] Bethell, C., Carle, D., Hudziak, J., Gombojav, N., Powers, K., Wade, R., Braveman, P., *Methods to Assess Adverse Childhood Experiences of Children and Families: Toward Approaches to Promote Child Well-being in Policy and Practice,* Academic Pediatrics, Sep-Oct 2017;17(7S):S51-S69. doi: 10.1016/j.acap.2017.04.161.

Household Incarceration	"Has anyone in your household ever gone to jail or prison?" Response options: Yes, No.

Four states now collect ACE data through their YRBSS and the CDC has adopted an ACEs module with all ten questions and six positive childhood experiences (PCEs) questions for future YRBSSs. Maryland should include these sixteen questions in future YRBSS.

PREVALENCE OF ACEs IN MARYLAND ADULTS:

Maryland collected baseline ACE data in 2015 and 2018. In the collection of this data, important insights into prevalence of ACEs were gained by examining the following characteristics of those impacted by ACEs:

- Social, Emotional, and Cognitive Impairment
- Adoption of Health-Risk Behaviors
- Disease, Disability, and Social Problems

Limitations to the Data

- BRFSS data does not survey adults living in institutions such as nursing facilities, group homes, or prisons. These populations may be disproportionately affected by ACEs and their exclusion may result in an underestimate of the true prevalence.
- Data does not indicate the severity or frequency of each ACE, but rather whether each ACE occurred or did not occur.
- Data does not indicate the temporality of each ACE; data indicates whether an ACE happened, not when it happened. Because data are cross sectional, we can only say the ACEs happened before the age of 18.
- In some instances, the sample size is small. This can increase variance and corresponding confidence intervals, thereby decreasing the precision of estimates. It can also limit the ability to look at prevalence of other state-added questions, such as sexual orientation by abuse type, as this stratification would further reduce the number of individuals in each category, making estimates even less precise.

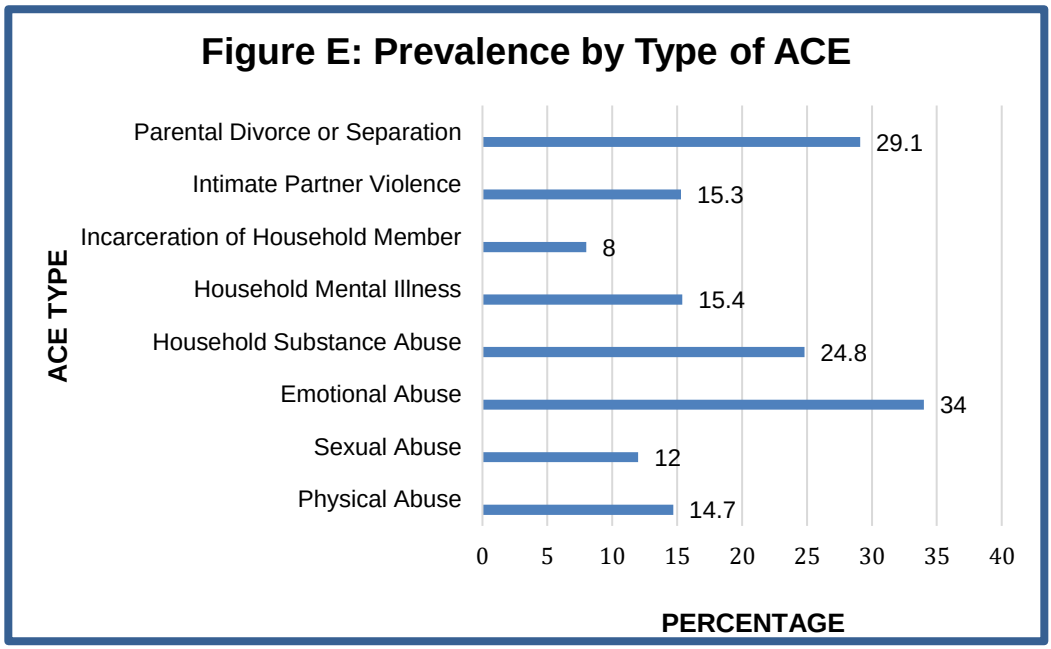
KEY FINDINGS in MARYLAND:

ACEs are COMMON:

Three fifths of the 12,000 BRFSS participants who completed the ACE module in Maryland in 2018 reported having at least one ACE at some point during their childhood. Approximately 24%, almost a quarter, reported three or more ACEs.

Prevalence by Type of ACE

The percentage of respondents who reported experiencing each of these types of ACEs at least once are indicated in the table above. The types of ACEs with the highest prevalence include “parents who were separated or divorced” and “emotional abuse.” See Figure E below.



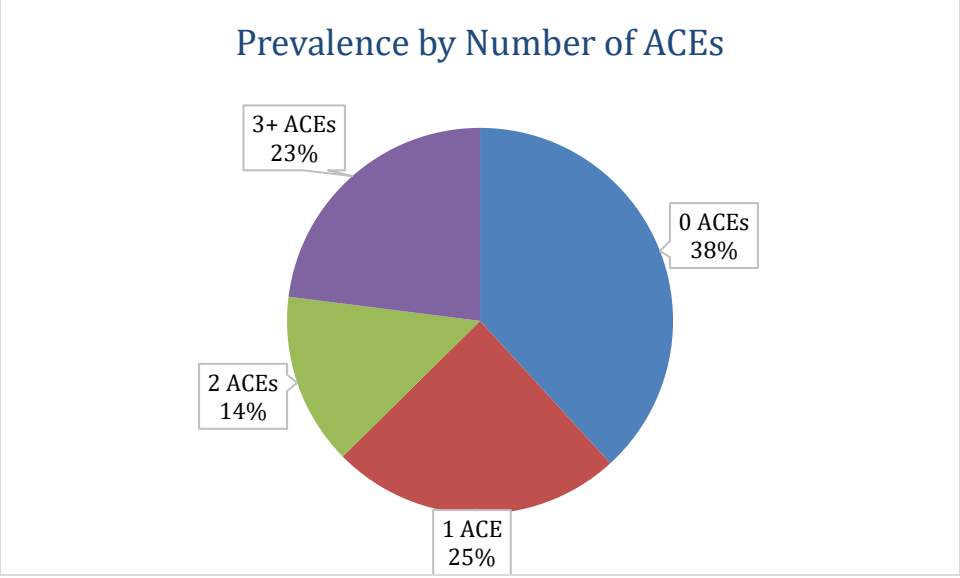
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

ACEs are RARELY FOUND IN ISOLATION− ACEs TEND TO OCCUR IN CLUSTERS:

The cumulative impact of ACEs is captured in the “ACE Score”. If an individual has experienced one ACE, they are likely to have multiple; 24.4% reported one ACE compared to 37.4% reporting 2 or more ACEs. The ACE score captures the potential extent of neuro-developmental disruption as a result of traumatic stress.

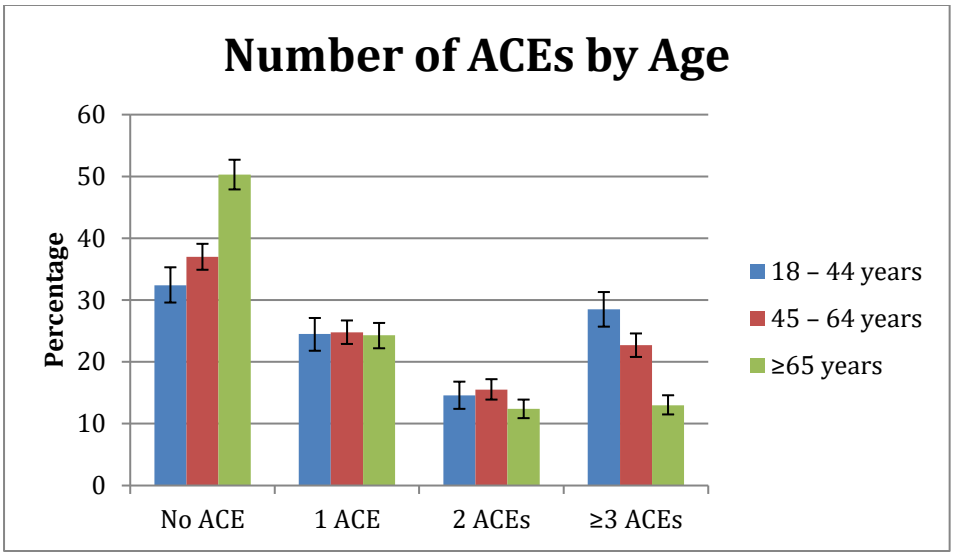
Prevalence by Number of ACEs

As reported in the 2018 Maryland BRFSS, approximately 38% of respondents reported zero ACE exposures, 25% reported 1 ACE, 14% reported2 ACEs, and 23% reported experiencing 3 or more different types of ACEs. For simplicity, we can think of this as no ACE exposure, low ACE exposure, or high ACE exposure. It is important to remember this does not give us information on which ACEs are occurring together.



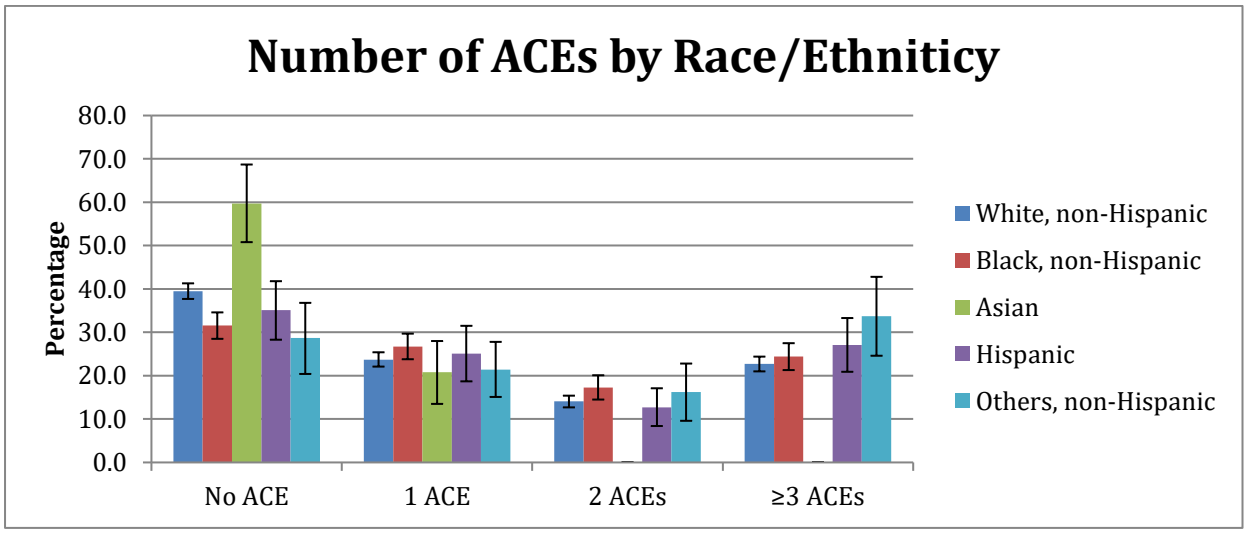
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

DEMOGRAPHICS



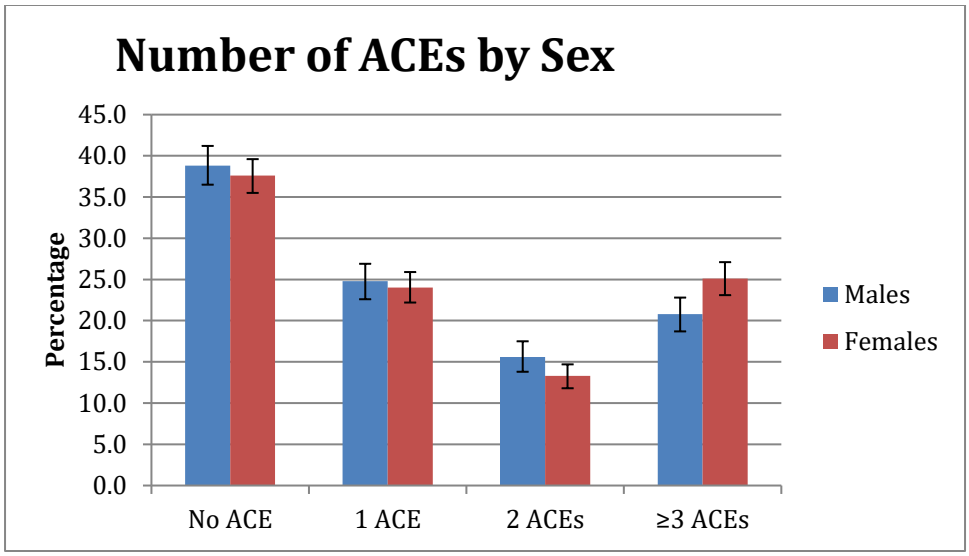
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

As respondent age increases, the frequency of reporting multiple ACEs decreases. Individuals over 65 are significantly more likely to report no ACE exposure and less likely to report greater than 3 ACEs compared to younger respondents. We can speculate that this could be a result of recall bias or more specifically, that as age increases our recollection decreases. Alternatively, we could hypothesize that younger generations are more aware of ACEs due to current discussions/information sharing about its importance to understanding health, and thus are more likely to report them. This data is interesting, yet we must be careful not to overstate its meaning.



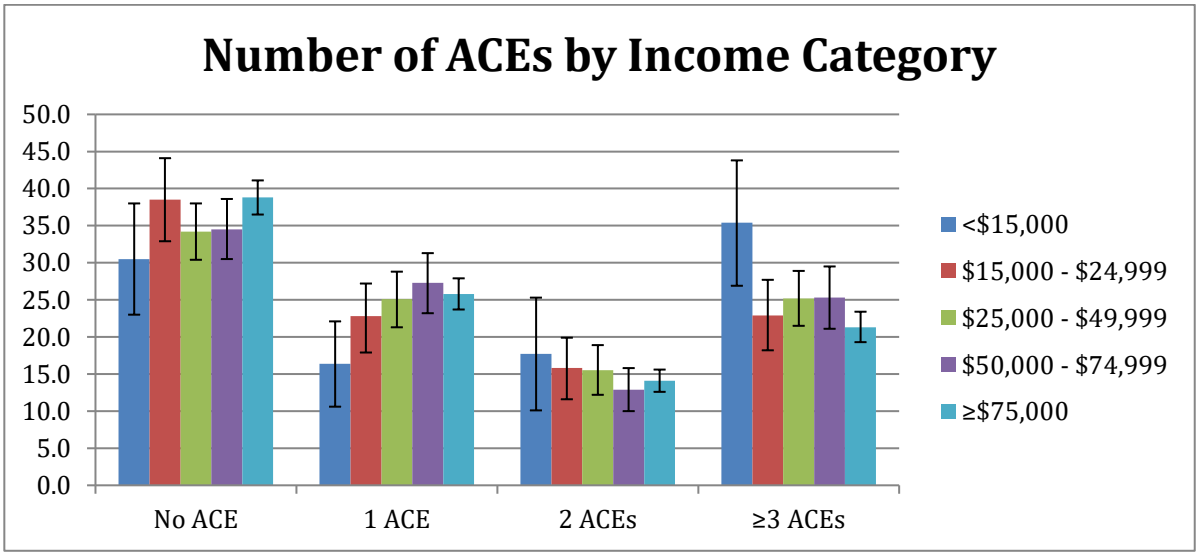
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.
Note: The sample size for Asian populations are too small to provide reliable estimates.

Adults who identified as “Asian” were significantly more likely to report no ACE exposure. No other differences were statistically significant.



Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

Males and females experience a similar proportion of ACE exposures. A statistically significant higher percentage of women report experiencing 3 or more ACEs.



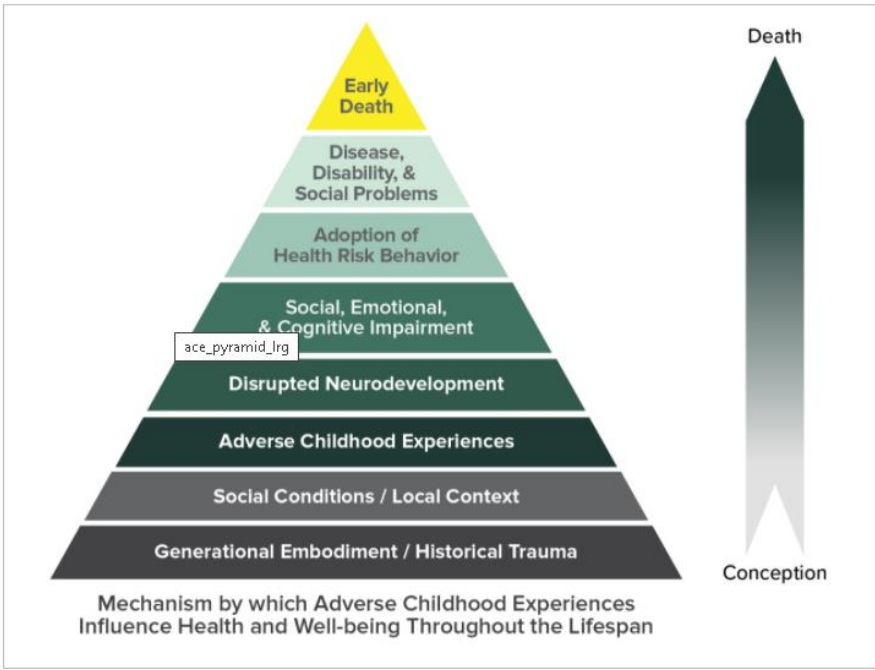
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

Thirty-five percent (35%) of respondents who reported having an income of less than $15,000 dollars per year have 3 or more ACEs, while 21-25% of those with higher annual incomes have 3 or more ACEs. This difference is only significant between those reporting less than $15,000 and those reporting greater than $75,000.

ACEs are STRONG DETERMINANTS OF ADULT SOCIAL WELL-BEING & HEALTH:

ACE-related problems have a strong, graded relationship to numerous health, learning, social, and behavioral problems *throughout a person's lifespan*. Many studies have shown as the number of ACEs increase in the life of an individual, there is an increased likelihood of risky behaviors and chronic physical and mental health conditions.[23]

ACEs and Poor Life Outcomes in Maryland:[24]



The ACE Pyramid above is a life course model from pre-conception to death that is designed to understand how adverse childhood experiences (ACEs) influence human development in predictable ways. ***This is important because what is predictable is preventable.*** Prior to the ACE Study, the experts primarily focused on the top three layers of the pyramid: How risk factors lead to disease and early death. Drs. Anda and Felitti, the principal investigators of the ACE study, knew that something must be missing – they could see this because health risks are not random, they are concentrated in some populations and not others. People who have one risk tend to have others; that is, they cluster.

The ACE Study tested their hypothesis that multiple forms of childhood adversity could be a major determinant of health. The ACE Study concept is that ACEs disrupt neurodevelopment, which in turn leads to social, emotional, and cognitive adaptations that can then lead to the risk factors for major causes of

---

[23] Childhood Adversity and Adult Chronic Disease An Update from Ten States and the District of Columbia, 2010 Leah K. Gilbert, MD, MSPH, Matthew J. Breiding, PhD, Melissa T. Merrick, PhD, William W. Thompson, PhD, Derek C. Ford, PhD, Satvinder S. Dhingra, MPH, Sharyn E. Parks, PhD; Associations Between Adverse Childhood Experiences, High-Risk Behaviors, and Morbidity in Adulthood, 2015 Jennifer A. Campbell, BS, Rebekah J. Walker, PhD, Leonard E. Egede, MD, MS; Unpacking the impact of adverse childhood experiences on adult mental health 2017 Melissa T. Merrick, Katie A. Ports, Derek C. Ford, Tracie O. Afifi, Elizabeth T. Gershoff, Andrew Grogan-Kaylor

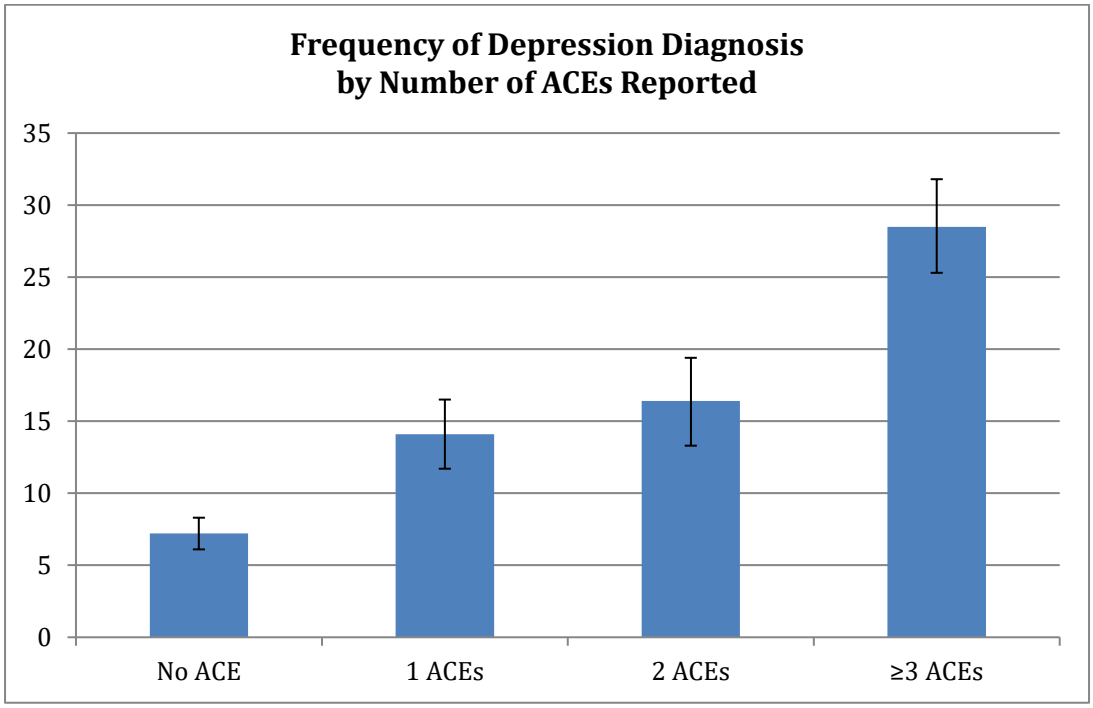
[24] Centers for Disease Control and Prevention. (2016). Adverse Childhood Experiences (ACE) Study. National Center for Chronic Disease Prevention and Health Promotion. Retrieved from https://www.cdc.gov/violenceprevention/acestudy/ACE_graphics.html.

An explanation of the ACE pyramid as a conceptual https://www.unmc.edu/bhecn/_documents/ace-handout-ne-specific.pdf

disease, disability, social problems, and early death. Since the time of the ACE Study, breakthrough research in developmental neuroscience and epigenetics show us that the hypothesis of the ACE Study is biologically sound. Neuroscience and epigenetic discoveries help us to understand the progression of adversity from preconception throughout the life course. Historical trauma and generational adversity increase risk for ACEs, which in turn, generate risk for disease, disability, and social problems.

Social, Emotional, and Cognitive Impairment

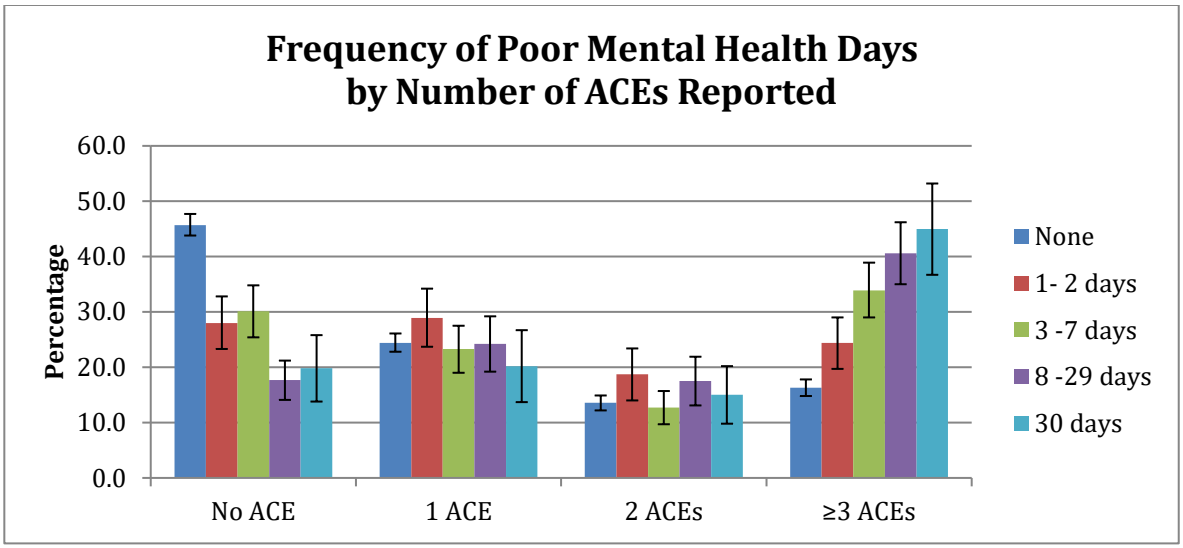
Science tells us healthy brain development is disrupted when there are no adults to buffer a child from adverse experiences. Moving up to the third tier from the bottom of the ACEs pyramid, the result of ACEs can be "social, emotional and cognitive impairment." The Maryland Department of Health (MDH) analyzed 2015 Maryland BRFSS ACE module data vis a vis four indicators within this tier: depression, anxiety, poor mental health days, and cognitive decline. All indicators showed a strong dose-response relationship[25] to increasing ACEs.[26] MDH has also analyzed the 2018 Maryland BRFSS ACE data vis a vis two indicators within this tier; depression and poor mental health days. Questions related to anxiety and cognitive decline were not asked in the 2018 questionnaire.



Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

There is a strong dose-response relationship when looking at depression in relation to ACEs. As ACE exposure increases, so does the likelihood of depression. Adults who report 0 ACEs have the lowest prevalence of depression (7.2 %) followed by those who experience 1 ACE (14.1 % reported depression), 2 ACEs (16.4% reported depression) and finally 3 or more ACEs (28.5% reported depression). All differences are statistically significant except between 1 ACE and 2 ACEs.

[25] A dose response relationship is defined as a relationship in which a change in the amount, intensity, or duration of exposure is associated with a change in risk of a specified outcome
[26] See SCCAN's 2018 Annual Report.

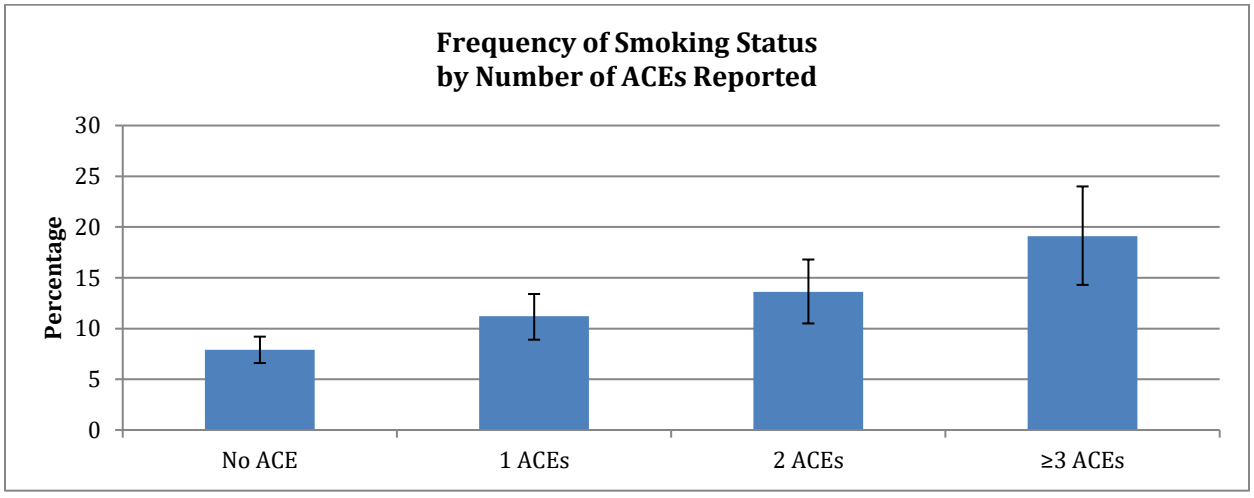


Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

Individuals who reported no ACEs were significantly more likely to report no poor mental health days in the past 30 days than to report any poor mental health days (1-2, 3-7, 8-29, or 30). Additionally, those with 3 or more ACEs were less likely to report no poor mental health days than to report any poor mental health days.

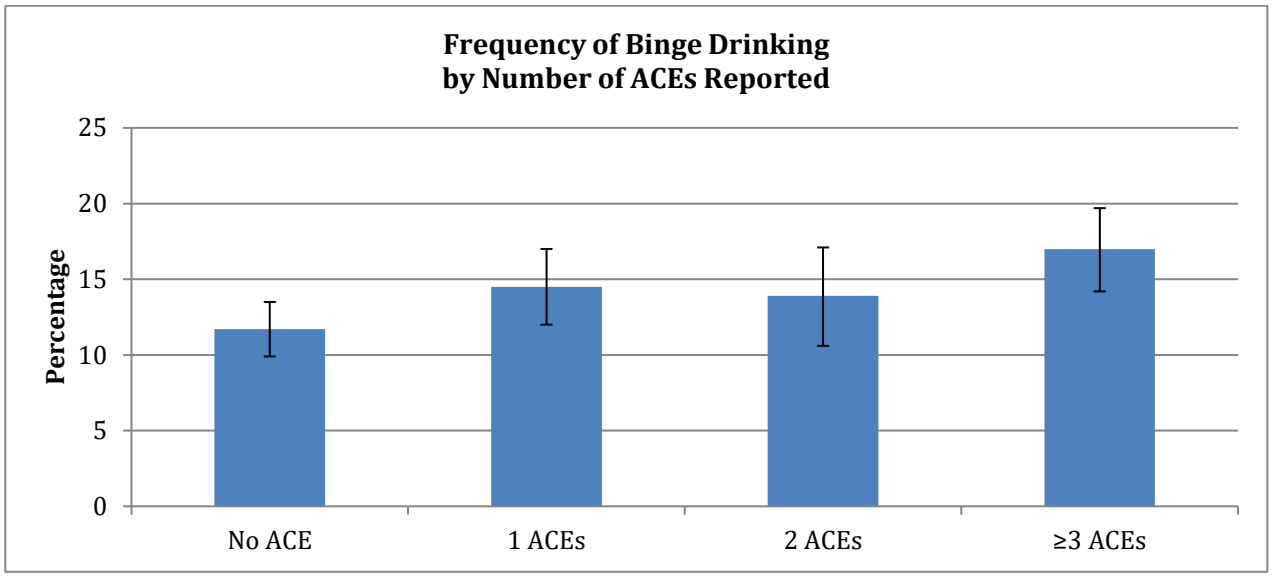
Adoption of Health-risk Behaviors

The next tier up on the ACEs Pyramid is the adoption of health-risk behaviors. Utilizing the 2018 Maryland BRFSS ACEs data, correlations with the adoption of unhealthy behaviors was analyzed. For all three unhealthy behaviors analyzed (current smoking, binge drinking, and seatbelt usage) there appears to be a dose response relationship; as the number of reported ACEs increase, the rates of unhealthy behaviors also increase.



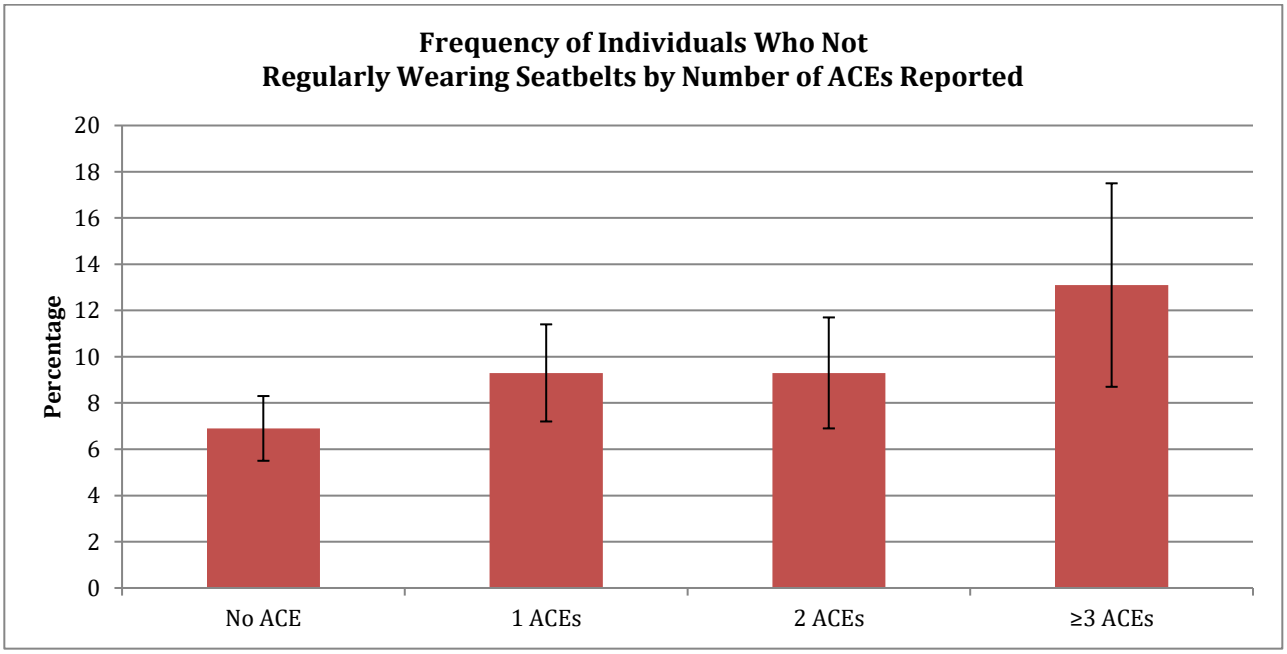
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

Individuals with no ACEs were significantly less likely to smoke (~7% smoke) than those with 3 or more ACEs (~18% smoke), indicating that the prevalence of current smoking behavior increases as reported ACE exposure increases.



Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

Individuals who report binge drinking were significantly less likely to report no ACE exposure. Additionally, a dose response can be seen; as individuals report more ACEs, the prevalence of binge drinking also increased.

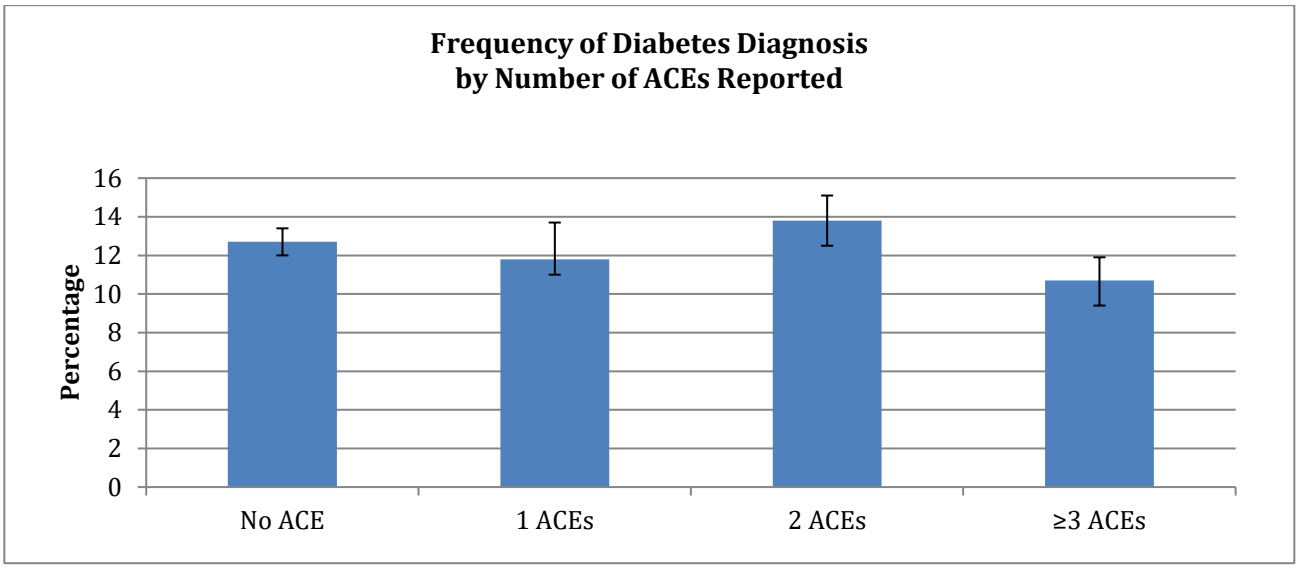


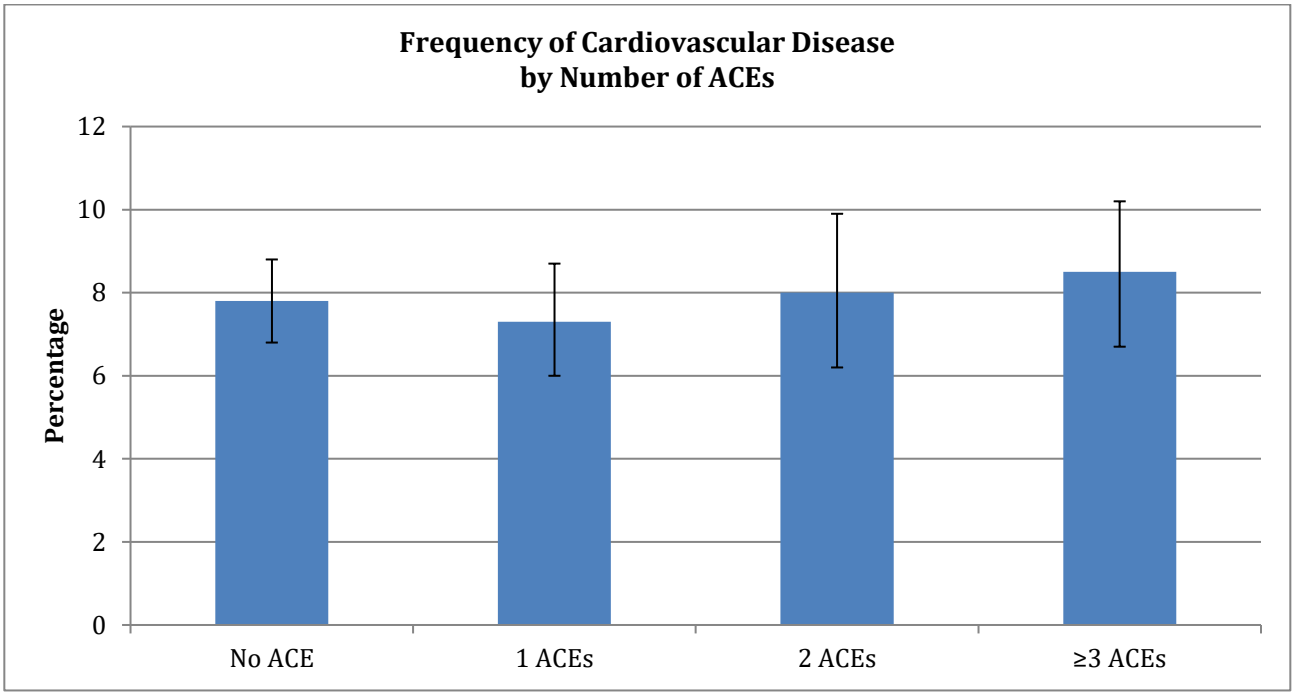
Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

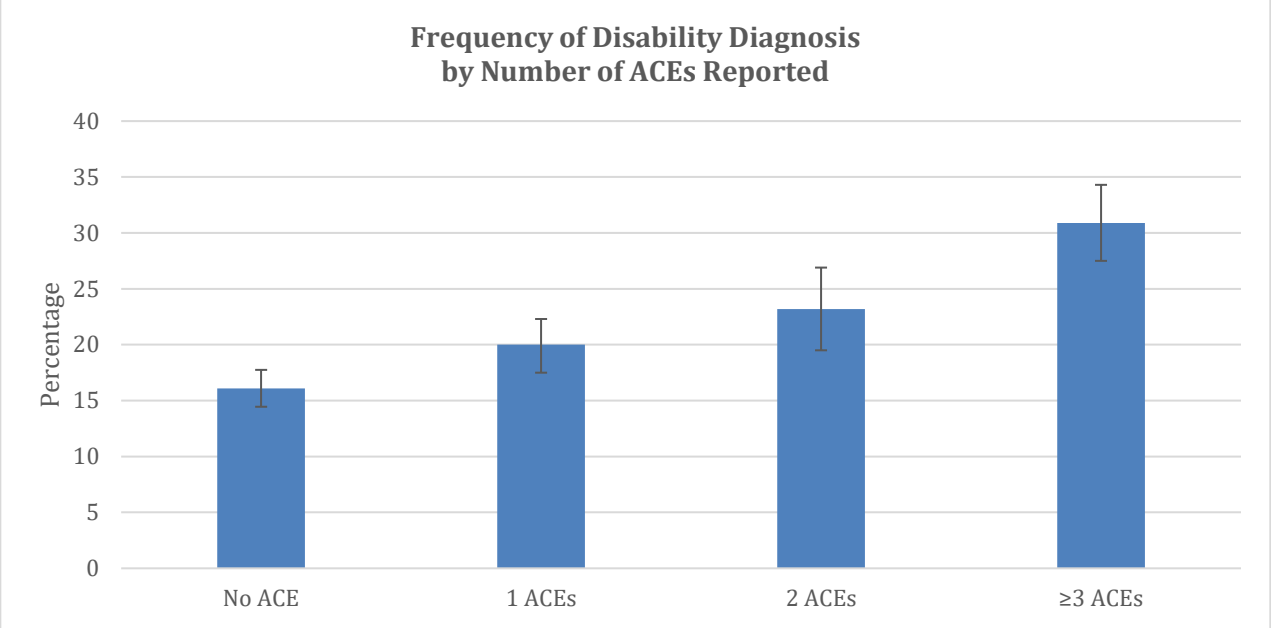
There appears to be a dose response relationship between ACE exposure and seatbelt use, although the relationship is not statistically signficiant. Individuals with 3 or more ACEs were less likely to wear seatbelts regularly than those with no ACEs.

Disease, Disability, and Social Problems

There were few statistically significant associations between ACE exposure and chronic health problems in the 2018 Maryland BRFSS data.







Source: 2018 Maryland Behavioral Risk Factor Surveillance System.

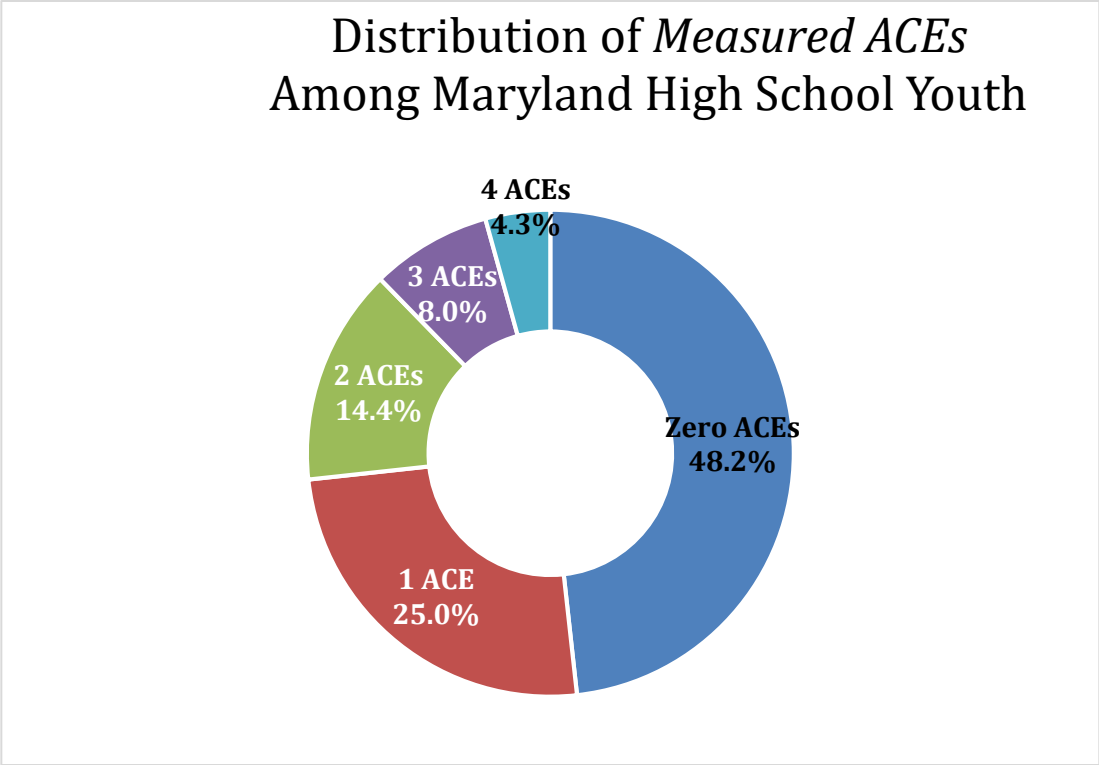
As can be seen in the previous graphs, although there are some differences in chronic disease prevalence by ACE exposure, they are not statistically significant for many chronic diseases. In the 2018 BRFSS analyses, one differing point is the rates by disability status. There appears to be a dose response relationship between number of ACEs and disability status, indicating that the prevalence of disability status increases as reported ACE exposure increases.

Considering the ACEs Pyramid and the ACE exposure, and their relationship to time, it appears that data associated with the bottom of the pyramid shows a stronger dose response relationship between ACEs and health behavior/outcome. As you move up the ACE Pyramid, the dose-response relationship becomes less strong, with fewer statistically significant associations. This is an interesting and noteworthy trend and may be related to the large number of risk factors that contribute to chronic disease.

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.[27] To get a clear 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 E)

ACEs are Common:

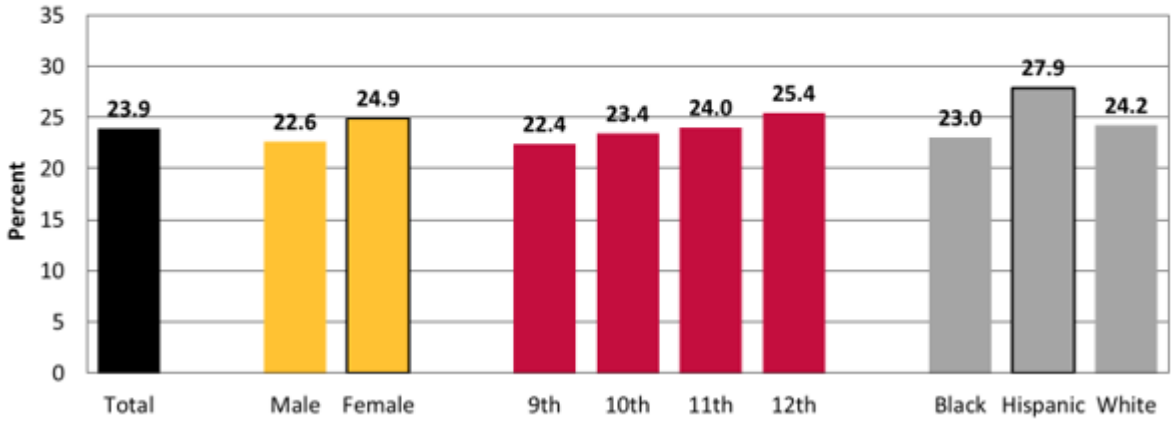


A little *more than one in two students were exposed to the measured ACEs*. 25% had one ACE, 14.4% had two ACEs, 8% had three ACEs and 4.3% had all four measured ACEs.

[27] 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).

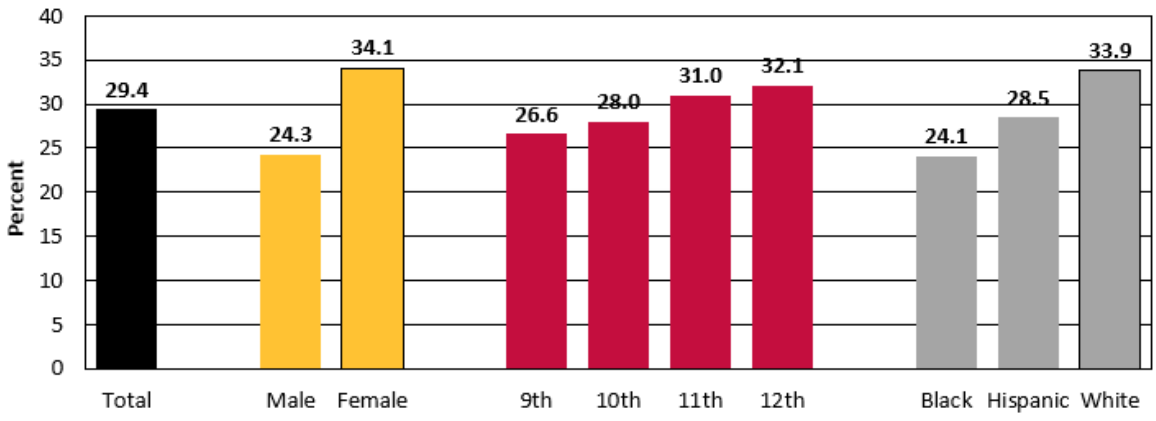
High Schoolers Exposure to the Four Measured ACEs:

Percentage of High School Students Who Have Ever Lived with Anyone Who Was an Alcoholic or Problem Drinker, Used Illegal Street Drugs, Took Prescription Drugs to Get High, or Was a Problem Gambler, by Sex,* Grade, and Race/Ethnicity,* 2018



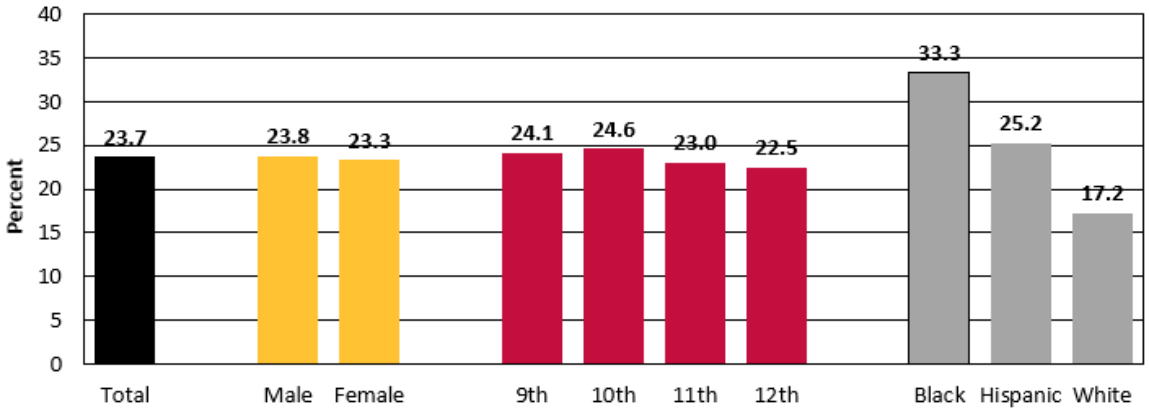
Not surprisingly, teens in higher grades were more likely to report living with someone with an addiction problem than those in early years of high school, as they had more time for potential exposure. Female teens were more likely than males to report living with someone with an addiction problem, and Hispanic teens were more likely to report living with someone with an addiction problem than Black or white teens.

Percentage of High School Students Who Ever Lived with Anyone Who Was Depressed, Mentally Ill, or Suicidal, by Sex,* Grade,* and Race/Ethnicity,* 2018



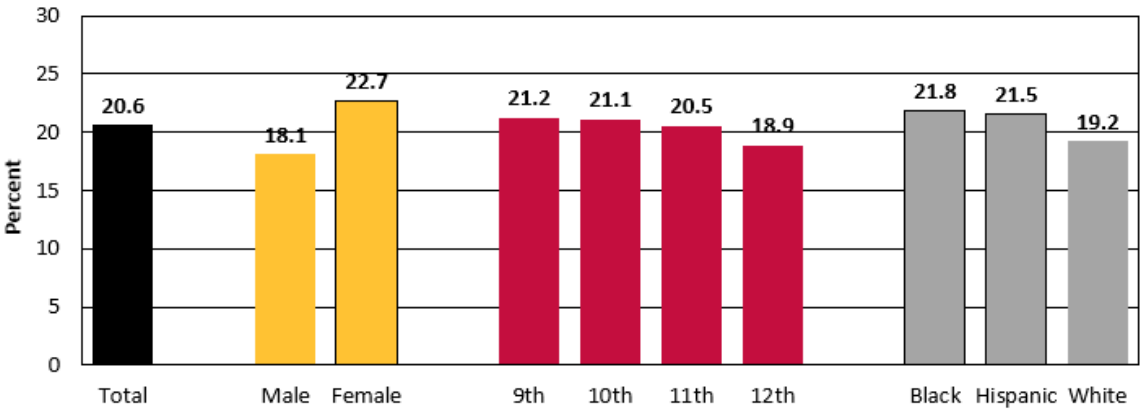
Females were more likely than males to report living with someone with a mental health issue. White teens were more likely to report living with someone with a mental health issue than Black or Hispanic teens.

Percentage of High School Students Who Reported Someone in Their Household Has Ever Gone to Jail or Prison, by Sex, Grade, and Race/Ethnicity,* 2018



Black teens were more likely than Hispanic or white teens to report living with someone who had been incarcerated. This data is consistent with national data showing disproportionate rates of incarceration among Black adults.[28]

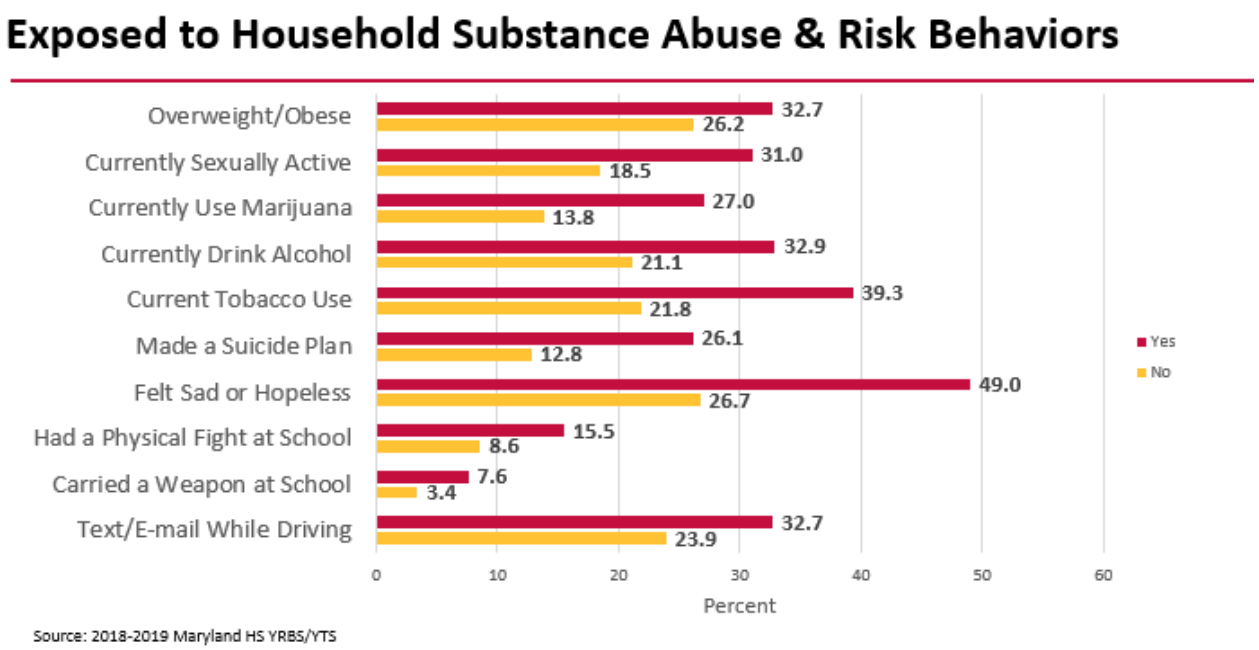
Percentage of High School Students Who Reported a Parent or Other Adult in Their Home Regularly Swears at Them, Insults Them, or Puts Them Down, by Sex,* Grade,* and Race/Ethnicity,* 2018



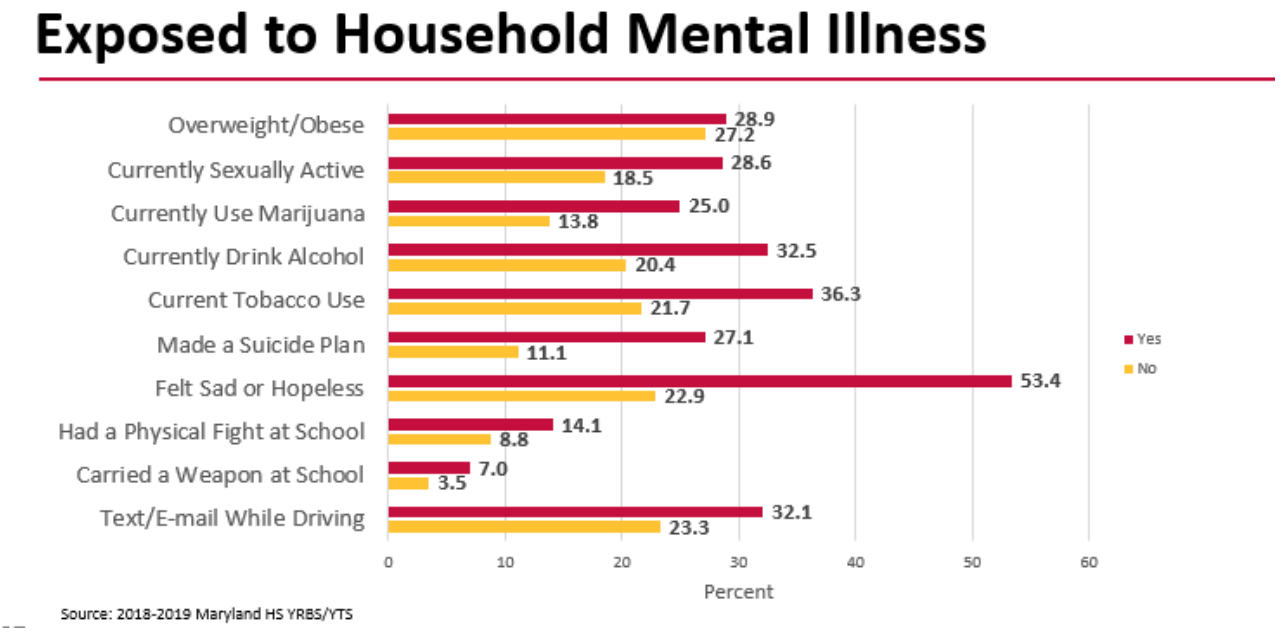
Approximately one in five Maryland teens reports regular emotional abuse by adults in their household. This is important because emotional abuse can have more deleterious effects on teen's mental health than even physical abuse.[29]

[28] https://www.pewresearch.org/fact-tank/2020/05/06/share-of-black-white-hispanic-americans-in-prison-2018-vs-2006/
[29] Miller-Perrin, et al. Child Abuse & Neglect, 2009

ACEs and Adolescent Risk Behaviors:

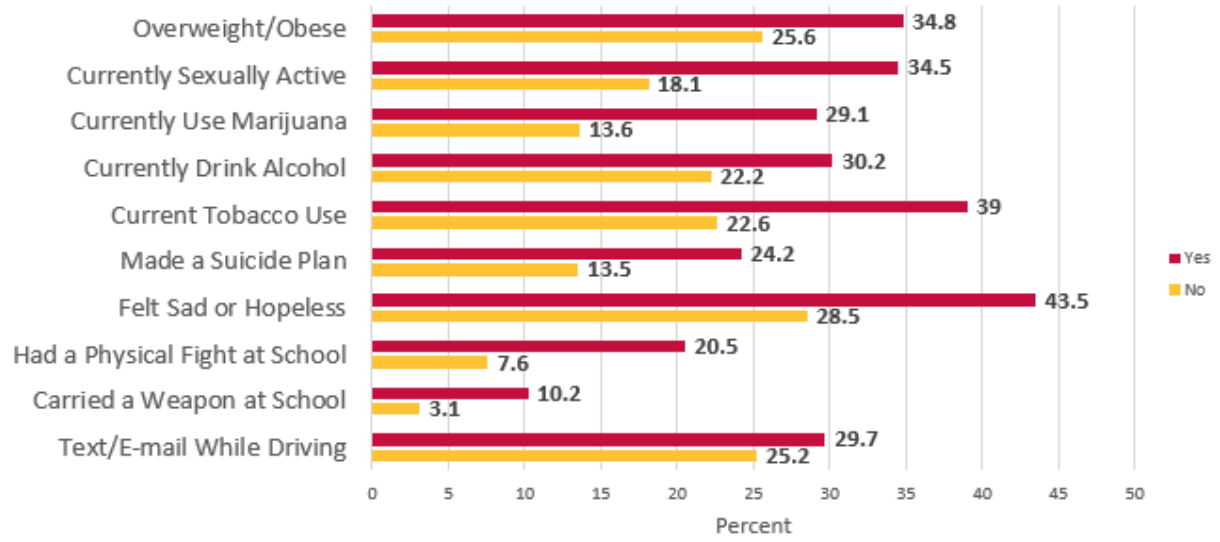


Teens exposed to household substance abuse have higher rates of obesity, risky behavior, and mental health issues compared to those not exposed to household substance abuse.



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.

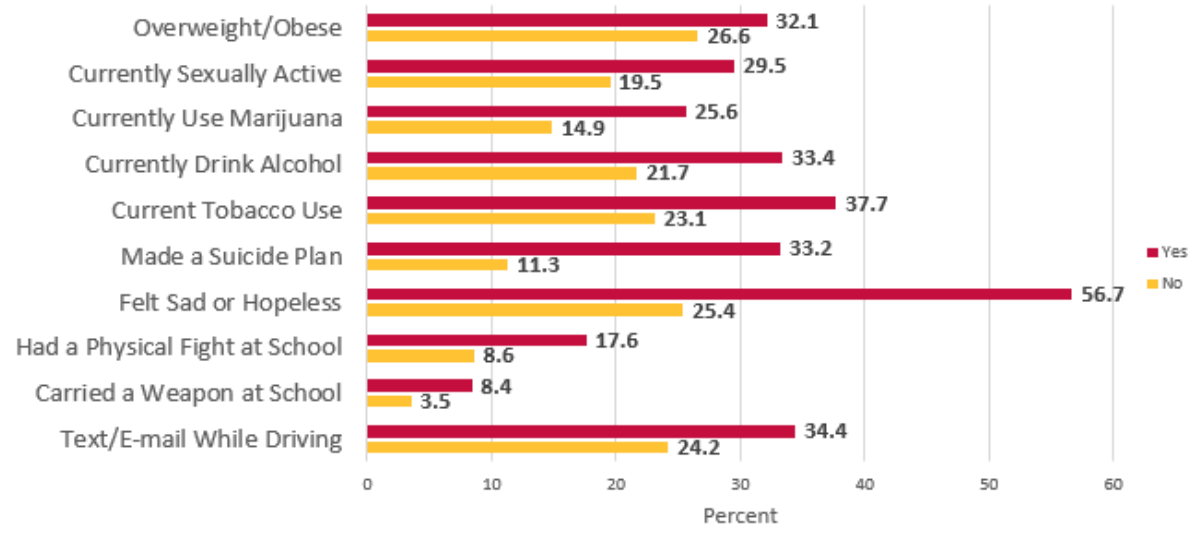
Exposed to Household Incarceration



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

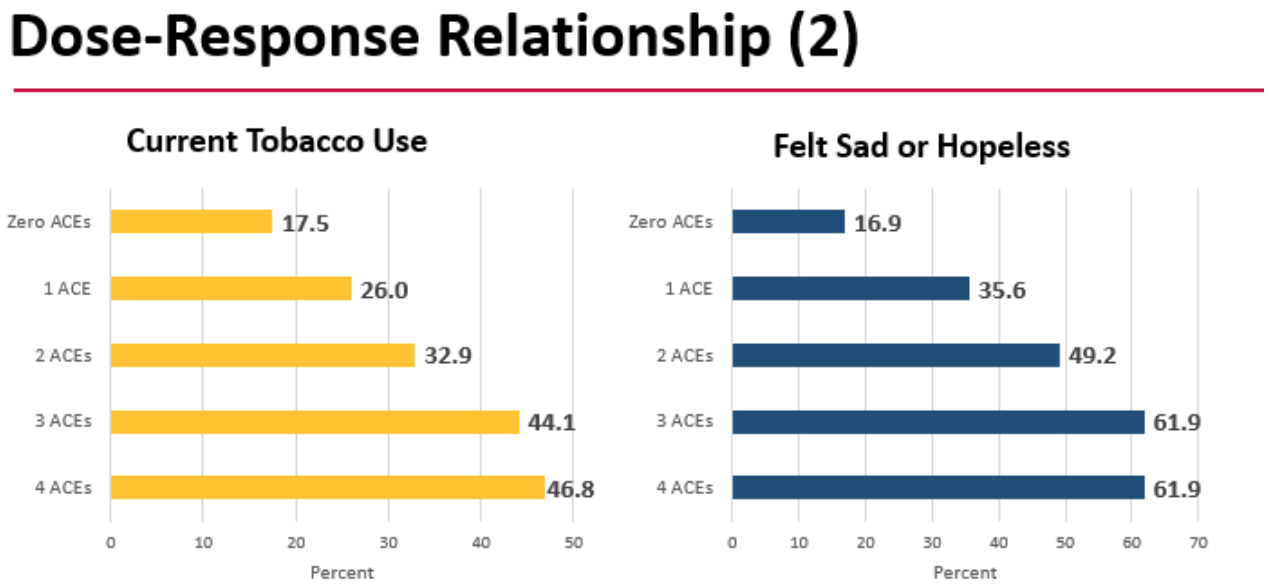


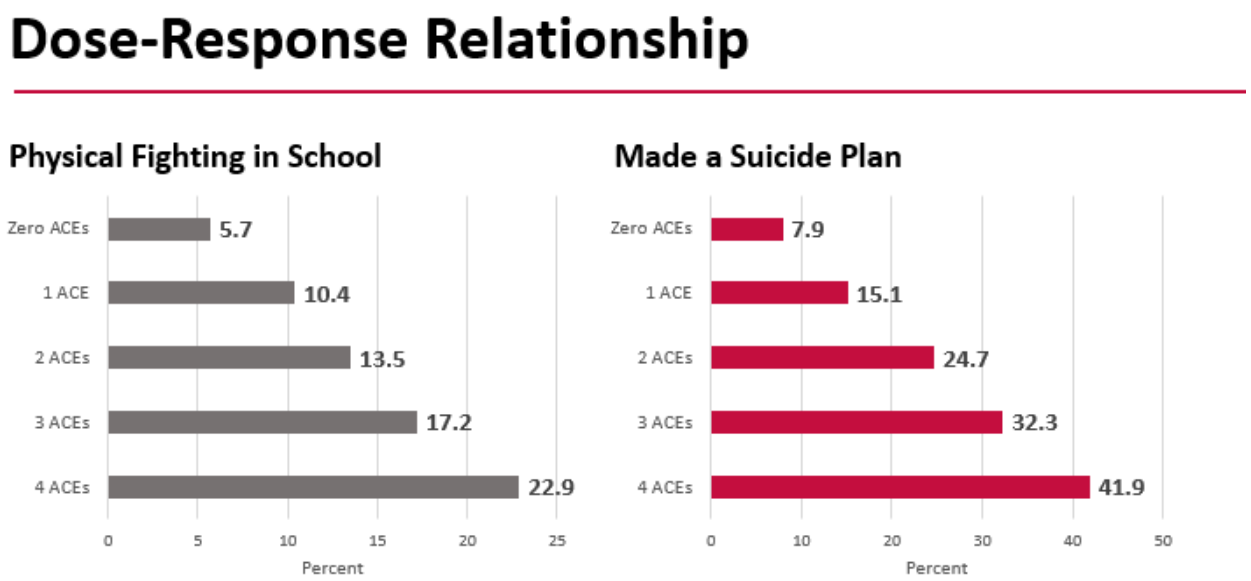
Source: 2018-2019 Maryland HS YRBS/YTS

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.

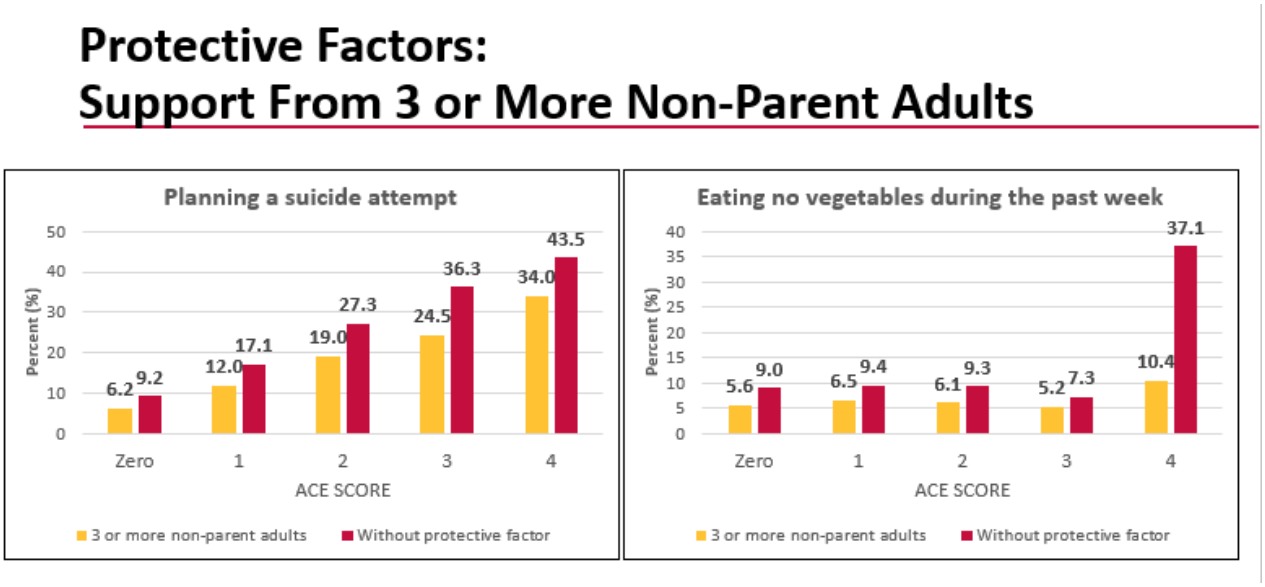
Dose Response Relationship ACEs and Risk Behaviors:





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 and 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 puts 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.

SCCAN'S ACTIONS & ACCOMPLISHMENTS 2019

Since 2006, SCCAN has focused its efforts and recommendations on preventing child abuse and neglect *before it occurs* and researching the extent to which the seminal Adverse Childhood Experiences (ACEs) Study is known and being used to inform systemic change in Maryland. 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 its partners, to create a statewide collective impact initiative to prevent child maltreatment and other ACEs, known as Maryland Essentials for Childhood.

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).[30] 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

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. Below is a brief description of key actions by SCCAN and MD EFC Partners to achieve these broad goals.

Key Successes of SCCAN & MD EFC Partners 2019-2020:

SCCAN and Maryland Essentials for Childhood Committee Members have achieved the following goals set out at SCCAN-Maryland Essentials for Childhood Retreat in July 2019:

GOAL 1: Raise awareness of N.E.A.R. Science and build commitment to put the science into action to reduce and mitigate ACEs by.

- Increased the breadth and reach of the ACE Interface Project[31] to spread the knowledge of the N.E.A.R. Science throughout Maryland public and private agencies and communities:
  - The ACE Interface Master Trainer cohort trained an additional 97 Master Presenters

[30] Channeling Change: Making Collective Impact Work, Stanford Social Innovation Review, https://ssir.org/articles/entry/channeling_change_making_collective_impact_work

[31] For more on the ACE Interface Project, see the 2018 and 2019 SCCAN Annual Reports.

representing all 24 Maryland jurisdictions to the original 30 Master Trainers; including two specialized cohorts:

- Opioid Epidemic – MDH's Regrounding Our Response[32] to the Opioid Crisis- a multi-disciplinary approach to understanding the overdose epidemic. (31 Master Presenters statewide)
- Education- MSDE and local education agency personnel. (36 Master Presenters statewide)

- Since its inception in December 2017 through March 2020, volunteer ACE Interface Master Trainers and Presenters have given 281 ACE Interface presentations (See Appendix F for list of key presentations) to over 8652 attendees across all 24 jurisdictions (See Appendix G for presentations by jurisdiction).

- Acted in a consulting capacity to Congressman Elijah Cummings Office on development of the first Congressional Hearing on Childhood Trauma which took place on July 11, 2019.
- Met with staffers of the Maryland Members of the U.S. House Committee on Oversight and Reform and Leader Hoyer to brief them on Maryland's efforts to reduce and mitigate childhood trauma.
- SCCAN's E.D. served on Congressman Cummings' fourteen member Baltimore City Childhood Trauma Roundtable to share SCCAN and MD EFC statewide efforts to prevent and mitigate childhood trauma and build resilience.
- Acted in a consulting capacity to Councilman Zeke Cohen on the Elijah Cummings Healing City Act (Trauma-Responsive Baltimore).
- Held the 1st full day ACEs Roundtable for Members of the Maryland General Assembly on December 13, 2019 sponsored by Delegate Vanessa Atterbeary and Senator Antonio Hayes, including presentations on the N.E.A.R. Science, The CDC's Best Available Evidence Research: ACE Data (MD & US) & Implications for Government Policy, the Economy, & Business, State Legislative Strategies to Prevent & Mitigate the Effects of ACEs, Translating the Science into Federal and State Policies Panel, Translating the Science Maryland's State and Local Efforts, and the "So What Now? World Café: Designing the Future" MGA Working Groups with "Call an expert" lifeline. By the end of the day, the group of legislators who attended committed to developing a Maryland Legislative Caucus to Prevent and Heal Childhood Trauma, arranging for a joint ACEs hearing for the Senate Judicial Proceedings and House Judiciary Committee, working with MD EFC to develop an ACE-informed platform of bills through the newly formed caucus, and encouraging their colleagues to attend the SCCAN-MD EFC ACEs Education & Advocacy Day at the General Assembly on Thursday, February 7th.
- Continued to develop and expand Maryland ACEs Action blog page on ACEs Connection[33]:
  - Recruited a lead Community Manager to recruit additional members
  - Doubled Membership, making Maryland ACEs Connection Community the 43rd largest of 285 Communities on ACEs Connection and the 6th largest statewide community after California, Washington, Arizona, Michigan, and Oklahoma.
  - Provided a statewide mapping of ACE Interface trainings on the Maryland ACEs

[32] For more on the Regrounding Our Response Initiative, see the 2019 SCCAN Annual Report.
[33] Developed Maryland ACEs Action blog page on ACEs 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.

Action Community Tracker and a link to Maryland BRFSS ACE data by county.

- Continued development of Maryland Essentials for Childhood webpage: https://mdessentialsforchildhood.org/.
- Supported development of and/or connection between local ACE Initiatives. St. Mary's and Talbot County have created ACE initiatives since the last report:
  - Frederick County, Local Health Improvement Plan Committee
  - Thriving Communities Collaborative (TCC), Baltimore City
  - Harford County ACEs Initiative
  - Center for Children, Southern Maryland
  - St. Mary's County ACEs Initiative
  - Talbot County Children's Initiative
  - Bester Community of Hope, Washington County

- GOAL 2: Identify and use data to inform actions and recommendations for systems improvement.
  - Successfully advocated for the inclusion of 4 ACE questions that were included in the Fall 2018 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.
  - Completed MCANF Reviews of child fatalities of children under the age of 5, An analysis of data and recommendations are forthcoming, as our volunteer reviewer time permits.

- GOAL 3: **Integrate the N.E.A.R. Science into and across Systems, Services, and Programs.**
  - 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.
  - 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.[34] 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.
  - Partnered with the Maryland Department of Health on their Regrounding Our Response (ROR) Initiative to effectively respond to the opioid crisis by tackling the persistent and ubiquitous misunderstandings, myths, and prejudices that underlie harmful stigma of opioid misuse. In its conception, ROR followed the model SCCAN and MD EFC used to create the ACE Interface Project i.e., cross-sector and interdisciplinary and regional dissemination of the science. The ROR curriculum includes five topic areas: Stages of Change training (Center for Community Collaboration) on how behavior changes. Adverse Childhood Experiences (ACE Interface/Maryland Essentials for Childhood) on why people use drugs. Social Determinants of Health (Office of Minority Health) on how and why drug use inequitably impacts populations. Understanding MAT (Medication-Assisted Treatment) as being the frontline overdose prevention gold standard. Drug User Health Framework (NASTAD - National Alliance of State and Territorial AIDS Directors) on what it means to meet someone "where they are at."
  - Partnered with the Maryland State Department of Education to build capacity in local

[34] See 2018 SCCAN Annual Report for prior info

education agencies (LEAs) to provide N.E.A.R. Science informed professional development for educators. Thirty-six educators from LEAs have been trained as ACE Interface Master Presenters.

- 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 2019 and 2020: Approximately 50 SCCAN and MD EFC Members participated on both February 7, 2019 and 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: SESAME Act, Hidden Predator Act, Trauma-Informed Schools Bill, $15 Minimum Wage Bill, Time to Care Act, Child Advocacy Center Defining Legislation, Equitable Graduation Requirements for Foster Youth, Parental Notification of Student Problematic Sexual Behavior and TANF Cash Assistance Eligibility Requirements. Delegate Vanessa Atterbeary spoke in 2019 on the importance of the science and ensuring that this information gets to all of her colleagues. In 2020, Frank Kros presented on the ACE Science and Policy to Members in attendance. SCCAN-MD Essentials for Childhood Leadership Awards were presented to in 2019 to Delegate C.T. Wilson, Legislator of the Year; Frank J. Kros, MSW, JD, Advocate of the Year; and, The Board & Staff of The Family Tree, Community Partner of the Year; and, in 2020 posthumously to Congressman Elijah Cummings, Legislator of the Year; and to Joan L. Stine, MHS, MS, Advocate of the Year; and, The Board & Staff of No More Stolen Childhoods, Community Partner 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. (See Appendix H)
  - 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 Appendix B), which outlines the N.E.A.R. science and catalogues ACE-informed policy and state legislation throughout the country.
  - Provided 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 C).
  - 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. **SESAME Act- HB 486/SB 541 passed unanimously and was signed by Governor Hogan.** Helps prevent child sexual abuse & exploitation in schools by eliminating hiring of personnel with prior history of abuse or misconduct. ALL STUDENTS HAVE THE RIGHT TO BE FREE FROM TRAUMA AT SCHOOL, INCLUDING FREEDOM FROM SEXUAL ABUSE AND MISCONDUCT.
2. **Hidden Predator Act -Child Sexual Abuse Civil Statute of Limitations Reform- 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. Hidden Predator Act -Child Sexual Abuse Civil Statute of Limitations Reform- HB 687 (2019) passed the House 135-3 however received an unfavorable report 5-5 in the Senate Judicial Proceedings Committee.** The Hidden Predator Act will eliminate the civil statute of limitations for child sexual abuse. Look-back

windows in other states have been proven to provide justice to survivors, as well as identifying and prosecuting hidden predators, thus preventing future child sexual abuse by these predators. Many SCCAN and MD EFC members and member 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.

3. **Education- Guidelines on Trauma-Informed Approach HB 277/SB 367 (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.
4. **$15 Minimum Wage- HB 16/SB 280 (2019) passed both Houses unanimously and became law.** Increases Maryland's minimum wage to $15/hour by 2023. INITIATIVES THAT INCREASE FAMILY INCOME REDUCE RATES OF CHILD MALTREATMENT
5. **2019 Time to Care Act- HB 341/SB 500 (2019) and HB 839/SB 539 (2020) died in the respective Economic Matters and Finance Committees**. Provides up to 12-weeks of paid family leave. PAID FAMILY LEAVE IS ASSOCIATED WITH DECREASED INFANT MORTALITY, IMPROVED CHILD HEALTH, IMPROVED PARENT-CHILD BONDING, & REDUCED CHILD MALTREATMENT
6. **Education – Child Care Subsidies – Mandatory Funding Levels- SB 379/HB 430 was signed into law in 2018.** The Maryland Family Network, a Maryland Essentials for Childhood partner, led the efforts on SB 379 which increases Maryland's child care subsidy rates to give parents access to quality care and establishes a new "floor" so that rates never again fall so low. Adequate child care subsidies with no waiting list for access are known to decrease rates of child abuse and neglect[35]
7. **Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations- SB 567 (2019) passed both Houses unanimously and was signed by Governor Hogan.** Establishes the Workgroup to Study Child Custody Court Proceedings Involving Child Abuse or Domestic Violence Allegations and requires the Workgroup to study State child custody court proceedings involving child abuse or domestic violence allegations. SCCAN's E.D., the ACE Interface Project Director, and other ACE Interface Master Presenters were represented on the Workgroup. The Workgroup's role will be to make recommendations about 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. The final report will be submitted to the Governor and General Assembly in September of 2020.
8. **Child Advocacy Center Defining Legislation- HB 1007/SB 739 passed both Houses unanimously and was signed by Governor Hogan.** Makes sure that every abused or victimized child in Maryland has access to an accredited children's advocacy center. CACs are a critical first stop after an allegation of abuse is made. CACs PROVIDE EVIDENCE-BASED, TRAUMA-INFORMED SERVICES THAT HELP CHILDREN COPE WITH AND RECOVER FROM CHILDHOOD TRAUMA.
9. **Temporary Cash Assistance (TCA) Funding- HB 339/SB 456 died in Appropriations**

[35] Klevens, J., Barnett, S. B., Florence, C., & Moore, D. (2015). Exploring policies to reduce child physical abuse and neglect. *Child Abuse & Neglect, 40,* 1-11

and Budget and Taxation Committees. The bill would have raised TCA from 61 to 71% of the Maryland Minimum Living Level over 5 years. INCREASES IN FAMILY INCOME IMPROVE FAMILY STABILITY, REDUCES FAMILY STRESS, AND MAY PREVENT CHILD NEGLECT.

10. **Family Investment Program - Temporary Cash Assistance – Eligibility- HB1313/SB 787- 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.

- 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. The statute mandates the creation of a Child Welfare Medical Director at DHS and the creation of an electronic health passport for foster youth.

    - Dr. David Rose began his position as Child Welfare Medical Director in April, 2019. Efforts toward improving the health care of children in foster care have included the following:
        - Alignment of DHS policies regarding health care service oversight and monitoring 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. The goal is to allow for improved planning and health care encounter recording. Requests for changes to the Code of Maryland Regulations (COMAR) to implement these changes has been made.
        - Required quarterly and annual internal reporting on existing foster care entry and periodic preventive care exams began in September 2019.
        - Work with MD THINK-CJAMS on the health-related measures for case management.
        - Examination of psychotropic medication and psychotherapy use in foster care based on community indicators
        - Work on the State of Maryland Task Force on Maternal and Child Health, which is charged with developing a plan for MDH, Medicaid, and the Health Services Cost Review Commission to prevent "key adverse health outcomes."
    - SCCAN's Chair and Executive Director serve on the Health and Education Workgroup of SSA's Families Blossom Initiative and have shared critical data points that should be included in the MD THINK-CJAMS project to help ensure inclusion of data necessary to develop and utilize an **electronic health record** required by HB 1582 for care coordination to:
        - Improve preventive health, and reduce mental health hospitalizations, psychotropic medication use, and unnecessary laboratory testing.

- Facilitate accurate and up-to-date medical information sharing amongst the child's various care providers/caregivers to prevent fragmented care and medical errors.

2. HB 1072- Child Sexual Abuse Prevention- Instruction & Training:

- SCCAN's Executive Director, Chair, and Child Sexual Abuse Prevention Workgroup Chair worked with national experts and the Commission on School Construction to develop the "GUIDELINES AND BEST PRACTICES FOR THE ASSESSMENT AND MODIFICATION OF PHYSICAL FACILITIES AND SPACES TO REDUCE OPPORTUNITIES FOR CHILD SEXUAL ABUSE" required by HB 1072. These guidelines were recently approved by both SCCAN and the Interagency Commission on School Construction.

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 science is clear; our children's pain, both current and generational unfolds daily before our eyes if we are willing to look; innovation and prosperity are possible; and require courage to create a seismic shift in how our child and family serving agencies care for those they are meant to serve.

GOVERNOR

Strong leadership is essential to raising awareness of Adverse Childhood Experiences (ACEs) and encouraging communities to invent wise responses in support of our children and Maryland's future prosperity. The science of brain development, ACEs, and resilience must be front and center in our conversations on health, education, the economy, and community well-being and safety. To ensure public policy and practice align with the science of the developing brain, we recommend that the Governor:

1.Take meaningful action to raise awareness of brain science, adverse childhood experiences (ACEs) and resilience and build community commitment to prevent, reduce, and respond to ACEs by launching an ACEs Initiative similar to Governor Bill Haslam and First Lady Chrissy Haslam's Launch Building Strong Brains Tennessee's ACEs Initiative or First Lady Tonette Walker's Fostering Futures, including Trauma-Informed State Agencies.[36] Maryland's Governor should take the following actions, similar to sister states, to create a trauma-informed and resilient state through an executive order or legislation::

- Establish a state lead coordinating body
- Develop and implement a State Plan for Preventing and Mitigating ACEs to
  - Incorporate 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.
  - Incorporate trauma-informed best practices across state child and family serving agencies
  - Provide executive level awareness trainings and opportunities
  - Enhance the State's ACEs surveillance system, data collection and analysis
  - Develop ACE awareness campaigns, employing science-based communication strategies
  - Make budgetary commitments to prevent and mitigate ACEs
  - Make use of the expertise and build upon the cross-sector and interdisciplinary partnerships and efforts of Maryland Essentials for Childhood
  - Recruit the support of private foundations, business, and faith-based communities in efforts to prevent and mitigate ACEs

2. Issue an executive order similar to Governor Carey's in Delaware [37] mandating child and family serving agencies participate in collective impact efforts to promote safe, stable, and nurturing relationships and

[36] Examples of other states with Brain/ACEs Initiatives: Wisconsin, South Carolina, North Carolina, Iowa, Colorado, Washington, California, Alaska, and Minnesota.

[37] Delaware Governor John Carney's Executive Order on Making Delaware a Trauma Informed State.

environments for children, build strong brains, prevent ACEs, and promote resilience. Building upon efforts of Maryland's Essentials for Childhood Initiative and local ACE community initiatives in Frederick, Washington, Harford Counties, and Baltimore City, designate a state lead agency for the Maryland Essentials for Childhood Initiative[38]

3. Require each member of the Children's Cabinet to designate authority to two members of their staff to lead their agency's full participation in the initiative.

4. Call upon key leaders in Maryland's business and faith-based communities to join in the Initiative.[39]

5. 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.[40]

6. 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.

CHILDREN'S CABINET AGENCIES
GOC, GOCCP, DHS, MDH, DJS, MSDE, DOD, DPSCS, DBM, DLLR

1. Review the Tennessee and Wisconsin examples of statewide models to create a culture change in child and family serving agencies to focus on a multi-generation approach to responding to childhood adversity based on the science of the developing brain, ACEs (trauma/toxic stress), and Resilience. Support Governor or General Assembly led action to create a trauma-informed and resilient state through the:
    - Establishment and participation in a state lead coordinating body
    - Development and implementation of a State Plan for Preventing and Mitigating ACEs to
        - Incorporate 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.
        - Incorporate trauma-informed best practices across state child and family serving agencies
        - Provide executive level awareness trainings and opportunities
        - Enhance the State's ACEs surveillance system, data collection and analysis
        - Develop ACE awareness campaigns, employing science-based communication strategies
        - Make budgetary commitments to prevent and mitigate ACEs
        - Make use of the expertise and build upon the cross-sector and interdisciplinary

[38] Include language that the policy decisions, statements, and funding announcements of Maryland Children's Cabinet agencies will acknowledge and embed the principles of early childhood brain development and will, whenever possible, consider the concepts of toxic stress, adverse childhood experiences, and buffering relationships, and note the role of 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 in human capital. Use a multi-generation approach- children come with parents and grandparents; and, will become parents themselves.

[39] 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

[40] https://ctfalliance.org/

partnerships and efforts of Maryland Essentials for Childhood
- Recruit the support of private foundations, business, and faith-based communities in efforts to prevent and mitigate ACEs

2. Review, analyze, and publish state and county-level ACE Module data from the 2015 and 2018 Maryland Behavioral Risk Factor Surveillance System (BRFSS).

3. Provide an ACE Interface presentation to all Children's Cabinet members.

4. Create a statewide plan to prevent and mitigate childhood trauma and build community resilience through the Children's Cabinet Three-Year Plan.

5. Offer free screenings and time to view the film *RESILIENCE: The Biology of Stress & The Science of Hope* to introduce agency staff to the brain science, ACEs, resilience and trauma-informed systems and provide opportunity for dialogue of how it might be used to provide better customer service.

6. As level II of the Governor's G.O.L.D. Standard Customer Service Training Initiative, have ACE Interface Master Trainers train all staff, beginning with supervisors.

7. Explore ways to increase awareness of the brain science and the impact of ACEs on the people your agencies serve. Integrate the science of the developing brain, ACEs, and resilience across agencies and within individual agencies by:

    - Participate in developing a State Plan to Prevent and Mitigate ACEs
    - Partner in Maryland Essentials for Childhood Initiative to ensure cross-agency coordination
    - Consider the appropriateness of screening clients for ACEs and resilience factors[41]
    - Provide pre-service and in-service training to all staff on brain science, ACEs and resilience
    - Research and develop Maryland guidelines for becoming a trauma-informed agency similar to The Missouri Model: A Developmental Framework for Trauma-Informed Approaches.
    - Ensure that state contracts require providers meet performance measures to become trauma-informed based on the above referenced Maryland guidelines.
    - Embed- the science into agency 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
    - Ensure agency policies and regulations reflect the science
    - Ensure agency practice models reflect the science
    - Invest resources in evidence-based trauma prevention and treatment interventions and creating trauma-informed agencies[42]
    - Partner with the 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 brain development. A similar plan in Tennessee included:

[41] 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*.

[42] See the National Child Traumatic Stress Network for resources on creating trauma-informed systems.

- Three scientific symposia: Neurobiology, the Science of Programmatic Innovations, and the Science of Policy Innovations
- Four three-day "FrameLabs" in which individuals from all sectors and professional disciplines learned values and metaphors that help even people who have no familiarity with child development.
- A three-day "Train the Trainer" workshop for curriculum designers and agency training leaders
- Ongoing technical assistance and a review of materials
- Advisory services for the initiative steering group
- 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.).

8. 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).

9. 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.***[43]

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 mandating child and family serving agencies' participation in collective impact efforts to promote safe, stable & nurturing relationships and environments for children (Essentials for Childhood (EFC)) & preventing ACEs.[44]

[43] See Appendix B

[44] 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

4. Pass legislation establishing a robust Children's/ACEs Prevention Trust Fund.[45]

   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. 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.

6. 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 D) Nine states have no civil statute of limitations for child sexual abuse.[46] Eleven states and the District of Columbia have created look back windows.[47] 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
   - Shifting cost of sexual abuse from the victim to those who caused it
   - Providing justice for victims ready to come forward

7. 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.

8. 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 all state agencies serving children and youth and youth-serving organizations to 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

[45] The National Alliance for Children's Trust & Prevention Funds.
[46] Child USA, 2019 Alaska, Connecticut, Delaware, Florida, Illinois, Maine, Minnesota, Nebraska, and Utah.

[47] Ibid. California, Connecticut, Delaware, District of Columbia, Georgia, Hawaii, Massachusetts, Michigan, Minnesota, New Jersey, New York, and Utah.

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.

9. Pass legislation to change the Medicaid eligibility categories to make identification of children in foster care more transparent.

   - Currently, the state uses eligibility categories that include subsidized adoption and subsidized guardianship cases to identify the foster care population. In addition, kinship care cases that are receiving TCA are excluded. Medicaid data that the state uses in reports and that could potentially be used to monitor the health of the foster care population is not an accurate reflection of the youth in foster care. Improving or redefining eligibility codes would allow the state to more accurately monitor health care utilization (including psychotropic medication) use for children in foster care. In addition, more transparent eligibility codes will allow programs that use these codes the ability to easily identify youth in foster care. Identification will result in improving coordination with the child welfare agency and will assist the state in providing Medical Assistance to former foster care youth until age 26.

JOINT DHS & MDH

1. In support of effective implementation of HB 1582, Human Services-Children Receiving Child Welfare Services-Centralized Comprehensive Health Care Monitoring Program, 2018:

   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. Suggested members of this panel are included in the footnote[48].The Panel's responsibilities should include:

[48] 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

- Medicaid;
- 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;

- 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

- See Children's Cabinet agency recommendations above.

- 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.

- 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 of parents receiving DHS services (CSE, FIA and SSA)[49]

- As level II of the G.O.L.D. Standard Customer Service Training, use ACE Interface Master Trainers to train all staff who work with the public in brain science, ACEs, and resilience.

- Increase efforts that promote fathers' and mothers' male partners' emotional support, rather than solely financial support, of their children and families.

  - 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 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:

· Maryland Legal Aid Bureau;

· Maryland CASA;

· Programs that currently contribute to medical and forensic services funding for children involved in the child welfare system

o Maryland Medicaid,

o MDH Center for Injury and Sexual Assault Prevention,

o GOCCP/VOCA).

[49] "Applying the science of Child Development in Child Welfare Systems", Center on the Developing Child, Harvard University.

- 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 DHR's Quality Assurance Processes in Maryland Child Welfare.[50]
- 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 have to 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, determine whether those services were received, and if not received, identify the reasons why not.[51]

Social Services Administration

1. See Children's Cabinet recommendations above.

2. See Joint MDH-DHS recommendations above.

3. Child Welfare data should be disaggregated by race, ethnicity, gender, and socio-economic status. This data should be publicly available on a regular basis.

---

[50] 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)

[51] 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.**

4. 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.

5. 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.

6. 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.

7. Involve fathers in child welfare cases as a matter of course.

MDH

1. 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.

2. Continue to collect BRFSS every three years and YRBS/YTS ACE module data in Maryland every two years. Resilience questions[52] similar to those being asked in Wisconsin's BRFSS should be added to Maryland BRFSS modules.

3. 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[53].

4. Fund the baseline collection of child maltreatment Awareness, Commitment, and Norms Survey[54] 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.

5. 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.

6. 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.[55]

[52] See Appendix I
[53] See Appendix E
[54] See Appendix J
[55] See MCANF preliminary observations under "Magnitude of the Problem in Maryland" section.

7. 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.[56]

8. Streamline the Postpartum Infant and Maternal Referral (PIMR) form and completion process in partnership with local health departments and birthing hospitals.[57]

9. Link completion of MPRA and PIMR and linkage to services to service provider fee payment.[58]

10. 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.

11. Increase Infant and Early Child Mental Health workforce training in the core competencies. Integrate core competencies into evidence-based programs serving young children.

12. 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.

13. 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.

MSDE

1. See Children's Cabinet recommendations above.

2. Support the collection of data on all ACE and resilience questions[59] recommended by the CDC through the Maryland YRBS/YTS for all middle schoolers and high schoolers.

3. 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.

---

[56] Ibid.

[57] 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.

[58] Ibid.

[59] See Appendix E

4. 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.

APPENDIX A

DHS RESPONSE TO SCCAN'S 2018 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, many recommendations have remained unanswered and unaddressed.***

The Council received a response to its 2018 report from the Executive Director of the Social Services Agency at DHS in September 2019. The Agency responded by enumerating current agency efforts that might address some Council recommendations in the2018 report:

DHS's response specifically addressed:

- State hotline for reporting child abuse and neglect
- SSA efforts on trauma, resiliency, and brain science
- SSA efforts to promote the voice of all family members
- Data sharing and reporting
    - SSA is looking for opportunities to improve data gathering and reporting within its CJAMS project.
- Health of children
    - Child Welfare Medical Director hired
    - Medical Director is a member of State Task Force on Maternal and Child Health
        - Examining Medicaid coverage for screening of ACEs and social determinants of health and appropriate referrals for positive screens
        - Task Force to make recommendations to MDH to prevent poor health outcomes
    - Medical Director serves on SSA Service Array Implementation Team focusing on health, education, well-being, and access to services
        - Team is considering a Child Welfare Health Coordination Expert Panel as an extension of the Team to assist in the formation and implementation of a statewide centralized health care monitoring program, including the appropriate prescribing of psychotropic medication.
    - Medical Director is serving as a consultant to the CJAMS project

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.*
- 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.
- 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.
- In support of effective implementation of HB 1582, Human Services-Children Receiving Child Welfare Services-Centralized Comprehensive Health Care Monitoring Program, 2018:
    - 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.*
- 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 "Promot[ing] the voice of all family members" 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 "Promot[ing] the voice of all family members" 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 it is looking for opportunities to improve data gathering and reporting within its CJAMS project, there is no mention of any specifics and no response regarding the requests for improved data below:*

    - Integrates child-welfare, birth, and death data in order to analyze fatal maltreatment.
    - Collects 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 of how children and their families who touch our child welfare system do. 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.
    - Complies 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.
    - Tracks 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.
    - Tracks 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.***

Maryland essentials for childhood

TOWARD A MORE PROSPEROUS MARYLAND

Legislative Solutions to Prevent and Mitigate Adverse Childhood Experiences (ACEs) and Build Resilient Communities

TABLE OF CONTENTS

INTRODUCTION

In Maryland, we take seriously our role as stewards of the next generation. We know that preparing Maryland for a prosperous future begins with recognizing that our ability to raise healthy children, who will lead the communities and economy of tomorrow, requires smart and innovative thinking today. The good news is that developmental science is clear about what children need to thrive.

We now know that the brain's architecture is built over time and from the bottom up, much like a house. Sturdy architecture is built when children have safe, stable, and positive experiences and relationships with caring adults at home and in the community.

> However, severe or repeated exposure to harmful or adverse childhood experiences (ACEs) without the support of caring adults can cause toxic stress responses in children, weakening brain architecture, and leaving children vulnerable to a range of health, learning, and behavior problems across their lifespan. [1]

Fortunately, research also suggests that there are things we can do to buffer toxic stress, preventing or reversing its effects. Safe, stable, and nurturing relationships and environments serve as protective factors and are essential for the health and well-being of our children, ensuring that every child in Maryland has equal opportunity to thrive. All Marylanders play a role in ensuring the health and well-being of the next generation and a prosperous future for all. No one individual, organization, sector, or branch of government alone can prevent ACEs and trauma or mitigate their impact. As lawmakers, Members of the General Assembly can promote lifetime success and responsible citizenship by advancing safe, stable, and nurturing environments through ACE- and resilience-informed policy and investment.

> Lawmakers around the country are educating themselves on cutting-edge neuroscience, epigenetics, the ACE study and resilience (NEAR Science) and taking policy actions to promote healthy development and a prosperous future for their constituents. This brief will share the basics of the NEAR Science, along with the evidence-based and innovative policies being implemented by federal and state governments to prevent and mitigate childhood trauma and promote family and community resilience.

Research is clear that parent and child well-being are inextricably linked.

The needs of parents and children overlap, but unfortunately, those needs are too often served in separate, siloed state systems. These systems do not often consider the inextricable link between parent and child. In order to develop effective policies, legislators must consider how multiple policies and systems interact with one another to create environments that promote the healthy development of children and their families. The implications of decisions in one system, impact another. It is critical to address not only the substantive issue (opioid epidemic, teen pregnancy, suicide, cancer, for example), but at the same time strengthen cross-system collaboration in order to effectively prevent and mitigate childhood trauma and build more resilient communities.

Health, education, social, and public safety policies at the federal, state, and local levels need to be updated to reflect what science has taught us about the causes, effects, mitigation, and preventability of childhood, adult, community, historical and intergenerational trauma. Achieving policy change of this meaning and magnitude requires multiple strategies. Ensuring that policies reflect scientific evidence requires a strategic long-term effort that, like any sound investment, will provide significant return over time. Each step will build on the ones before it, making sustained progress toward a full integration of resilience and trauma-informed principles into the policies and practices of government, private industry, and non-profits across health, education, housing, justice, child welfare, and other sectors. This requires a "legacy mindset" by legislators and other policy makers.

N.E.A.R. SCIENCE 101

Converging developments in the rapidly growing sciences of neurobiology, epigenetics, ACEs, and resilience vis a vis healthy child development point to major implications for policy and practice across systems and the lifespan.

Throughout this document we will refer to "NEAR" science, coined by The Foundation for Healthy Generations in Washington State, to describe the body of science that explains the impact of adverse childhood experiences on human development, health, and well-being across the lifespan.

NEUROBIOLOGY OF TOXIC STRESS - TEN CONCEPTS EVERY LEGISLATOR SHOULD KNOW [2]

1	**Healthy Development Builds a Strong Foundation for Kids and Society**
2	**Experiences Build Brain Architecture** A strong foundation in the early years increases the probability of positive outcomes. A weak foundation increases the odds of later difficulties. It is easier and less costly to form strong brain circuits during the early years than it is to intervene or "fix" them later.
3	**Responsive Relationships - "Serve & Return Interactions"** Shape Brain Circuitry Richly responsive, back-and-forth interactions between caregiver and child establish a sturdy architecture on which future learning is built. If a caregiver's responses are unreliable or inappropriate, the brain's architecture does not form as expected, which has negative implications for later learning and behavior.

4	**Brains are Built from the Bottom Up** Skills Beget Skills Emotional well-being and social competence provide a strong foundation for budding cognitive abilities, and together they comprise the foundation, the bricks and mortar, of human development. Science therefore directs us away from debating which capacities children need most, and toward the realization that they are all intertwined.
5	**The Biology of Toxic Stress and Adverse Childhood Experiences (ACEs) Derails Healthy Development** In early infancy and even prenatally, the body engages in a "fight, flight, or freeze" response when exposed to stress that stimulates a surge of stress hormones and other biophysical responses throughout the body. This response is normal and not harmful to a child in small doses. However, when a child is exposed to repeated adversity for a prolonged period, this stress becomes toxic. Such chronic and unrelenting stress in early childhood derails development by setting the body's default stress response system in high alert, weakening brain architecture and impairing the development of all-important executive function skills. In the absence of the buffering protection of adult support, toxic stress becomes built into the body and brain of the developing child.
6	**Biological Responses to Toxic Stress During Childhood are Adaptive, Not Maladaptive. "The Child May Not Remember, But the Body Remembers." - Jack Shonkoff** Humans possess brains that are exquisitely sensitive to their environments and are equipped to adapt to early stress."3 "A behavior is adaptive insofar as it helps an organism survive. Within a violent context, hyper-arousal, vigilance, and aggression are clearly useful. However, many associated features of these adaptations confer risk in other contexts." [4]
7	**The Presence of Responsive Adults at Home & in the Community Lessens the Impact of Toxic Stress** The good news is that potentially toxic stressors can be made tolerable if children have access to stable, responsive adults – parents, home visitors, childcare providers, teachers, coaches, mentors, etc. Additionally, the brain has the ability to change continuously throughout an individual's life, a concept known as neuroplasticity. Innovative States and communities design high-quality programs to prevent Adverse Childhood Experiences from occurring in the first place and to effectively respond to them with strong, nurturing supports to ameliorate their impact when prevention is not possible.

8	**Executive Function & Self- Regulation Skills Are Critical for Learning and for Life** Science has identified a set of skills that are essential for school achievement, positive behavior, good relationships, preparation and adaptability of our future workforce, and for avoiding a wide range of health and relational problems. In the brain, the ability to hold onto and work with information, focus thinking, filter distractions, and switch gears is like an air traffic control system to manage the arrivals and departures of dozens of planes on multiple runways. Scientists refer to these capabilities as executive function and self-regulation—a set of skills that relies on three types of brain function: working memory, mental flexibility, and self-control.
9	**These Essential "Air Traffic Control Skills" are Built in Relationships and the Place in which Children Live, Learn, and Play** Children are not born with these skills; they are born with the ability to develop them. These skills begin to develop in early childhood and mature through early adulthood. The quality of interactions and experiences provided in families and communities either strengthens or undermines these budding skills.
10	**Rethinking Our Policies: What is Predictable, is Preventable** Childhood experiences build the foundation for a skilled workforce, a responsible community, and a thriving economy. As Marylanders understand the impact of ACEs, they will realize that the future economic development and prosperity of the state depends on rethinking our policies in health, education, public safety, justice, public assistance, child welfare, and juvenile justice to reflect what the N.E.A,R. science teaches us. To bring about population level change for children facing adversity and stem the tide of ever-more costly social problems, it is key to focus on building healthy brain architecture for every child and coordinating our efforts across all our child and family-serving systems. This investment improves outcomes for children now and is a significant foundation for solutions to many of the long-standing and systemic challenges we face as a state.

EPIGENETICS: THE INTERGENERATIONAL TRANSMISSION OF TRAUMA

The new scientific field of epigenetics explains how experience "gets under our skin." New research tells us that trauma can attach a chemical mark to a person's DNA at particular genes. The chemical mark can be passed down from one generation to the next. While the chemical mark does not mutate or damage the gene directly, it alters the mechanism by which the gene's message is able to be opened or not, allowing its instructions to be read and expressed. The hopeful part of epigenetics is that positive life experiences may reverse the negative impacts of ACEs and have positive effects on human development, health and well-being[5].

ADVERSE CHILDHOOD EXPERIENCES (ACES) STUDY:

> "The largest public health discovery of our time, perhaps of all time."
>
> –Dr. Robert Anda, Laura Porter

In 1995, the U.S. Centers for Disease Control and Prevention (CDC) and Kaiser-Permanente (KP) conducted the Adverse Childhood Experiences (ACEs) study. Therein, 17,000 participants - mostly white, middle-class adult patients at Kaiser-Permanente in San Diego - were surveyed about their health and well-being.

Participants were asked about ten ACEs, including all forms of child abuse and neglect, and five family dysfunctions, including divorce, parental incarceration, parental mental health or substance abuse disorders, and domestic violence.

10 ACE Categories Examined in the CDC Study on Childhood Adversities

After advocacy by member organizations of Maryland Essentials for Childhood, including SCCAN, Maryland joined other states in collecting state and county-level ACE prevalence data through the Behavioral Risk Factor Surveillance System (BRFSS). In 2018, Maryland became the first of 2 states to collect ACE data in middle and high schools through the Youth Risk Behavior Surveillance System (YRBSS).

THE MAGNITUDE OF THE PROBLEM: ACE STUDY FINDINGS IN MARYLAND AND BEYOND

ACEs are COMMON:

INITIAL ACE STUDY FINDINGS (SAN DIEGO, 1995): 67% of study participants reported having at least one ACE. 26% reported having three or more ACEs.[6]

MARYLAND ACE FINDINGS (2015): Approximately 60% of survey participants reported at least one ACE. 24% reported having three or more ACEs.[7]

CHILD ABUSE & NEGLECT			FAMILY DYSFUNCTION		
ACE	% Within Population		ACE	% Within Population	
Study	K-P (1995)	MD (2015)		K-P (1995)	MD (2015)
Physical Abuse	28%	16.9%	Substance Abuse	27%	24.9%
Sexual Abuse	21%	11.1%	Parental Separation/ Divorce	23%	27.5%
Emotional Neglect	15%	Not Collected	Mental Illness	17%	15%
Emotional Abuse	11%	31.2%	Battered Mother	13%	17.4%
Physical Neglect	10%	Not Collected	Criminal Behavior	6%	7.6%

ACEs are Rarely Found in Isolation and Tend to Occur in Clusters:

The cumulative impact of ACEs is captured in the "ACE Score:" the number of ACEs an individual has experienced. If an individual has experienced one ACE, they are likely to have multiple. An individual's ACE score indicates the likelihood of experiencing consequences of toxic stress during development.[8]

ACE SCORE	PREVALENCE	
	K-P (1995)	MD (2015)
0	33 %	40%
1-2 ACEs	42 %	36%
3 or More	26 %	24%

ACEs are Strong Determinants of adolescent & Adult Social Well-Being and Health:

ACE-related problems have a strong, graded relationship to numerous health, learning, social, and behavioral problems throughout a person's lifespan. As the number of ACEs increase in the life of an individual, there is an increased likelihood of the following risky behaviors and chronic physical and mental health conditions.[9]

AN ENHANCED UNDERSTANDING OF THE TYPES OF ACES

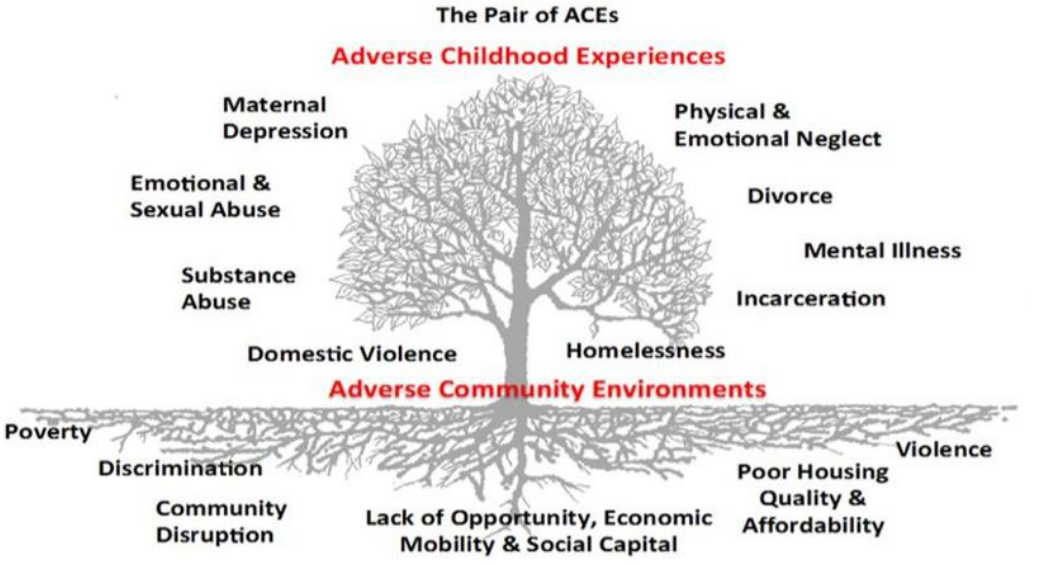
In designing the ACE Study, Dr. Anda and Dr. Felitti had to make some hard choices in order to keep the length of the questionnaire manageable, so that study participants could complete it. They chose experiences where there are organizations set up to prevent or treat specific ACEs such as child abuse and neglect and domestic violence and substance abuse. Some stressful experiences, like parental death or illness, are not directly addressed as "preventable" by existing organizations. Since the original ACE study, research has revealed additional adverse experiences that like the original ten ACEs, engage a child's brain and body in a chronic "fight, flight, or freeze" response and lead to poor social, educational, and health outcomes across the lifespan.

Philadelphia or Urban ACE Study

The Philadelphia ACE Study expanded the original ACE study to include an additional five adverse community experiences: witnessing violence, racism, neighborhood safety, bullying, and living in foster care. Researchers found that almost 40 percent of Philadelphians had experienced four or more of these expanded, community-level ACEs with similar impacts on risk behaviors and poor health outcomes.[10]

Adverse Community Environments

Drs. Wendy Ellis, PhD and William Dietz, PhD developed the Pair of ACEs tree depiction below that illustrates the relationship between adversity within a family and adversity within a community.

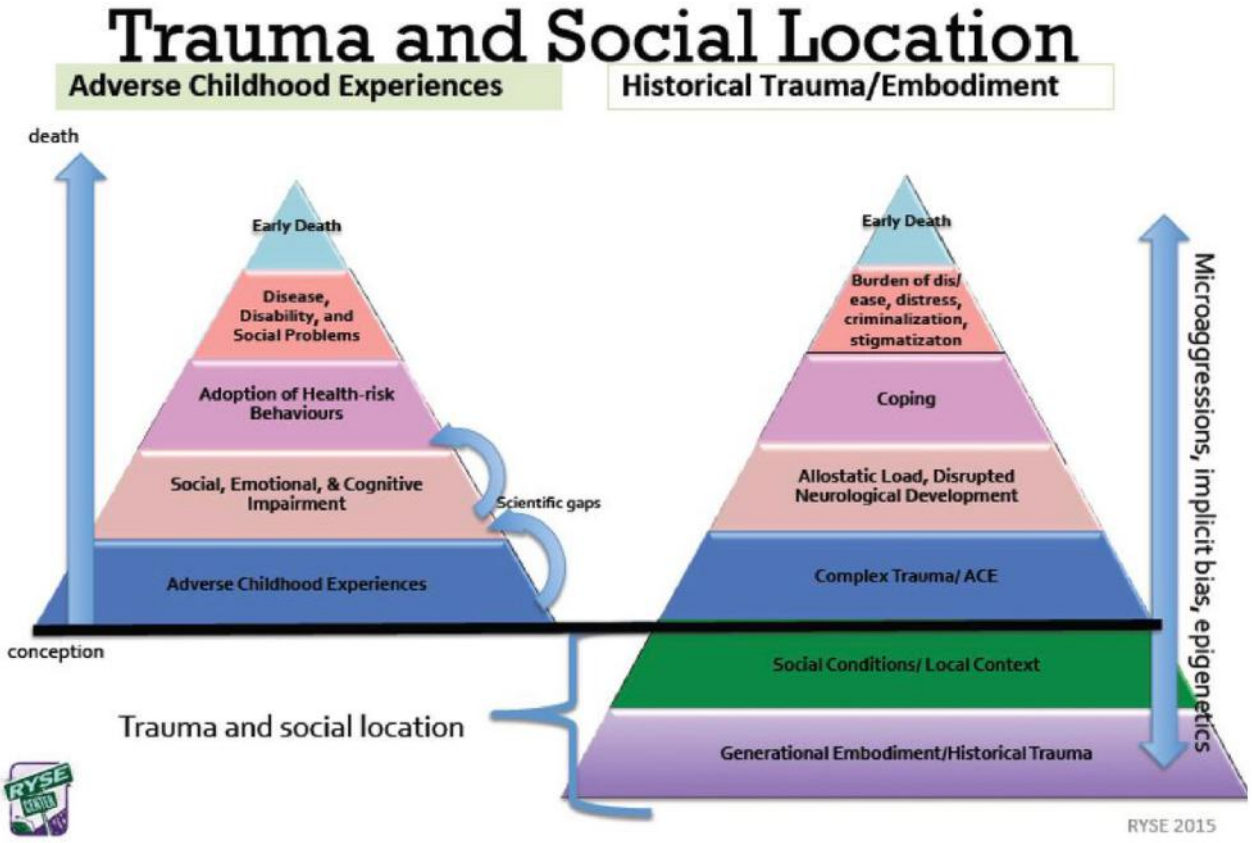


Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

The leaves on the tree represent the 'symptoms' of ACEs that are easily recognized in clinical, educational and social service settings, such as well-child visits or pre-school classrooms. The tree is planted in poor soil (or a community) that is steeped in systemic inequities, robbing it of nutrients necessary to support thriving individuals and communities. Adverse community environments such as unaffordable and unsafe housing, community violence, systemic discrimination, and limited access to social and economic mobility compound one another, creating a negative cycle of ever-worsening soil that results in withering leaves on the tree.

Historical and Intergenerational Trauma

The ACE Pyramid and the Expanded ACE Pyramid below are life course models, from pre-conception to death that are designed to help us understand how Adverse Childhood Experiences (ACEs) influence human development in predictable ways. This is important because **what is predictable is preventable**. The hypothesis of the original ACE Study was that ACEs disrupt neurodevelopment, which in turn leads to social, emotional and cognitive adaptations that can then lead to the risk factors for major causes of disease, disability, social problems, and early death.



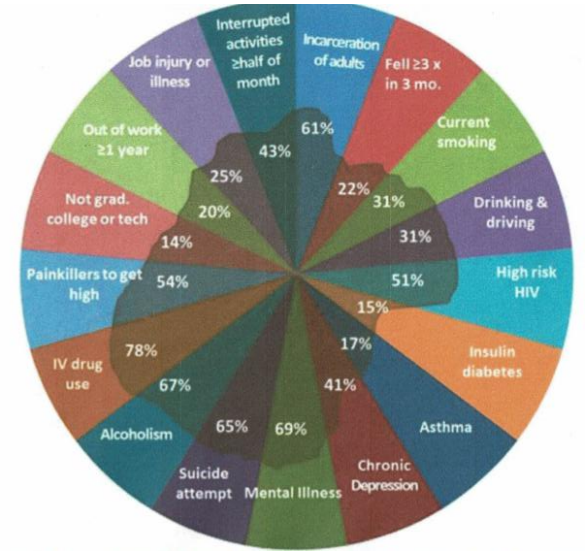
Since the time of the ACE Study, the breakthrough research in developmental neuroscience and epigenetics, mentioned above, has shown us that the hypothesis of the ACE study is biologically sound. Neuroscience and epigenetic discoveries help us to understand the progression of adversity from preconception throughout the life course. Historical trauma and generational adversity increase the risk for ACEs, which in turn generate risk for disease, disability, and social problems.[11]

THE MAGNITUDE OF THE SOLUTION

Preventing and Mitigating Multiple Health and Social Problems at the Same Time

From the findings of the ACE study and subsequent research, we understand that ACEs are common and have a strong cumulative impact on the risk of common health and social problems across the lifespan. Preventing ACEs and their intergenerational transmission is the greatest opportunity for improving the well-being of human populations. In fact, many believe this is the greatest opportunity of our time... perhaps of all time. The diagram below shows the percentage of various health and social problems that epidemiologists estimate are

caused by ACEs. The calculation that is commonly used to do this in public health studies is called Population Attributable Risk; this is displayed as a percentage of an "oil spill" on the diagram. The percentage of a problem coated by the oil spill represents the percentage of each problem that is potentially preventable by preventing ACEs. The percentages are quite large. In fact, these figures are rarely seen in public health studies. The cumulative effects of ACES reflect a powerful opportunity for prevention – whether working to prevent heart disease or cancer, end homelessness, or improve business profitability – as legislators align a portion of their work around a common goal of preventing ACEs and moderating their effects, they will reduce all of these problems, and many others, all at once.



Underperformance in schools and in jobs, poor mental health, substance abuse, and a variety of adverse health outcomes can all be partially attributed to childhood adversity. This wide scope of impact means that there are multiple opportunities to prevent and mitigate the harmful consequences of childhood adversity through numerous avenues of public policy. If lawmakers enact policies that prevent childhood adversities and mitigate their effects, each one of these problems will grow smaller.

The CDC conservatively estimates lifetime costs associated with child maltreatment at approximately $2 trillion nationwide.[12] This estimate does not include the cost of ACEs associated with family dysfunction, urban ACEs, and other childhood trauma known to chronically activate the biological "fight, flight, freeze response." Legislation aimed at preventing and mitigating childhood trauma not only works to improve the public health of our state, but can significantly reduce costs across all systems-- health care, education, criminal and juvenile justice, and welfare—over the long term.

THE ROAD TO RESILIENT INDIVIDUALS & COMMUNITIES

HOPE: HEALTH OUTCOMES OF POSITIVE EXPERIENCES

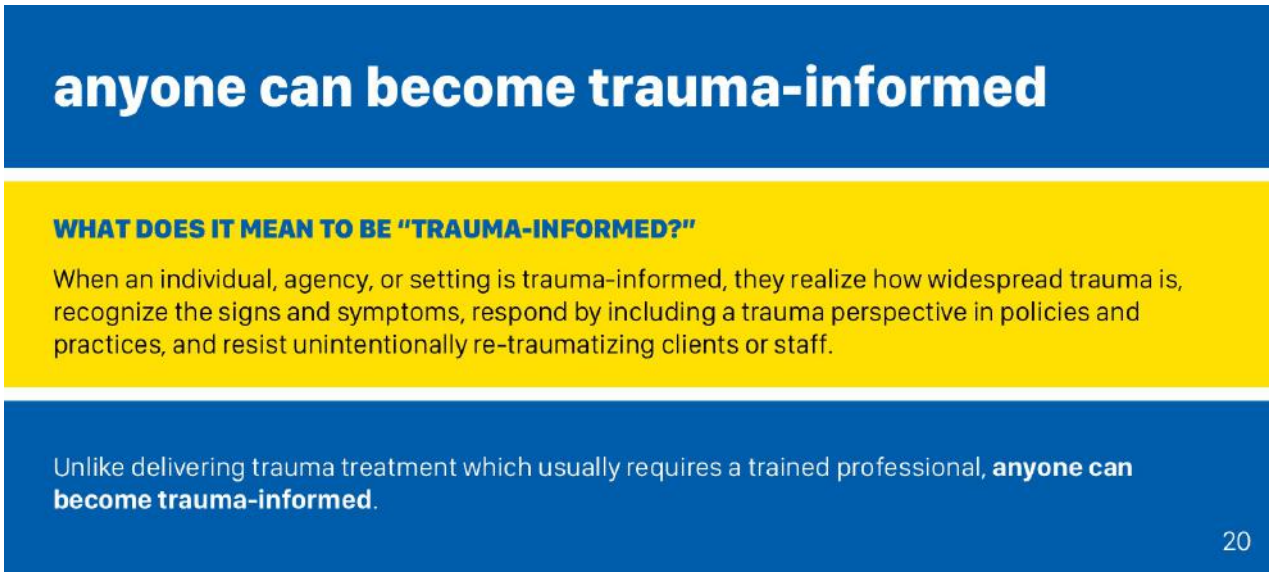
While the ACE study shows that adversity in childhood has lifelong impacts, subsequent studies have also shown that there are successful interventions not only for preventing exposure to ACEs, but also for mitigating their effects once they occur. **Positive experiences in childhood have also been shown to impact health across the lifespan**.[13] Positive experiences have been measured alongside ACEs in at least one state (Wisconsin) through their Behavioral Risk Factor Survey (BRFSS). Results showed that health is positively impacted by positive experiences, reflected in the following measures: (1) felt able to talk to their family about feelings; (2) felt their family stood by them during difficult times; (3) enjoyed participating in community traditions; (4) felt a sense of belonging in high school (not including those who did not attend school or were home schooled); (5) felt supported by friends; (6) had at least 2 non-parent adults who took genuine interest in them; and (7) felt safe and protected by an adult in their home. In considering responses to the health, social, and economic outcomes of ACEs and trauma, equal "attention should be given to the creation of those positive experiences that both reflect and generate resilience within children, families, and communities."[14]

Building resilience to traumatic experiences is a crucial factor in preventing the onset of negative health consequences as a result of exposure to ACEs, as resilience has been shown to provide the needed buffer to return the body to its base-line state following a stress response.[15] Skills required to build resilience can be taught and include fostering positive, supportive relationships, developing strong coping skills, and developing a sense of competence, character, and control in both children and parents.[16]

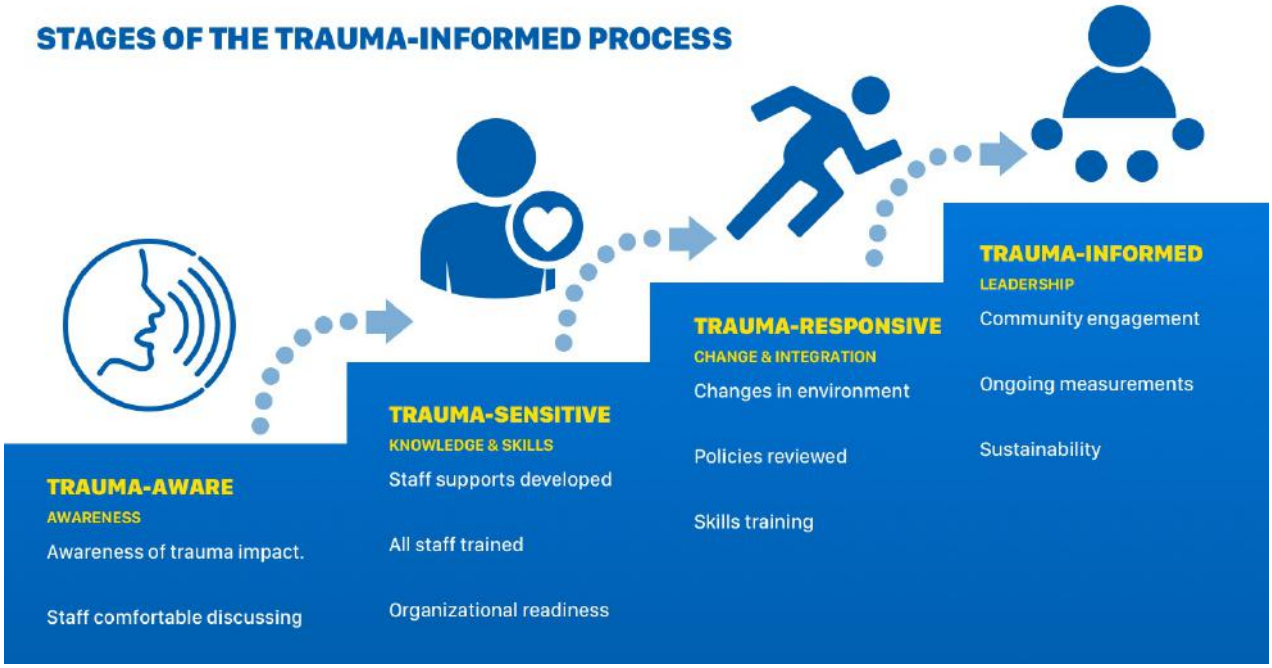
MITIGATING CHILDHOOD TRAUMA: TRAUMA-INFORMED SYSTEMS OF CARE

An important component of effective health, behavioral health, education, human, justice, and correctional service delivery is addressing the trauma of those served and serving. At a population level, effectively responding to trauma requires a multi-pronged, multi-agency public health approach that includes public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment.[17] In order to maximize impact, states must ensure that services to the public are trauma-informed, i.e., based on the knowledge and understanding of trauma and its far-reaching implications. Research indicates that with trauma-informed supports and intervention, people can recover and heal. Unfortunately, most systems are not trauma-informed and people go without needed services and supports. Unaddressed trauma significantly increases the risk of mental and substance use disorders as well as chronic physical diseases.[18]

Additionally, many organizations and public agencies provide services in ways that are often themselves trauma-inducing. "The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma. These program or system practices and policies often interfere with achieving the desired outcomes in these systems."[19] These systems are beginning to reassess and adjust how they offer services by becoming trauma-informed.



Becoming a trauma-informed system happens in multiple stages depicted in the illustration of the Missouri Model for becoming trauma-informed, below. **The first step in addressing trauma is for an individual, organization, system, or community to become aware of how trauma affects members and clients of the organization, system, or community**. The fundamental shift in providing support using a trauma-informed approach is to move from thinking 'What is wrong with you?' in response to the behavior of a client or colleague to considering 'What happened to you?'



SELF-HEALING & RESILIENT COMMUNITIES

The Washington Family Policy Council (FPC) has made groundbreaking efforts over a decade to disseminate NEAR (Neurodevelopment, Epigenetics, ACEs, and Resilience) science and provide technical assistance and coaching to local communities. The FPC employed a Self- Healing Communities Model (SHCM) to build upon the capacity of communities to generate new cultural norms and thereby improve health, safety, and productivity for current and future generations. **As Washington communities developed the capacity to shift typical cultural patterns, individuals within the community gained new knowledge and skills, and the communities as a whole became learning environments that continued to invite growth and wellbeing.** The SHCM demonstrated success in improving the rates of many interrelated and intergenerational health and social problems, resulting in incredible reductions in key child outcomes within those communities. As an example, in just one county over a ten-year period there was a:

- 62% reduction in teen births;
- 43% decrease in infant mortality;
- 98% decrease in teen suicide;
- 53% decrease in juvenile arrests for violent crimes;
- 47% decrease in high school dropout rates

The monetary savings to the state for that period are estimated at $1.4 billion.[22]

RESEARCH INFORMED POLICY STRATEGIES & APPROACHES TO PREVENT AND MITIGATE ACES

Our greatest public health problem requires a policy response at the federal, state and local level.

POLICY RESEARCH

Researchers at the U.S. Centers for Disease Control and Prevention (CDC) have worked to identify policies that are most effective in preventing ACEs from occurring in the first place. **Promoting safe, stable, nurturing relationships and environments, at a population level, is key**. Effective policies and interventions aimed at preventing and mitigating ACEs generally fall into six strategies: strengthen economic supports for families; promote social norms that protect against violence and adversity; ensure a strong start for children; teach skills to caregivers, children, and youth; connect children and youth to caring adults and activities; and intervene to lessen immediate and long-term harms of ACEs.[23]

6 EVIDENCE INFORMED STRATEGIES TO PREVENT ACES

1. Strengthen Economic Supports for Families

Research has shown that policies that **strengthen household financial security** and **family-friendly work policies** increase economic stability and family income, increase maternal employment, and improve parent's ability to meet children's basic needs and obtain high quality childcare. These types of policies can also prevent ACEs by reducing parental stress and depression and by protecting families from losing income to care for a sick child or family member.[24] Strengthening economic supports for families is a multi-generation strategy that addresses the needs of parents and children so that both can succeed and achieve lifelong health and well-being.[25]

Policies may include:

- Living wage
- Paid sick and safe leave
- Paid family and medical leave
- Flexible and consistent schedules
- Child support pass-through
- Increased tax credits
- Increased enrollment in social benefits - SNAP, TANF
- Assisted housing mobility
- Subsidized childcare
- Family-friendly work policies in government and private industry

2. Promote Social Norms that Protect Against Violence & Adversity

Norms are beliefs and expectations held by groups that inform how members of the group should think and behave. The CDC explains that "changing social norms that accept or allow indifference to violence and adversity is important in the prevention of ACEs. There are a number of norms that can protect against violence and adversity, including those that:

- Promote community norms around a shared responsibility for the health and well-being of all children
- Support parents and positive parenting, including norms around safe and effective discipline
- Foster healthy and positive norms around gender, masculinity, and violence to protect against violence towards intimate partners, children, and peers
- Reduce stigma around help-seeking
- Enhance connectedness to build resiliency in the face of adversity."[26]

Suggested approaches in shifting social norms toward preventing ACEs include:

- Public education campaigns
- Legislative approaches to reduce corporal punishment
- Bystander approaches and efforts to mobilize men and boys as allies in the prevention of violence and abusive behaviors

3. Ensure a Strong Start for Children

A strong educational foundation greatly increases a child's resilience and chance to prosper throughout their childhood and adulthood. Policies may include:

- Support for effective home visiting programs
- High quality Pre-K and preschool enrichment programs with family engagement
- Increased licensing and accreditation standards for childcare facilities
- Increased access to trauma-informed services in childcare and education facilities
- Increased childcare subsidies to make care accessible to all children.[27]

4. Teaching Skills to Caregivers, Children, & Youth

When parents are supported and educated in positive parenting practices, they can thrive as parents and create safe, stable, and nurturing homes for their children. Policies that promote positive parenting include:

- Evidence-based home visitation services
- Evidence-based parenting classes and family building programs that improve developmental outcomes in children and decrease instances of abuse and neglect[28]

Parents, teachers, and other caregivers, as well as children, youth, and young adults in settings from childcare to higher education can benefit from being taught:

- Social Emotional Learning (SEL)
- Healthy relationship skills: programs such as Dating Matters®, Safe Dates, and the Fourth R teach healthy relationship skills to adolescents
- Skill-based parenting and family relationship approaches, e.g., The Incredible Years® and Strengthening Families[29]

- Trauma-informed and responsive skills and systems[30]
- Executive function and self-regulation skills, which are foundational to school readiness, academic success, and healthy relationships in adults and children. These are mental processes that enable us to plan, focus attention, remember instructions, and juggle multiple tasks successfully. When children experience ongoing trauma without the buffering of supportive adults, these skills are less likely to fully develop. [31]

5. Connect Children & Youth to Caring Adults and Activities

It is important to both prevent and mitigate ACEs by connecting youth to other caring adults and activities. These experiences buffer against other difficulties in the home, parental absence, frequent moves, and exposure to negative influences in school and the community. Opportunities to develop and practice leadership, decision-making, self-management, and social problem-solving skills have documented benefits. Supportive policies and funding promote:

- Mentoring programs
- After-school programs[32]

6. Intervene to Lessen Immediate & Long-Term Harms of Childhood Trauma and Adversity

Primary prevention of violence and maltreatment has been proven to be the best way to avoid the harmful social, health, and economic costs of childhood adversities.[33] By stopping the problem before it starts, we can greatly reduce the costs associated with ACEs. However, studies have shown that a large population of Maryland's children and adults have already experienced some form of childhood adversity or trauma.[34] To avoid the harmful health outcomes that result from this exposure, policies must provide appropriate, trauma-informed care and treatment for childhood adversity. These policies include:

- Enhanced primary care, including:
    - Early screening and detection of childhood trauma
    - Expansion of insurance coverage for mental, behavioral, and social-emotional healthcare treatments
    - Safe Environment for Every Kid (SEEK) model, an evidence-based intervention developed at the University of Maryland School of Medicine, which screens for ACE exposures in the family environment.
- Victim-centered services
- Treatment to lessen the harms of ACEs
- Treatment to prevent problem behavior and future involvement in violence
- Family-centered treatment for substance use disorders may be used to simultaneously address substance misuse by parents and the needs of their children with this ACE exposure
- Training and skill building programs for childcare providers, healthcare professionals, and educators on the signs, symptoms and effects of trauma, and increased access to these resources[35]

FEDERAL AND STATE ACE-INFORMED LEGISLATIVE ACTION

National, state, and local legislators are employing at least five legislative mechanisms to prevent and reduce ACEs, mitigate their impact, and promote the safe, stable, and nurturing relationships and environments that build resilient communities:

CREATING INFRASTRUCTURE TO TACKLE ACEs - FIVE LEGISLATIVE MECHANISMS

1. **ACEs Resolutions:**
   Many states have passed ACE Resolutions that recognize NEAR science, the importance of preventing ACEs and mitigating their impact, and the need to consider research when developing state policy. 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 science into the hands of the general public, in developing innovative legislative strategies to prevent and mitigate ACEs, and creating a system of public services that is ACE-Trauma-and-Resilience-Informed.
2. **ACE & Trauma-Informed Legislative Caucuses:**
   At least two states, Hawaii and Wisconsin, have created Children's Caucuses which they use as a mechanism to develop comprehensive strategies to integrate NEAR science into all policies that impact children and their families.
3. **ACEs Task Forces/Workgroups:**
   ACE-informed 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.
4. **Encourage and Coordinate Cross-System Collaboration:**
   policies and practices and achieving improved outcomes for children, families, communities, and the State, requires coordination across public and private systems that serve children and families. Systems reform must use a multi-generational approach to solving the complex problems associated with childhood trauma, including strengthening the core capabilities of all adults who care for children. Coordination must take place at both the state and local levels.
5. **Dedicated Funding:**
   Dedicated state and local prevention funding to work across systems is critical. With a small investment, the Washington Family Policy Council was able to support significant change in local communities.[36] Most states across the country have developed robust prevention trust funds with combined annual revenues in excess of $100 million dedicated to prevention. Robust Children's Trust Funds in other states generate $1-18 million annually from the corpus of their Funds. Children's Trust Fund Boards actively raise funds to support statewide prevention efforts.[37] The absence of such a trust fund is a significant gap in Maryland's infrastructure to support prevention.

FEDERAL LEGISLATION

Beginning in 2017, Congress has passed the following ACE-Informed legislation:

- Passed A Resolution Recognizing the Importance and Effectiveness of Trauma-Informed Care (H.Res. 443/S.Res. 346) during the 2017-2018 legislative session.
- Passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (H.Res. 6 or previously titled the Opioid Crisis Response Act). Enacted in 2018, the SUPPORT Act offers significant provisions taken from or aligned with the goals of the Heitkamp-Durbin Trauma-Informed Care for Children and Families Act (S. 774), including the creation of an interagency task force to identify trauma-informed best practices and grants for trauma-informed practices in schools.

- U.S. Government Accountability Office issued a report "CHILDREN AFFECTED BY TRAUMA: Selected States Report Various Approaches and Challenges to Supporting Children" in April 2019.
- Introduced the bipartisan Resilience Investment, Support, and Expansion (RISE) from Trauma Act (H. Res. 3180/S. 1770) in June 2019. The "RISE from Trauma" Act would expand and support the trauma-informed workforce in schools, health care settings, social services, first responders, and the justice system, and increase resources for communities like Chicago to address the impact of trauma.

MARYLAND ACE-INFORMED LEGISLATION

Enacted Legislation

Members of the Maryland General Assembly have passed the following legislation that will help reduce children's exposure to ACEs in a variety of issue areas, including healthcare, family and social services, education, and more. While all of these bills may have an impact on the prevention of ACEs according to the research literature, only three of the bills were formulated with ACEs in mind and mention the impact of the legislation to reduce ACEs and their consequences.

1. Strengthen Economic Supports to Families

Increasing Minimum Wage

- Passed Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen) (H.B. 166/S.B. 280) in 2019. Raises the minimum wage to $15/ hour by 2024. Increasing Earned Income Tax Credit
- Passed Income Tax – Child and Dependent Care Tax Credit - Alteration (H.B. 810/S.B. 870) in 2019. Expanded 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.

2. Promote Social Norms that Protect Against Violence & Adversity

- ***None Identified***

3. Ensure a Strong Start for Children

- Passed Education – Child Care Subsidies – Mandatory Funding Levels (H.B. 430/S.B. 379) in 2018. Increases Maryland's low childcare subsidy rates to give parents access to quality care, and establishes a new "floor" so that rates never again fall so low. In terms of investment, breadth of benefit, and lasting impact, this was the most significant victory for early care and education in more than a decade.
- Passed Education – Child Care Subsidies – Mandatory Funding Level (H.B. 248/S.B. 181) in 2019. Building on landmark legislation from 2018 to give parents access to quality care, this bill accelerates a mandated increase of childcare subsidy rates. Beginning in July 2020, subsidy rates must equal or exceed 60 percent of market rates—and must remain at or above the 60th percentile in the future
- Passed Education – Commission on Innovation and Excellence in Education (H.B. 1415/S.B. 1092) in 2018. Preserves $22.3 million in pre-K expansion dollars that might otherwise have been lost when a federal grant expired.
- Passed State Employees – Parental Leave (H.B. 775/S.B. 859) in 2018. Provides up to 12 weeks of paid leave for State employees following the birth or adoption of a child.

- Passed Education – Head Start Program – Annual Funding (The Ulysses Currie Act) (H.B. 547/S.B. 373) in 2018. Restores a $1.2 million budget cut imposed in 2009, potentially increasing services for more than 2,100 Head Start children.
- Passed Maryland Prenatal and Infant Care Coordination Services Grant Program Fund (Thrive by Three Fund) (H.B. 1685/S.B. 912) 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.

4. Teach Skills to Caregivers, Children, & Youth

Home Visitation Services

- Passed The Home Visiting Accountability Act of 2012 (H.B. 699/S.B. 566). Requires the state fund only evidence-based and promising home visiting models; and, that 75% of funding go to evidence-based models.

5. Connect Children & Youth to Caring Adults and Activities

- ***None Identified***

6. Intervene to Lessen Immediate & Long-Term of Childhood Trauma and Adversity

Trauma-Informed and Responsive Schools

- Passed The Blueprint for Maryland's Future (S.B. 1030) in 2019. Endorses the sweeping policy recommendations of the Kirwan Commission and requires a 3-year "down-payment" on the implementation of those recommendations, totaling approximately $1 billion. State funding for pre-kindergarten will expand by $31.7 million in FY 2020 and an estimated $53.6 million in FY 2021. The teacher professional development program established under the bill may include "training in trauma-informed approaches to meet student needs."

Ensure Childhood Trauma and Associated Health Outcomes are Addressed by the Child Welfare System

- Passed Human Services – Children Receiving Child Welfare Services - Centralized Comprehensive Health Care Monitoring Program (H.B. 1582) in 2018. Creates a Centralized Comprehensive Health Care Monitoring Program for Children in the Child Welfare System, including an electronic health passport for children in out-of- home placement. The law recognizes ACEs and their associated long-term outcomes on physical and mental health of children within the child welfare system.

Ensuring Quality and Expanding the Access, and Scope of Child Advocacy Centers (CACs)

- Passed Child Advocacy Center - Expansion (S.B. 739) in 2019. Requires the Governor's Office of Crime Control and Prevention establish, sustain, and ensure that all children have access to multi-disciplinary child advocacy centers and that those centers meet or exceed national accreditation standards. Further it requires that child advocacy centers must assist in the response to or investigation of allegations of sexual crimes against children and sexual abuse of minors; and, may assist in the response to or investigation of allegations of child abuse and neglect or a crime of violence in the presence of a minor. The bill recognizes both the importance of a multi-disciplinary response to children's exposure to trauma, including expanding the types of trauma/adversity to which CACs may respond.

Preventing Child Abuse & Fatalities

- Passed an Expanded Birth Match law: Child Abuse and Neglect – Disclosure of Identifying Information (S.B. 490) in 2018. Expands from 5 to 10 years cross-checking of birth records of newborns (Vital Statistics) to information held by the Department of Human Services (DHS) on biological parents who have had their parental rights terminated by a court due to the abuse of a previous child. This allows for an offer of preventative services, or in egregious cases, removing the newborn to a safe environment. It also requires the courts to provide identifying information regarding an individual who has been convicted of the murder, attempted murder, or manslaughter of a child. And finally, it adds a requirement for the Department of Human Services (DHS) to contract with an independent entity to develop a data collection process.
- Passed Child Abuse and Neglect – Substance-Exposed Newborns – Reporting (H.B. 1744) in 2018. Requires hospitals to report cases of substance exposure in newborns to local Department of Social Services. There must be both an oral report immediately following contact with the newborn and a written report filed within 48 hours.[38]

Preventing Child Sexual Abuse

- Passed HB1072 Education - Child Sexual Abuse Prevention - Instruction and Training (H.B. 1072) in 2018. Defines "sexual misconduct." Requires County Boards of Education and nonpublic schools that receive State funds to train all employees who have direct contact with minors in the primary prevention of child sexual abuse. Requires County Boards of Education to establish policies and codes of conduct to prevent child sexual abuse by school employees.
- Passed Education - Personnel Matters - Child Sexual Abuse and Sexual Misconduct Prevention (SESAME) Act (H.B. 486) in 2019. Bans nondisclosure agreements involving sexual abuse for school employees who have direct contact with children and requires prospective employers to conduct a thorough review of the applicant's employment history, requiring applicants to disclose and instances which they were investigated (unless found false), disciplined, discharged or lost license, provides immunity for employers from civil and criminal liability for providing information in good faith about potential misconduct.[39]

2019 ACE-Informed Legislation Introduced, Not Enacted

In 2019, additional legislation was proposed, but not enacted that were NEAR Science Informed:

Strengthening Economic Supports to Families:

- H.B. 341 was introduced to provide 12 weeks paid family or medical leave to parents with newborns (including adoptive or foster children), individuals who must care for sick family members, and those who are themselves experiencing a serious medical condition.[40] Providing paid leave combats ACEs by reducing parental stress and allowing new parents the time to create lasting bonds with their young children, both of which can prevent abuse and neglect later on in a child's life.
- H.B. 339 would have, if passed, increased Temporary Cash Assistance (TCA) from 61% to 71% of minimum living income level in Maryland by 2025.[41] Legislation that aims to increase TCA, along with other social benefits, is useful in combatting ACE exposure because it reduces financial burden and parental stress, which in turn allows parents to provide for their children and thrive as a family.

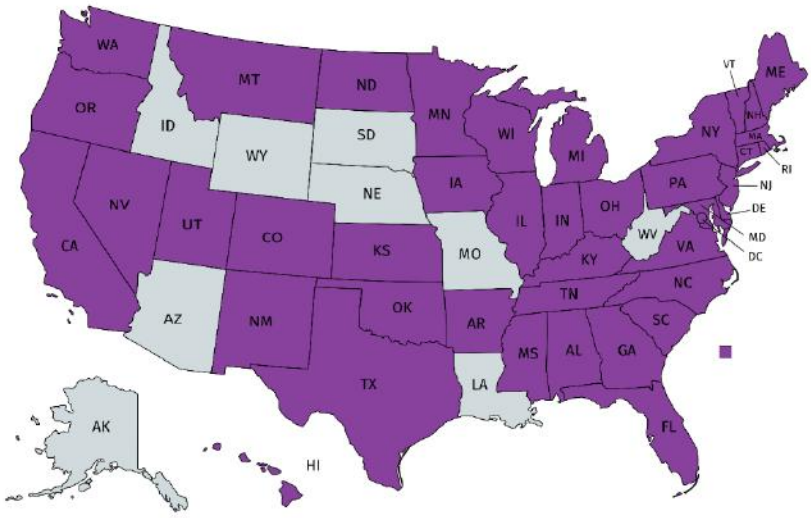
Intervene to Lessen Immediate & Long-Term of Childhood Trauma and Adversity

- H.B. 256 established a definition for "trauma-informed approaches" and proposed funding to help implement trauma-informed practices in schools. Training aims to both identify trauma and address its impacts for students and teachers.[42] This legislation deserves bipartisan support from Maryland lawmakers because it takes large steps towards creating trauma-informed schools, which have been shown to reduce student dropout rates, suspensions, and absences, contributing to the wellbeing of our students and teachers alike.
- H.B. 687, Civil Statute of Limitations Reform, Hidden Predator Act of 2019, 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.[43]

SISTER STATES LEGISLATION

ACE science has been recognized in over 280 proposed bills and 60 enacted statutes in 42 states across the country. These efforts focus on policy solutions in a variety of contexts, including health, education, social services, economic development, public safety, and more.44 In 2019 alone, over forty states introduced ACE- Informed legislation.

Map of States that Introduced ACE Legislation in 2019 [45]



This legislation builds awareness of science among policy makers and their constituents; assists in lifting the stigma surrounding trauma, mental illness, and substance abuse; provides an environment in which to freely discuss the consequences of exposure to ACEs; and encourages innovative solutions to reduce ACEs and mitigate their impact.

The appendix to this document, "State Legislative Strategies to Prevent and Mitigate ACEs," outlines and provides links to many key bills passed in Maryland and sister states. The legislative bills are organized according to **five legislative mechanisms** states have used to prevent and respond to ACEs; and, the **six evidence-informed strategies** outlined by the Centers for Disease Control and Prevention in its' recent publication, "Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence."

Citations

1. Oral, Resmiye, et al. "Adverse childhood experiences and trauma informed care: the future of health care." Pediatric research 79.1 (2016): 227-233.
https://www.nature.com/articles/pr2015197/

2. The common language used in this section comes from a combination of sources: Harvard Center for the Developing Child; Frameworks Institute; CDC Essentials for Childhood; and Tennessee's Building Strong Brains: ACEs Initiative.

3. Mead, Hilary K., Theodore P. Beauchaine, and Katherine E. Shannon. "Neurobiological adaptations to violence across development." Development and psychopathology 22.1 (2010): 1-22.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2813461/

4. Id.

5. Szyf, Moshe, and Johanna Bick. "DNA methylation: a mechanism for embedding early life experiences in the genome." Child development 84.1 (2013): 49-57.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4039199/

6. CDC. "About the CDC-Kaiser ACE Study."
https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html

7. Maryland Behavioral Risk Factor Surveillance System. "Adverse Childhood Experiences (ACEs) in Maryland: Data from the 2015 Maryland BRFSS (Data Tables ONLY)." (2017)
https://phpa.health.maryland.gov/ccdpc/Reports/Documents/MD-BRFSS/2015_MD_BRFSS_ACEs_Data_Tables.pdf

8. CDC. "About the CDC-Kaiser ACE Study."
https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html

9. Felitti, Vincent J., et al. "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study." American journal of preventive medicine 14.4 (1998): 245-258.
https://www.ajpmonline.org/article/S0749-3797(98)00017-8/fulltext

10. Philadelphia ACE Project. "Philadelphia Ace Survey." (2019)

11. ACE Interface Training, Slide 28: ACE Pyramid, Robert Anda, MD, MS, Laura Porter (2015).

12. Peterson, Cora, Curtis Florence, and Joanne Klevens. "The economic burden of child maltreatment in the United States, 2015." Child abuse & neglect 86 (2018): 178-183.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6289633/

13. Bethell, Christina, et al. "Positive childhood experiences and adult mental and relational health in a statewide sample: associations across adverse childhood experiences levels." JAMA pediatrics 173.11 (2019): e193007-e193007.
https://jamanetwork.com/journals/jamapediatrics/fullarticle/2749336

14. Id.

15. Garner, Andrew S., et al. "Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health." Pediatrics 129.1 (2012): e224-e231.
https://pediatrics.aappublications.org/content/pediatrics/129/1/e224.full.pdf

16. Id.

17. US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. "SAMHSA's concept of trauma and guidance for a trauma–informed approach." (2014): 14-4884.

18. Id.

19. Id.

20. Alaska Resilience Initiative. Toward a Trauma-Informed, Resilient, and Culturally Responsive Alaska." (2018) (Used with permission.)
https://www.akresilience.org/s/TraumaInformed_final_print.pdf

21. Id.

22. Porter, L., K. Martin, and R. Anda. "Self-healing communities: A transformational process model for improving intergenerational health." Princeton, NJ: Robert Wood Johnson Foundation (2016).
https://criresilient.org/wp-content/uploads/2018/07/Self-healing-community-report.pdf

23. CDC. "Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence." (2019)
https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

24. Id.

25. Bellazaire, Amber. "Preventing and Mitigating the Effects of Adverse Childhood Experiences." National Conference of State Legislatures (2018)
https://www.ncsl.org/Portals/1/HTML_LargeReports/ACEs_2018_32691.pdf

26. CDC. "Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence." (2019)
https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

27. Id.

28. Di Lemma, Lisa CG, et al. "Responding to Adverse Childhood Experiences." (2019).
https://www.bangor.ac.uk/news/documents/RespondingToACEs-PHW2019-english.pdf

29. Id.

30. Substance Abuse and Mental Health Services Administration. "SAMHSA's concept of trauma and guidance for a trauma-informed approach." HHS Publication No.(SMA) 14-4884 (2014).
https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf

31. Center on the Developing Child. “InBrief: Executive Function: Skills for Life and Learning.” (2015). https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2015/05/InBrief-Executive-Function-Skills-for-Life-and-Learning-2.pdf

32. CDC. "Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence." (2019) https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

33. Association of State and Territorial Health Officials. “Adverse Childhood Experiences: Primary Prevention.” (2019). https://www.astho.org/ASTHOBriefs/Adverse-Childhood-Experiences-Primary-Prevention/

34. Child & Adolescent Measurement Initiative. "Adverse childhood experiences among Baltimore and Maryland’s children." (2014). https://www.childhealthdata.org/docs/default-source/local-area-synthetic-estimates/adverse-childhood-experiences-among-baltimore-maryland-s-children.pdf

35. CDC. "Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence." (2019) https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

36. Porter, L., K. Martin, and R. Anda. "Self-healing communities: A transformational process model for improving intergenerational health." Princeton, NJ: Robert Wood Johnson Foundation (2016). https://criresilient.org/wp-content/uploads/2018/07/Self-healing-community-report.pdf

37. https://ctfalliance.org/childrens-trust-funds/

38. Maryland State, Legislature. House Bill 1744. Maryland State Legislature. (2018). https://legiscan.com/MD/text/HB1744/id/1795761

39. Associated Press. “Maryland Moves Toward Curbing Abusive Teachers’ Job Movement.” (2019). https://wtop.com/maryland/2019/03/maryland-joins-states-moving-to-stop-teacher-sex-abuse-cycle/

40. Maryland State, Legislature. House Bill 341. Maryland State Legislature. (2019). https://legiscan.com/MD/supplement/HB341/id/95306

41. Maryland State, Legislature. House Bill 339. Maryland State Legislature. (2019). http://mgaleg.maryland.gov/2019RS/bills/hb/hb0339f.pdf

42. Maryland State, Legislature. House Bill 341. Maryland State Legislature. (2019). https://legiscan.com/MD/supplement/HB341/id/95306

43. Maryland State, Legislature. House Bill 687. Maryland State Legislature. (2019). https://legiscan.com/MD/bill/HB687/2019

44. ACEs Connection. “At a Glance: State Statutes and Resolutions ACEs/Trauma-Informed Policy.” (2019) https://www.acesconnection.com/g/state-aces-action-group/blog/snapshot-of-aces-statutes-and-resolutions

45. National Conference of State Legislatures. “Injury Prevention Legislation Database: Opioid Abuse Prevention.” (2019).
https://www.ncsl.org/research/health/injury-prevention-legislation-database.aspx

Appendix

STATE LEGISLATIVE STRATEGIES TO PREVENT & MITIGATE ACES*

This document is 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." 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 five different legislative mechanisms used to advance the science of ACEs and resilience within policy-making. These five mechanisms are:

1. Joint resolutions establishing statewide policy on ACEs
2. Funding for primary prevention of ACEs
3. ACE- or trauma-informed caucus
4. ACE task forces/workgroups
5. Creation or use of an existing coordinating body for cross-sector collaboration

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

JOINT RESOLUTIONS 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		Alaska: HCR 21 (2016). Urging 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. Alaska: S105 (2018). Revises licensure of martial and family therapists and creates a state policy directive that "policymakers, administrators, and those working within state programs and grants to 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: 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. Delaware: Executive Order 24 (2018), "Making Delaware a Trauma-Informed State" declares Delaware a trauma informed state and recognizes significance of early intervention for children and caregivers exposed to ACEs. 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. (pending)

		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. 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.

FUNDING FOR PRIMARY PREVENTION OF

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	Hawaii: HI Rev Stat § 350B-4 (2016). Kansas: Children's Trust Fund Statute. Massachusetts: S2130, General Laws Sec. 202 (1987) and Sec. 50.

	Children's Trust Fund.	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). Amends 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"		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		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. Colorado: S10 (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. 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.

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.

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"	No general Task Force on ACEs. State Council on Child Abuse and Neglect (SCCAN) focuses its' efforts and recommendations on ACEs. SB567 (2019). Establishing 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. HB666 (2020) Establishing 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	Georgia: HR421 (2019). Creates the Committee on Infant and Toddler Social and Emotional Health. 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. New York: A2451(2019). Establishes a task force to identify evidence based and evidence informed solutions to reduce children's exposure to adverse childhood experiences.

	should take after screening a minor for mental health disorders that may be caused by or related to ACEs.	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. S5903/ Act 360 (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.

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"	No designated agency lead on coordinating NEAR Science interventions statewide.	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. 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 coordinated public health approaches to addressing ACES, toxic stress, and resilience. Washington: RCW 70.190.010 (1994.) Establishes the Washington Family Policy Council to facilitate services at the local level. HB1965 (2011) "An Act Relating to Public and Private Partnership in Addressing Adverse Childhood Experiences". Creates the Washington State ACEs Public Private Initiative
		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.

SECTION B:

THE CDC'S SIX RESEARCH INFORMED POLICY STRATEGIES TO PREVENT OR MITIGATE ACEs

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.

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,1 in 10 live in deep poverty, and research consistently links low incomes to ACE exposure and poor long-term health, educational, and social outcomes.

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.	Increased Minimum Wage Passed HB166/ SB280 "Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen)" in 2019, Raises the minimum wage to $15/ hour by 2024.	Illinois: SB81 (2018). Increases minimum wage to $15/hour by 2025. Massachusetts: H4640 (2018) Increases minimum wage to $15/ hour over five years. New Jersey: A15 (2019), Raises 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	Paid Family Leave Passed SB 859 / HB 775 "State Employees – Parental Leave" in 2018. Provides up to 12 weeks	California: Act 686 (2017). Establishes aid family leave and disability insurance across the state.

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, increased breastfeeding and health benefits for mother and child, vaccination completion, decreased infant mortality, increased placement in high quality stable childcare, and a reduction in child abuse.	of paid leave for State employees following the birth or adoption of a child. Proposed: HB341/SB500 Labor and Employment - Family and Medical Leave Insurance Program – Establishment- Time to Care Act of 2019. Died in Committee.	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). Passed paid leave finding it is associated with health benefits, including reduced infant mortality and increased well-baby visits, 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.
PAID SICK & SAFE LEAVE	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, increases health insurance coverage, school performance, and parents' ability to provide	Increased Earned Income Tax Credit Passed HB 810 / SB 870 "Income Tax – Child and Dependent Care Tax Credit - Alteration" in 2019. Expanded 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.	Colorado: HB17-1002 (2017). Grants an earned income tax credit expansion for child care expenses for families who earn an adjusted gross income of $25,000 or less. The tax credit is equal to 25% of child care 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.

for their children physically and emotionally.		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.
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.	Passed SB 379 / HB 430 (2018) Increases child care subsidy rates, establishing mandatory funding levels so that rates never again fall so low. Passed HB 248 / SB 181 (2019). Accelerates the mandated increase of child care subsidy rates. Beginning July 2020, subsidy rates must equal or exceed and remain at 60 percent of market rates.	California: Act 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 child care 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		None known or reported by NCSL that reference N.E.A.R. Science.

risk factors for multiple forms of violence.		
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 with low or moderate incomes, help ensure that each child has a safe place to live.		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.
MULTI- GENERATIONAL APPROACH TO HUMAN SERVICES BENEFITS		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)

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."

Pieces of legislation that promote community norms around a shared responsibility for the health and well-being of all children; support parents and positive parenting, including norms around safe and effective discipline; foster healthy and positive norms around gender, masculinity, and violence to protect against violence towards intimate partners, children, and peers; reduce stigma around help-seeking; and

enhance connectedness to build resiliency in the face of adversity , 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, reduce children's exposure to parental anger and conflict and reduce child behavior problems.		None known or reported by National Conference of State Legislatures (NCSL) that reference N.E.A.R. Science.
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. 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.		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		None known or reported by NCSL that reference N.E.A.R. Science.

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."		

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.

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.	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. Passed SB 373 / HB 547 "Education – Head Start Program – Annual Funding (The	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.

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.	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. Passed 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.	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 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.	Passed SB 379 / HB 430 (2018) Increases child care subsidy rates, establishing mandatory funding levels so that rates never again fall so low. Passed HB 248 / SB 181 (2019). Accelerates the mandated increase of child care subsidy rates. Beginning July 2020, subsidy rates must equal or exceed and remain at 60 percent of market rates.	None known or reported by NCSL that reference N.E.A.R. Science.
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.	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. Passed HB 1415 (2018). Preserves $22.3 million in pre-K expansion dollars that might otherwise have been lost when a federal grant expired.	None known or reported by NCSL that reference N.E.A.R. Science.

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, child care 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. 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.	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.	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. 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 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 parental practices,		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

which are associated with positive child behavior and development.		multigenerational childhood trauma.
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.		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.		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. 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. 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. 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.

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. 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		None known or reported by NCSL that reference N.E.A.R. Science.

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		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		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 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.
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. For children, assessments are completed with parents/caregivers to identify risks such as parental substance use, intimate partner violence, depression, stress and the use of harsh punishment. Screening and assessing adults would identify a history of ACE exposures and help mitigate risk and improve treatment outcomes. Strong policies would ensure that intervention services are tailored to assessment findings and coordinated with and between community agencies.		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 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 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.		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. New Jersey: A3035 (2017). The Mental Health Access Act of 2017 increases Medicaid reimbursement rates for evidence-based behavioral health services. 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.
FUNDING EVIDENCE – BASED PROGRAMS IN PRIMARY CARE –	SEEK is a model created and tested in Maryland by Dr. Howard Dubowitz, MD and his	None known or reported by NCSL that reference N.E.A.R. Science.

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. SEEK is also associated with less maternal psychological aggression, fewer minor maternal physical assaults, and improvements among providers in addressing depression, substance misuse, intimate partner violence, and serious parental stress."	team at the University of Maryland, School of Medicine.	
PREVENTING & MITIGATING THE HARMS OF CHILD SEXUAL ABUSE STATUTE OF LIMITATIONS REFORM 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. 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.	No Criminal SOL Civil SOL: HB687, (2019). **Hidden Predator Act.** Passed the House 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.	In 2019 alone, nineteen states have passed statute of limitations reforms to better reflect the average age of disclosure. California: AB218 2019. 3-year window: 3-year window will open on January 1, 2020 for expired claims against perpetrators, private organizations and government. 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,

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.		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. New Jersey: S477 2019. 2-year window: 2-year window will open on December 1, 2019 for expired claims against perpetrators, private organizations and government. Window applies to child sex abuse victims and those sexually assaulted as adults. New York: A2863 2019. 1-year window: 1-year window opened on August 14, 2019 for expired clams against perpetrators, private organizations and government. North Carolina: H37 (2019). 2-year window: 2-year window will open on January 1, 2020 for expired claims against perpetrators, private organizations and 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	Sb739, (2019). Child Advocacy Centers (CACs)Expansion bill defined and strengthened CACs across the state to ensure trauma-informed services to	Florida: Act 151 (2017). Provides for trauma informed care for children who have been sexually exploited. Establishes an accountability system for

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.	child victims of child sexual and physical abuse.	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: 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:		Colorado: H1017 (2019). Requires the department of education to select a school district to partake in a pilot

• 4 times more likely to develop depression 2 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. 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. 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.		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. 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,	HB256/SB233 State Department of Education - Guidelines on Trauma-Informed Approach proposed in 2019. Creates a pilot project to create trauma-informed schools. Died in Committee. Trauma Informed language from the bill was included in the Blueprint for Maryland's Future.	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. Resolution 166, (2019) was enacted to urge local education agencies to provide the training developed by the Department of Education to all teachers. New York: A11081 (2019). Requires ACEs training for licensed day care providers. 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.

crime, and conduct problems, results which also produce large returns on the investments made in the programs themselves.		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: 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. 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.
SCHOOL SAFETY PLANS School safety plans are a method of preventing violence, suicide, and major crises in schools. Though not included in the original study, The Philadelphia ACE Study added and studied bullying as an ACE, as it results in the same toxic stress response and can lead to the same negative mental and physical health outcomes. Children who have been bullied are more likely to use drugs and alcohol, experience anxiety, depression, and suicide, and engage in violent behaviors themselves. To address the possibility of student crises, some states have enacted school safety plans that		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

include methods for students to report violence and bullying in schools, training for teachers on addressing trauma, and programs for violence and suicide prevention.		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. States have		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-

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.		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. Massachusetts: H4742, (2018). Establishes 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		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.		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. 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. 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. Hawaii: 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. 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. 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		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	SB567, (2019). Establishing 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	

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.	trauma-informed decision making. and make recommendations about how State courts could incorporate the science into child custody proceedings.	
POLICIES & PRACTICES TO ENSURE NEXT GENERATION PREVENTION & TRAUMA-INFORMED RESPONSE IN CHILD WELFARE	HB1582, (2018). Recognizing the high prevalence of ACEs for children involved in child welfare, it creates a Child Welfare Medical Director and electronic health passport for children in the child welfare system. Mandates a report by the Child Welfare Medical Director to the General Assembly annually on the health and well-being of children in out-of-home placement.	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: 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 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.

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.

1. "Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings", Judy Hall, Laura Porter and Dario Longhi, Jody Becker-Green, Susan Dreyfus, Journal of Prevention & Intervention in the Community, 40:325–334, 2012. https://www.researchgate.net/publication/230840485_Reducing_Adverse_Childhood_Experiences_ACE_by_Building_Community_Capacity_A_Summary_of_Washington_Family_Policy_Council_Research_Findings

2. Id.

3. Id.

4. Centers for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

5. Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Preventing child abuse and neglect: a technical package for policy, norm, and programmatic activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

6. Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T., & Gilbert, L. (2017). Preventing intimate partner violence across the lifespan: a technical package of programs, policies, and practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

7. Stith, S. M., Liu, T., Davies, L. C., Boykin, E. L., Alder, M. C., Harris, J. M., Som, A., McPherson, M., & Dees, J. E. M. E. G. (2009). Risk factors in child maltreatment: a meta-analytic review of the literature. Aggression and Violent Behavior, 14, 13-29.

8. Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. Partner Abuse, 3(2), 231-80.

9. Child Trends Databank. (2019). Children in poverty. Retrieved from https://www.childtrends.org/?indicators=children-in-poverty

10. Id.

11. Shonkoff, J. P., Garner, A. S., & Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care and Section on Developmental and Behavioral Pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. Pediatrics, 129(1), e232-e246.

12. Cooper, K., & Stewart, K. (2013). Does money affect children's outcomes? A systematic review. York, UK: Joseph Rowntree Foundation. Retrieved from http://www.jrf.org.uk/publications/does-money-affect-childrens-outcomes

13. “Preventing and Mitigating the Effects of Adverse Childhood Experiences”. National Conference for State Legislators, August 2018. http://www.ncsl.org/Portals/1/HTML_LargeReports/ACEs_2018_32691.pdf .

14. Curtis Skinner & Susan Ochshorn, “Paid Family Leave: Strengthening Families and Our Future,” (January 2014): accessed September 1, 2016, http://bit.ly/1M7HrRv

15. M. Baker & K. Milligan, “Maternal employment, breastfeeding, and health: Evidence from maternity leave mandates,” Journal of Health Economics 27(2008): 871-887; R. Huang & M. Yang, “Paid maternity leave and breastfeeding practice before and after California’s implementation of the nation’s first paid leave program,” Journal of Economics & Human Biology 16(2015): 45-59.

16. Skinner & Ochshorn, “Paid Family Leave”; Mark Daku, Amy Raub, & Jody Heymann, “Maternal leave policies and vaccination coverage: A global analysis,” Social Science & Medicine 74(2012): 120-124.

17. M. Rossin, “The effects of maternity leave on children’s birth and infant health outcomes in the United States,” Journal of Health Economics 30(2011): 221-239; S. Tanaka, “Parental leave and child health across OECD countries,” The Economic Journal 115(2005): F7-F28.

18. National Partnership for Women & Families, “Expecting Better.” (2016).

19. Joanne Klevens, Feijun Luo, Likang Xu, Cora Peterson, & Natasha E Latzman, “Paid family leave’s effect on hospital admissions for pediatric abusive head trauma,” Injury Prevention (2016): Doi: 10.1136/injuryprev-2015-041702

20. “MD HB775”. General Assembly of Maryland, 2018. http://mgaleg.maryland.gov/webmga/frmMain.aspx?id=hb0775&stab=01&pid=billpage&tab=subject3&ys=2018rs .

21. Centers for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. And “The Earned Income Tax Credit”. Center on Budget and Policy Priorities, June 2019. https://www.cbpp.org/sites/default/files/atoms/files/policybasics-eitc.pdf .

22. “MD HB810”. General Assembly of Maryland, 2019. http://mgaleg.maryland.gov/webmga/frmMain.aspx?id=hb0810&stab=01&pid=billpage&tab=subject3&ys=2019RS .

23. Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. (2019), p.11.

24. http://www.ncsl.org/Portals/1/HTML_LargeReports/ACEs_2018_32691.pdf

25. 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.

26. David-Ferdon, C., Vivolo-Kantor, A. M., Dahlberg, L. L., Marshall, K. J., Rainford, N. & Hall, J. E. (2016). A comprehensive technical package for the prevention of youth violence and associated risk behaviors. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

27. Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Preventing child abuse and neglect: a technical package for policy, norm, and programmatic activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

28. Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T., & Gilbert, L. (2017). Preventing intimate partner violence across the lifespan: a technical package of programs, policies, and practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

29. Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., & Wilkins, N. (2017). Preventing suicide: a technical package of policies, programs, and practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

30. Fortson, et.al. (2016)

31. Id.

32. Basile, et.al.(2016)

33. David-Ferdon, et.al. (2016)

34. Niolon, et.al. (2017)

35. Stone, et.al. (2017)

36. Id.

37. Centers for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

38. Id.

39. Forston, et.al. (2016)

40. Poole, M. K., Seale, D. W., & Taylor, C. A. (2014). A systematic review of universal campaigns targeting child physical abuse. Health Education Research, 29(3), 388-432.

41. Id.

42. Id.

43. Research has shown adverse childhood experiences to have multiple negative impacts throughout an individual's life. More ACEs reduce the likelihood of high school graduation and holding a skilled job (Giovanelli et al, 2016). More ACEs also increase the likelihood of teen pregnancy and fetal death in pregnancy (Hillis et al, 2004); behavioral problems (Greeson et al, 2014); juvenile arrest, and felony charges (Giovanelli et al, 2016). Moreover, ACEs can negatively impact a wide range of health and social factors including an increased risk of homelessness (Herman et al, 1997), illicit drug use (Dube et al, 2003) and depression (Giovanelli et al, 2016; Anda et al, 2005). Anda, R. F., V. J. Felitti, J. D. Bremner, J. D. Walker, Ch Whitfield, B. D. Perry, Sh R. Dube, and W. H. Giles. 2005. "The Enduring Effects of Abuse and Related Adverse Experiences in Childhood." European Archives of Psychiatry and Clinical Neuroscience 256 (3): 174–86. Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, and Anda RF. 2003. "Childhood Abuse, Neglect,

and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experiences Study." Pediatrics 111 (3): 564–572 9p. Giovanelli, Alison, Arthur J. Reynolds, Christina F. Mondi, and Suh-Ruu Ou. 2016. "Adverse Childhood Experiences and Adult Well-Being in a Low-Income, Urban Cohort." Pediatrics, April, peds.2015-4016. Greeson, Johanna K. P., Ernestine C. Briggs, Christopher M. Layne, Harolyn M. E. Belcher, Sarah A. Ostrowski, Soeun Kim, Robert C. Lee, Rebecca L. Vivrette, Robert S. Pynoos, and John A. Fairbank. 2014. "Traumatic Childhood Experiences in the 21st Century Broadening and Building on the ACE Studies With Data From the National Child Traumatic Stress Network." Journal of Interpersonal Violence 29 (3): 536–56. Herman, D B, E S Susser, E L Struening, and B L Link. 1997. "Adverse Childhood Experiences: Are They Risk Factors for Adult Homelessness?" American Journal of Public Health 87 (2): 249–55. Hillis, Susan D., Robert F. Anda, Shanta R. Dube, Vincent J. Felitti, Polly A. Marchbanks, and James S. Marks. 2004. "The Association Between Adverse Childhood Experiences and Adolescent Pregnancy, Long-Term Psychosocial Consequences, and Fetal Death." Pediatrics 113 (2): 320–27.

44. https://www.bangor.ac.uk/news/documents/RespondingToACEs-PHW2019-english.pdf

45. "Review of ACE Study Confirms Supporting Parent-Child Relationship is Key". ACEs Connection, June 2019. https://www.acesconnection.com/blog/review-of-ace-studies-confirms-support-that-strengthens-parent-child-relationship-is-key.

46. Centers for Disease Control (2019).

47. Id.

48. "MD SB1030". General Assembly of Maryland, 2019. http://mgaleg.maryland.gov/webmga/frmMain.aspx?id=sb1030&stab=01&pid=billpage&tab=subject3&ys=2019RS .

49. Using Brain Science to Design New Pathways Out of Poverty", Elisabeth D. Babcock, MCRP, PhD, Crittendon

50. Women's Union 2014, p. 13. "Review of ACE Study Confirms Supporting Parent-Child Relationship is Key". ACEs Connection, June 2019. https://www.acesconnection.com/blog/review-of-ace-studies-confirms-support-that-strengthens-parent-child-relationship-is-key.

51. "Home Visiting Enacted Legislation in States (2008-2016)". National Conference of State Legislatures, 2017. http://www.ncsl.org/documents/cyf/HV_Enacted_08_16.pdf .

52. "Responding to Adverse Childhood Experiences". Bangor University, https://www.bangor.ac.uk/news/documents/RespondingToACEs-PHW2019-english.pdf .

53. "Vermont H500". Trackbill, 2019. https://trackbill.com/bill/vermont-house-bill-500-an-act-relating-to-universal-home-visiting-and-parenting-classes/1708522/.

54. "Integrated Substance Abuse and Child Welfare Services for Women: A Progress Review". US National Library of Medicine, 2012. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3076740/ .

55. https://futureofchildren.princeton.edu/sites/futureofchildren/files/media/foc-policy_brief_spring_2018__0.pdf

56. Centers for Disease Control (2019).

57. Fortson, B.L., et.al. (2016).

Maryland Essentials for Childhood

Maryland Essentials for Children is a statewide collective impact initiative to prevent child maltreatment and adverse childhood experiences (ACE's). We 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.

Maryland Essentials for Children includes public and private partners from across the state; and, receives technical assistance from the U.S. Centers for Disease Control.

www.mdessentialsforchildhood.org

Our Mission

To develop a common agenda across multiple agencies and stakeholders to align activities, programs, policies and funding so that all Maryland children, youth and their families have safe, stable, nurturing relationships and environments.

Special Thanks

This report was produced through the generous support of:

No More Stolen Childhoods

Sondheim Nonprofit Leadership Program

July 2020

HIDDEN PREDATOR ACT (HB974)

Will Maryland protect its children or protect its predators?

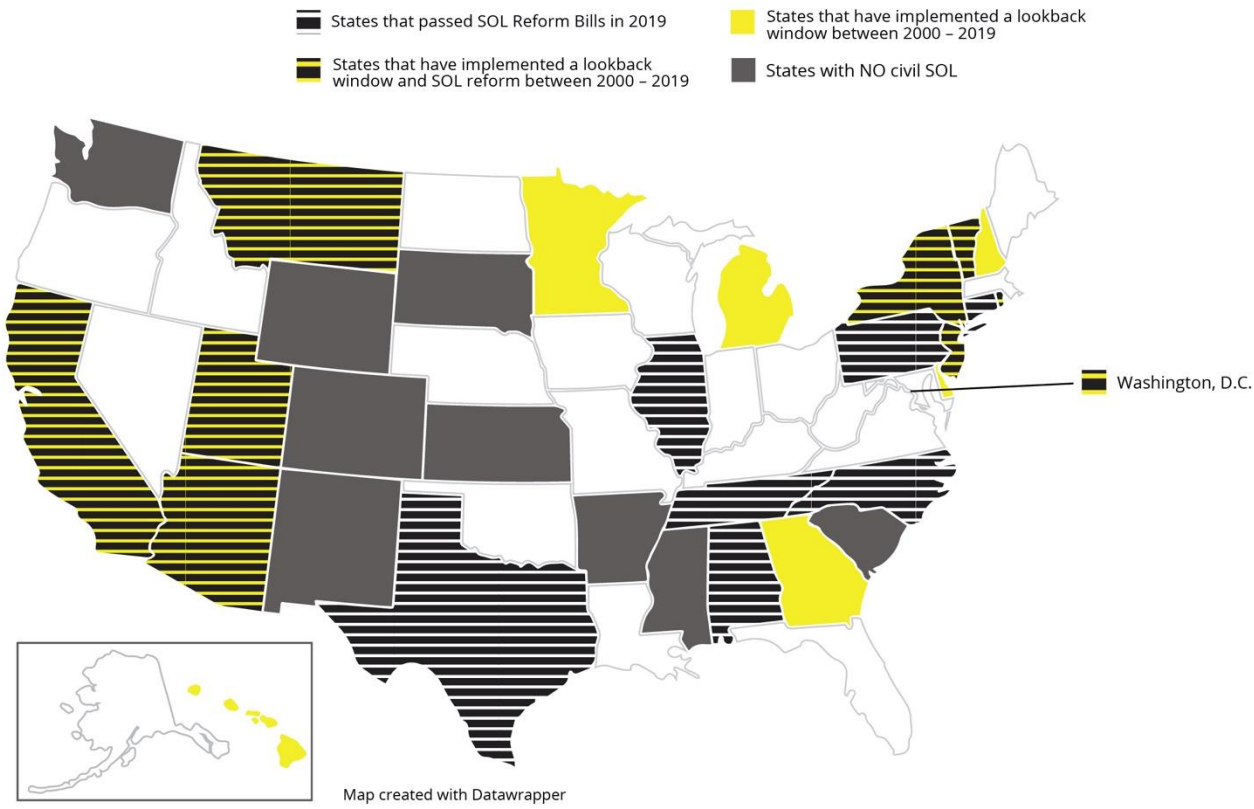
GOALS OF HIDDEN PREDATOR ACT (HB974)

- 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 (HB974) 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 (HB974)

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 (HB974) 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

SCCAN

MARYLAND essentials for childhood

No More Stolen Childhoods

APPENDIX E

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 discriminatio n*	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 question-naire, it	*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

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	*Incidence of feeling a sense of*	Do you agree or disagree that you feel close to people at your school? A. Strongly agree B. Agree

question is the same question that is already required for DASH-funded LEAs	*belonging at school*	C. Not sure D. Disagree E. Strongly disagree

APPENDIX F

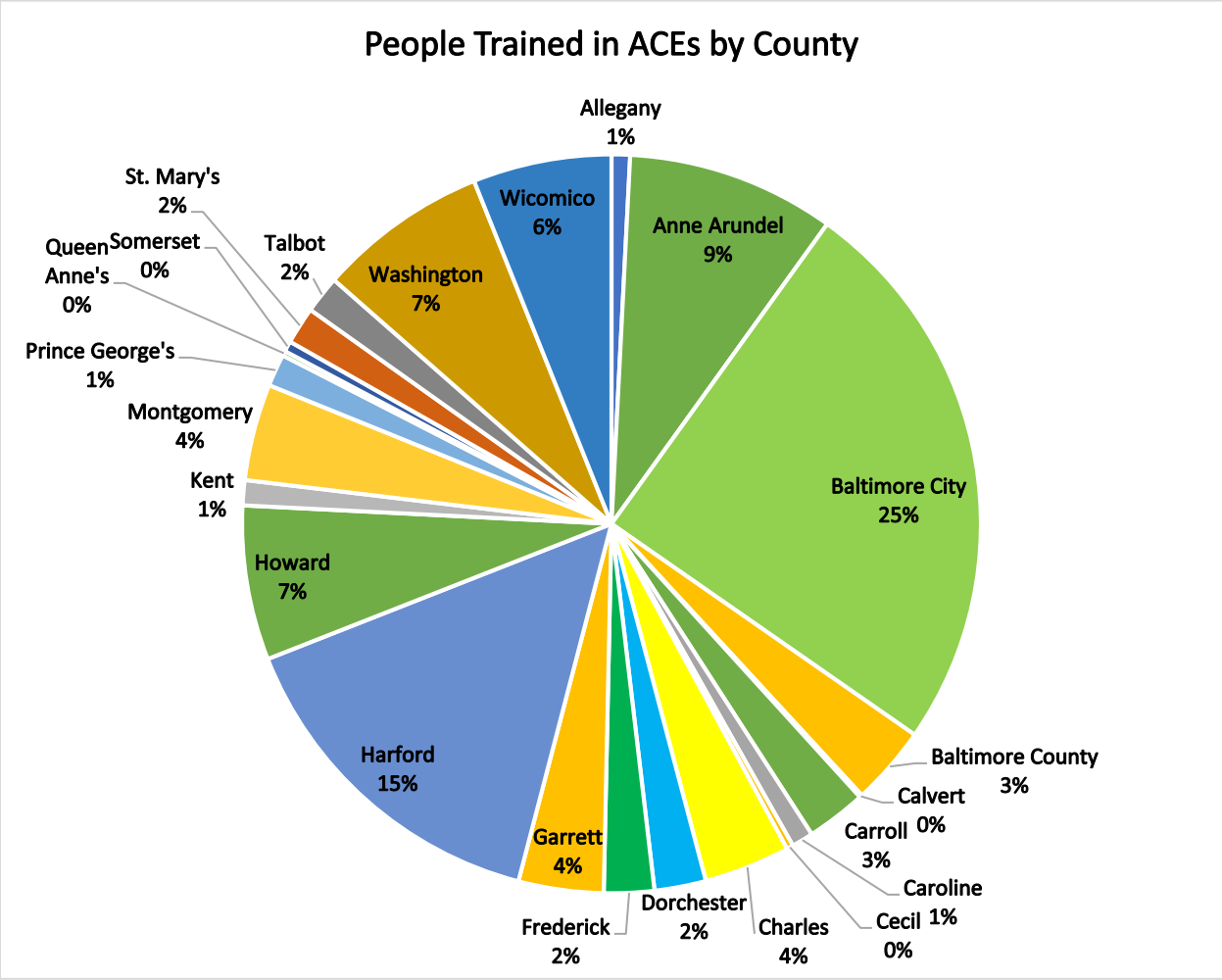
Select strategic ACE Interface Presentations January 2019-March 2020 included:

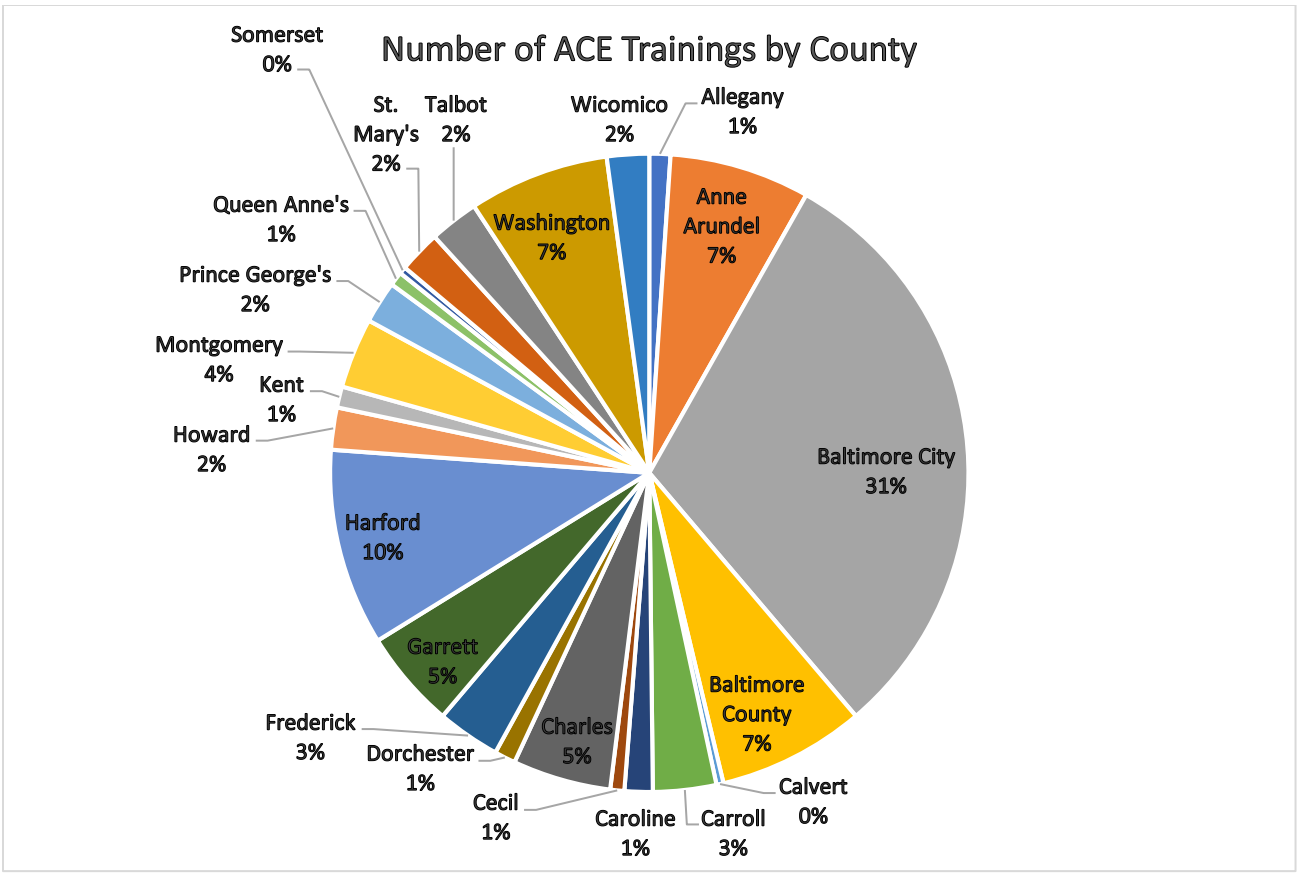
- MARYLAND GENERAL ASSEMBLY ACES ROUNDTABLE
- OPIOID OPERATIONAL COMMAND CENTER MEMBERS
- OPIOID OPERATIONAL COMMAND CENTER BEST PRACTICES CONFERENCE
- CANCER COUNCIL CONFERENCE
- MARYLAND STATE POLICE
- MARYLAND CHIEFS OF POLICE ASSOCIATION ANNUAL PROFESSIONAL DEVELOPMENT SEMINAR
- ENOCH PRATT LIBRARIES
- MARYLAND CASA CONFERENCE
- LOCAL DEPARTMENTS OF SOCIAL SERVICES: BALTIMORE COUNTY, CARROLL, GARRETT. MONTGOMERY, HOWARD, TALBOT
- CHILD WELFARE ACADEMY – UNIVERSITY OF MARYLAND, SSW: RESOURCE (FOSTER) PARENTS
- LOCAL HEALTH DEPARTMENTS: BALTIMORE CITY, FREDERICK, GARRETT, MONTGOMERY
- PUBLIC SCHOOLS: BALTIMORE CITY, HARFORD, MONTGOMERY, WICOMICO, MD ASSOCIATION OF PUPIL PERSONEL
- MIECHV CONFERENCE
- MOST NETWORK
- FAITH-BASED ORGANIZATIONS: CATHOLIC CHARITIES, EPISCOPAL, KINGDOM RESTORATION, METHODIST, OPEN CHURCH
- COLLEGE & UNIVERSITIES: UM, SSW, HOOD COLLEGE OF NURSING, SOUTHERN MD
- MARYLAND STATE ADVISORY COUNCIL ON HEALTH & WELLNESS
- MARYLAND STATE ADVISORY COUNCIL ON CANCER CONTROL

APPENDIX G

ACE Interface Training Locations by Maryland County

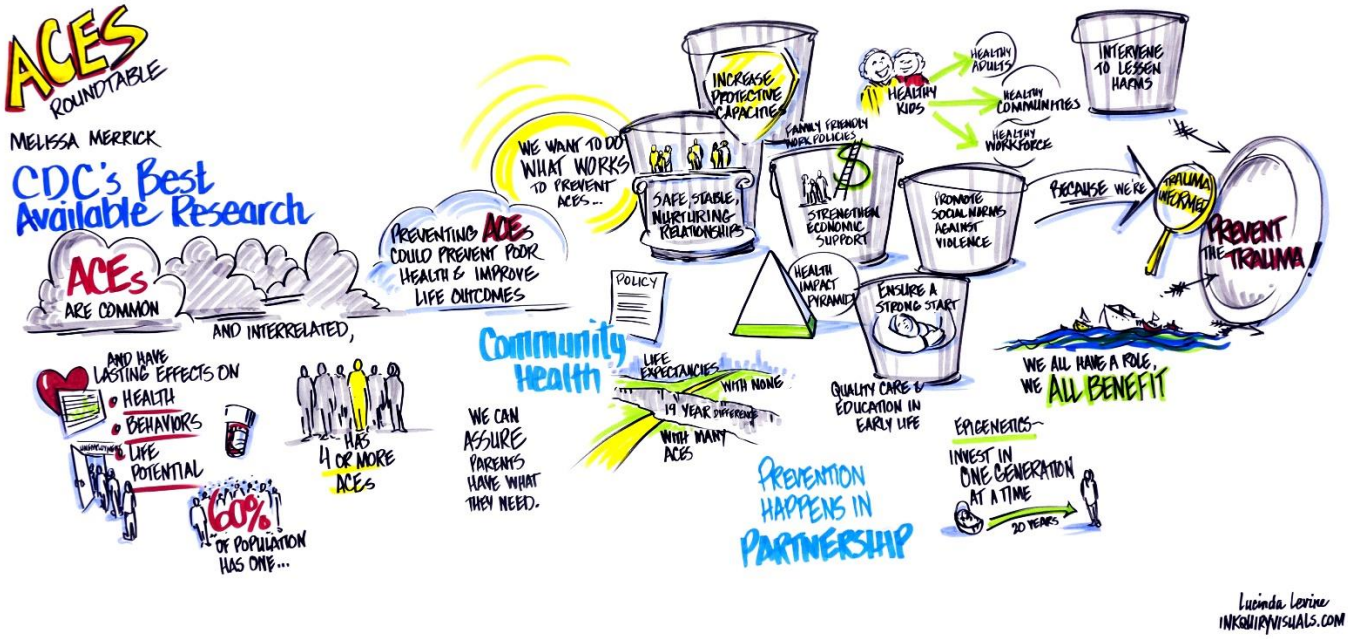
Between December 2017 and March 2020 ACE Interface Master Trainers have given 281 ACE Interface presentations to more than 8652 attendees across all of Maryland's 24 jurisdictions. The graphs below show the percentage of trainings by number of people trained and number of trainings per jurisdiction.

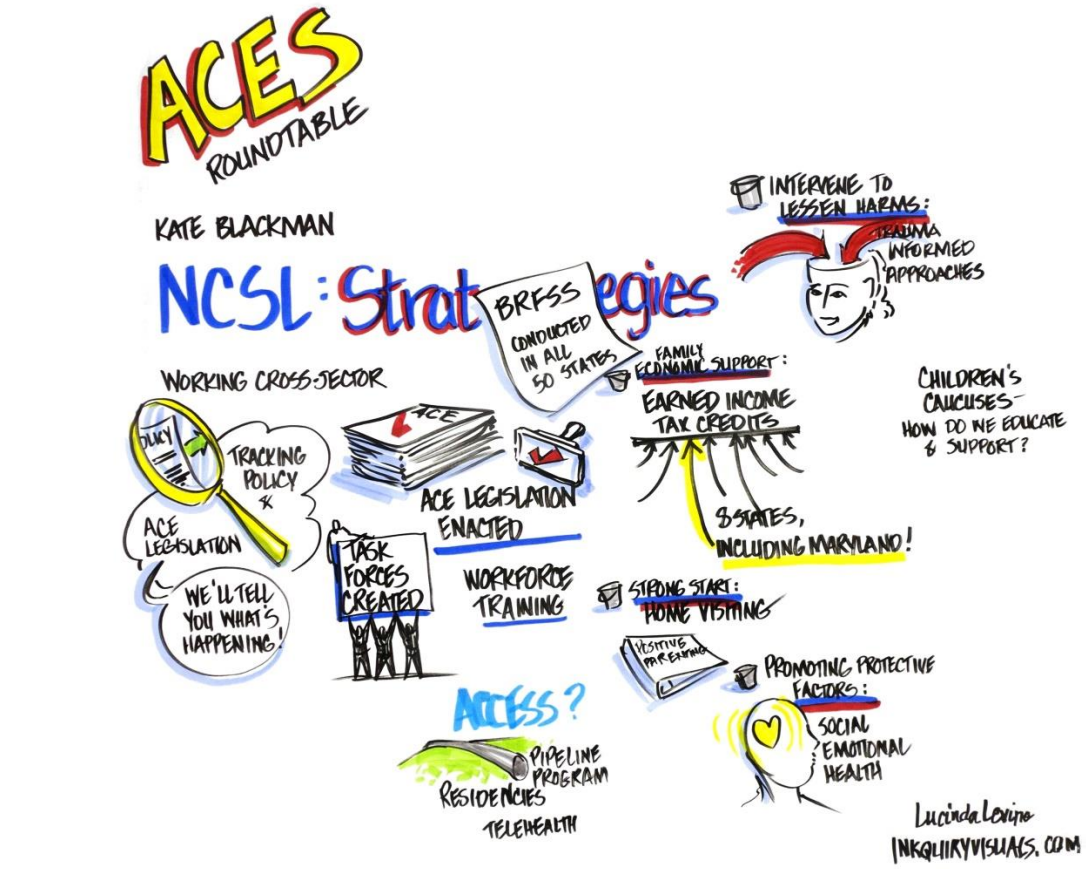


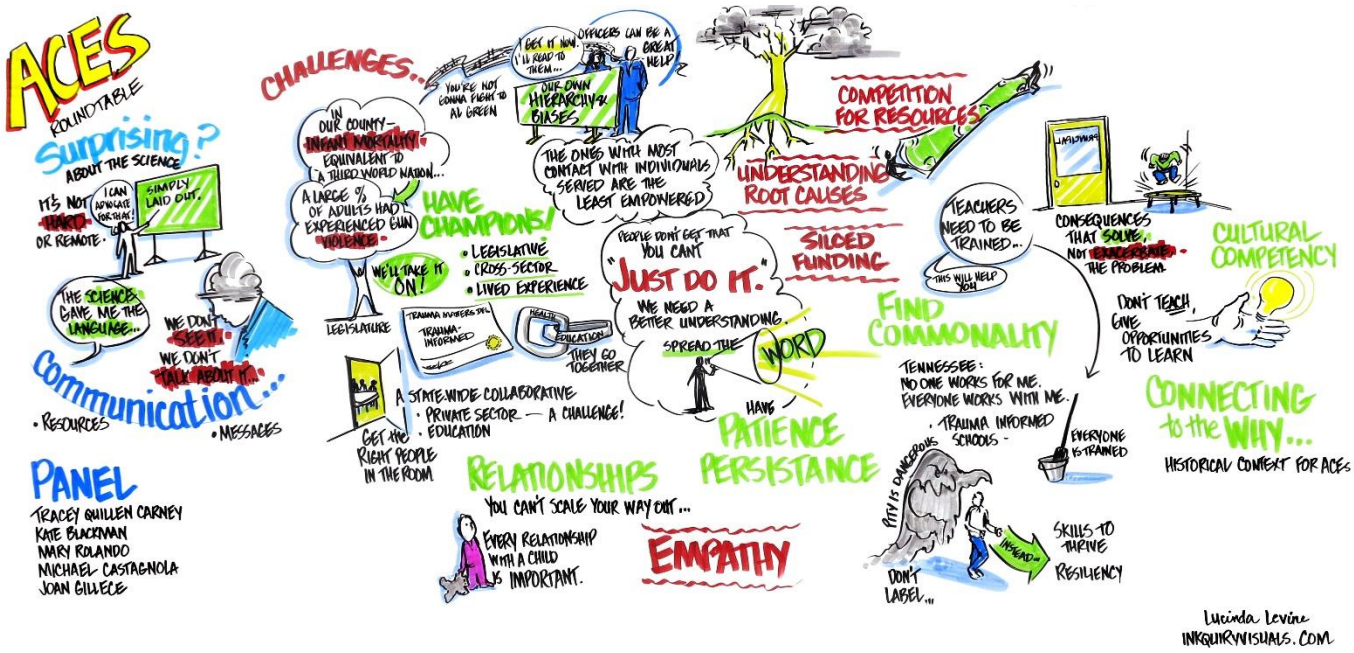

Number of ACE Trainings by County
Somerset 0%
St. Mary's 2%
Talbot 2%
Wicomico 2%
Allegany 1%
Queen Anne's 1%
Washington 7%
Anne Arundel 7%
Prince George's 2%
Montgomery 4%
Kent 1%
Howard 2%
Baltimore City 31%
Harford 10%
Garrett 5%
Baltimore County 7%
Frederick 3%
Dorchester 1%
Charles 5%
Calvert 0%
Cecil 1%
Caroline 1%
Carroll 3%

APPENDIX H

Maryland General Assembly ACEs Roundtable Graphic Recordings




ACES
ROUNDTABLE
KATE BLACKMAN
NCSL: Strategies
BRFSS
CONDUCTED IN ALL 50 STATES
INTERVENE TO LESSEN HARMS:
TRAUMA INFORMED APPROACHES
WORKING CROSS-SECTOR
POLICY
TRACKING POLICY
ACE LEGISLATION
WE'LL TELL YOU WHAT'S HAPPENING!
ACE
ACE LEGISLATION ENACTED
TASK FORCES CREATED
WORKFORCE TRAINING
FAMILY ECONOMIC SUPPORT:
EARNED INCOME TAX CREDITS
3 STATES, INCLUDING MARYLAND!
CHILDREN'S CALCULUS-
HOW DO WE EDUCATE & SUPPORT?
STRONG START:
HOME VISITING
POSITIVE PARENTING
PROMOTING PROTECTIVE FACTORS:
SOCIAL EMOTIONAL HEALTH
ACCESS?
PIPELINE PROGRAM
RESIDENCIES
TELEHEALTH
Lucinda Levine
INKQUIRYVISUALS.COM


ACES
ROUNDTABLE
Surprising?
ABOUT THE SCIENCE
IT'S NOT HARD OR REMOTE
I CAN ADVOCATE FOR THAT!
SIMPLY LAID OUT.
THE SCIENCE GAVE ME THE LANGUAGE...
WE DON'T SEE IT
WE DON'T TALK ABOUT IT...
Communication...
• RESOURCES
• MESSAGES
PANEL
TRACEY QUILLEN CARNEY
KATE BLACKMAN
MARY ROLANDO
MICHAEL CASTAGNOLA
JOAN GILLECE
CHALLENGES...
IN OUR COUNTY- INFANT MORTALITY EQUIVALENT TO A THIRD WORLD NATION...
A LARGE % OF ADULTS HAD EXPERIENCED GUN VIOLENCE
WE'LL TAKE IT ON!
LEGISLATURE
HAVE CHAMPIONS!
• LEGISLATIVE
• CROSS-SECTOR
• LIVED EXPERIENCE
TRAUMA INFORMED
EDUCATION
THEY GO TOGETHER
A STATE-WIDE COLLABORATIVE
• PRIVATE SECTOR — A CHALLENGE!
• EDUCATION
GET THE RIGHT PEOPLE IN THE ROOM
BEST OF LUCK I'LL ROOT FOR THEM...
YOU'RE NOT GONNA FIGHT TO AL GREEN
OFFICERS CAN BE A GREAT HELP
OUR OWN HIERARCHY & BIASES
THE ONES WITH MOST CONTACT WITH INDIVIDUALS SERVED ARE THE LEAST EMPOWERED
COMPETITION FOR RESOURCES
UNDERSTANDING ROOT CAUSES
SILOED FUNDING
PEOPLE DON'T GET THAT YOU CAN'T "JUST DO IT."
WE NEED A BETTER UNDERSTANDING.
SPREAD THE WORD
HAVE PATIENCE PERSISTANCE
RELATIONSHIPS
YOU CAN'T SCALE YOUR WAY OUT...
EVERY RELATIONSHIP WITH A CHILD IS IMPORTANT.
EMPATHY
TEACHERS NEED TO BE TRAINED...
THIS WILL HELP YOU
CONSEQUENCES THAT SOLVE, NOT EXACERBATE THE PROBLEM
CULTURAL COMPETENCY
DON'T TEACH, GIVE OPPORTUNITIES TO LEARN
FIND COMMONALITY
TENNESSEE: NO ONE WORKS FOR ME. EVERYONE WORKS WITH ME.
• TRAUMA INFORMED SCHOOLS -
EVERYONE IS TRAINED
CONNECTING to the WHY...
HISTORICAL CONTEXT FOR ACES
PAIN IS DANGEROUS
DON'T LABEL...
INSTEAD...
SKILLS TO THRIVE
RESILIENCY
Lucinda Levine
INKQUIRYVISUALS.COM

APPENDIX I

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 J

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

APPENDIX K

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
Faith Cantor	Rabbi, Beth El Congregation, Pikesville, Maryland	Baltimore County	faith@bethelbalto.com	8101 Park Heights Ave., Pikesville, MD 21208
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
Darlene Hobson	Reverend Personal Experience	Baltimore City	mightywomenofgod@aol.com	Refreshing Spring Worship Center 6709 Holabird Avenue, Baltimore, MD 21222
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 Ramsey	Deputy Director, Family Support/HR Officer, Maryland Family Network (Maryland's CBCAP lead agency)	Baltimore City	lramsey@marylandfamilynetwork.org	Maryland Family Network 1001 Eastern Avenue, Second Floor Baltimore, MD 21202-4325
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
Hillary Hollander	The Body Image Therapy Center	Baltimore County	hillaryshankman@gmail.com	8514 Countrybrooke Way, Lutherville, MD 21093
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
VACANT	Representative of the Judicial Branch appointed by the Chief Judge of the Maryland Court of Appeals		
John McGinnis	Pupil Personnel Specialist, Maryland Department of Education	john.mcginnis@maryland.gov	Pupil Personnel Specialist Maryland Department of Education200 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

May 12, 2021

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 Services Administration (DHS/SSA) appreciates the advocacy that the members of Maryland's State Council on Child Abuse and Neglect (SCCAN) provide to Maryland throughout the year in an effort to improve the outcomes and well-being for Maryland's children and families, and the work that has gone into the annual report including recommendations to DHS/SSA. Just as SCCAN looks to make system changes and improvements to the health, safety, and well-being of Maryland's children, DHS/SSA is on a parallel path to transform our child welfare system in partnership with public and private agencies, courts, and community partners, so that the children, youth, and families we serve and support 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
5. Partnered with safe, engaged, and well-prepared professionals that effectively collaborate with individuals and families to achieve positive and lasting results.

In order to meet the goals that will lead to a transformation of Maryland's child welfare system, DHS/SSA has been involved in the following activities which are in alignment with many of the recommendations outlined in the annual report.

Family First implementation
Over the past year, Maryland DHS/SSA has added the Family First Implementation Team to assist in the implementation of the Family First Prevention Services Act (FFPSA) in Maryland. The Family First Team consists of members from other state agencies, Local Departments of Social Services (LDSS), technical assistance (TA) partners, and families with lived experience. Within the larger Family First Team, focused workgroups have been created to ensure engagement on specific aspects of FFPSA such as Continuous Quality Improvement (CQI). With the support of this Team, DHS/SSA continues to focus on prevention and connecting eligible families to prevention programs that meet the evidence level required by FFPSA and best align with the needs of children identified as at imminent risk of entering foster care or pregnant and parenting young people and their families. Services are provided in a trauma-informed framework, while leveraging skilled community-based service providers, and are currently implemented in multiple Maryland jurisdictions.

Trauma, resiliency, and brain science
SSA works closely with the University of Maryland School of Social Work Child Welfare Academy (CWA) around providing timely and relevant training to all child welfare staff and resource parents. Over the past several years, pre-service training for new staff and in-service training for current staff around trauma, resiliency and brain science has been offered. Similar training is also provided to resource parents with a focus on parenting a child who is affected by trauma experiences. Efforts continue to be made to utilize data and assessments to better understand Adverse Childhood Experiences (ACEs). Staff complete assessments for youth and families utilizing two assessment tools: The Child and Adolescent Needs and Strengths (CANS) assessment and the Child and Adolescent Needs and Strengths-Family version (CANS-F) assessment. Within the past year, the State has piloted a redesigned version of the training around the two assessments that focuses on increasing the core practices of teaming, assessing, and planning.

DHS/SSA's strategic plan for a trauma-responsive child welfare system is being implemented by SSA's Integrated Practice Implementation Team. This team is made up of SSA and LDSS representatives and various community stakeholders. The strategies that have been identified are:

- Organize existing trauma-informed efforts (practices and procedures);
- Define, train, and translate core competencies of trauma-informed practice;
- Conduct a trauma-informed and race equity review of each SSA policy;
- Develop youth and family peer support networks for child welfare involved families;
- Establish a statewide learning collaborative for providing trauma-informed care;
- Ensure that evidence-based practices are trauma-informed or trauma-adapted;
- Create a standing child welfare trauma-informed service committee.

While SSA acknowledges Maryland's child welfare system has not yet established a completely trauma-responsive system, we recognize the importance of such a system and have a strategy in place for the families and youth we serve and for our workforce and resource parents.

Increasing collaboration with families and systems
SSA has continued to promote and improve its Integrated Practice Model (IPM) to serve as the foundation for how Maryland’s child welfare system works with families and partners. During SSA's federal Program Improvement Plan (PIP) convening, SSA and LDSS representatives were able to gain the insights of system stakeholders (judges, advocates, resource parents, parents, and youth) and make meaningful use of data regarding the current state of Maryland's child welfare system to ensure that the Integrated Practice Model is implemented successfully.

Over the past year, DHS/SSA has worked collaboratively with families, workers, and supervisors to develop and implement an IPM training for the workforce. Training provides information on key behavioral components or activities of each core practice and is tailored to the various child welfare service programs.

The core values of Maryland's child welfare system that are reinforced by the IPM include:

- Collaborating with children, youth and families and their community partners to ensure the safety and well-being of children, youth and families while helping them better understand and address their adverse experiences and challenges;
- Advocating for services and supports that are evidence-based, informed and designed to help children, youth, and families achieve their goals;
- Respecting each individual's unique experiences; and
- Empowering professionals and youth and families served by building and strengthening their resiliency, self-sufficiency, stability, and lasting connections.

Maryland has also continued its partnership with the Maryland Coalition of Families which helps to support and ensure family involvement. Having access to lived experience from parent, caregiver and youth voice has been an invaluable addition to enhancing connections, supporting, and empowering families and youth involved with Maryland's child welfare system.

Additionally, work has been done to ensure that systems operate in a more collaborative fashion, not only with families but with other systems who intersect with the child welfare system. To ensure collaboration with the court and legal system, several Implementation Teams have added representatives from these systems. For example, the CPS/Family Preservation Implementation Team added representatives from the legal system last year to allow for dialogue around prevention efforts and review of child welfare data.

Data sharing and reporting

As SCCAN is aware, 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). During this work, SSA leveraged opportunities to improve data gathering and report output that was previously limited in SSA's prior automated system. 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.

Workforce development efforts

To better equip the DHS/SSA workforce, SSA's Workforce Development (WFD) network was instrumental in redesigning pre-service training for new staff. The WFD network includes a wide variety of stakeholders and technical assistance partners who support the needs of DHS staff across the State. In addition to the redesign of pre-service training, the network incorporated evaluative feedback from LDSS supervisors and staff. Transfer of learning activities have also been an area of emphasis to ensure practical use of training information. These efforts are anticipated to not only improve retention and worker satisfaction, but to also improve outcomes for families, youth and children.

These are among the numerous initiatives that SSA has undertaken, as we strive to improve the well-being and outcomes of children who are impacted by Maryland's child welfare system. As always, SSA invites and greatly appreciates members of SCCAN participation on any of our various Implementation Teams or cross-cutting networks as partners in our work.

Sincerely,

Michelle L. Farr, LCSW-C, LICSW
Executive Director
Social Services Administration

Citizens Review Board For Children

CRBC
Citizens Review Board for Children

MARYLAND

ANNUAL REPORT

FISCAL 2020

(July 1st 2019 - June 30th 2020)

Table of Contents

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 Resources (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.

The local Boards meet at the local department of social services in each jurisdiction to conduct reviews of children in Out-of-Home Placement. Individual recommendations regarding permanency, placement, safety and well being are sent to the local juvenile courts, the local department of social services and interested parties involved with the child's care.

This CRBC FY2020 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 Fiscal 2020 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. This makes it even more imperative to ensure that efforts to support and provide services are trauma informed.

During fiscal year 2020, the Citizens Review Board for Children reviewed 871* cases of children and youth in Out-of-Home Placements. 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. This report includes Out-of-Home Placement review findings and CRBC activities including legislative advocacy and recommendations for system improvement.

Health and Education Findings for statewide reviews include:

CRBC conducted on site reviews at local department of social services statewide. Reviews included face to face 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 370 (42%) of the 871 total cases reviewed, the health needs of the children/youth had been met.
- Approximately 396 (45%) of the children/youths were prescribed medication.
- Approximately 323 (37%) of the children/youths were prescribed psychotropic medication.
- The local boards found that there were completed medical records for 360 (41%) of the total cases reviewed.
- The local boards agreed that 599 (69%) of the children/youth were being appropriately prepared to meet educational goals.

Demographic findings for statewide reviews include:

- 521 (60%) of the children/youth were African American.
- 266 (31%) of the children/youth were Caucasian.
- 427 (49%) of the children/youth were male.
- 444 (51%) of the children/youth were female.

CRBC conducted 335 Reunification reviews. Findings include:

- 34 cases (10%) had a plan of reunification for 3 or more years.
- The local boards agreed with the placement plan for 316 (94%) of the cases reviewed.

* Due to the COVID-19 pandemic and the Governor of Maryland issuing a mandatory teleworking order effective March 13th 2020, some case reviews scheduled for March 2020 and all of the case reviews scheduled the fourth quarter were not held.

- The local boards found that the local departments made efforts to involve the family in case planning for 213 (64%) of the cases reviewed.
- The local boards found that service agreements were signed for 151 (45%) of the eligible cases.
- The local boards agreed that 148 (98%) of the 151 signed service agreements were appropriate to meet the needs of the child.

CRBC conducted 143 Adoption reviews. Findings include:

- 18 (13%) of the 143 cases had a plan of adoption for 3 or more years.
- The local boards agreed with the placement plan for 141 (99%) 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 293 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 youth with a permanency planning goal of APPLA remain in care until their case is closed on their 21st birthday. Findings include:

- 55 (19%) of the 293 cases had a plan of APPLA for 3 or more years.
- The local boards agreed with the permanency plan of APPLA in 99% of the 293 cases statewide. 282 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 268 (91%) of the 293 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 connection was appropriate for 263 (90%) of the 293 cases.

Barriers/Issues

The local boards identified the following barriers to permanency/issues:

- No service agreement with parents
- Non-compliance with service agreement .
- No current safety or risk assessment

- Lack of concurrent planning
- Lack of follow-up (general)
- Child has behavior problems in the home
- Issues related to substance abuse
- Other physical health barrier
- Other placement barrier
- Other service resource barrier
- Other child/youth related barrier
- Youth placed outside of home jurisdiction
- Youth has not been assessed for mental health concerns
- Youth refuses mental health treatment including therapy
- 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 = 534 cases)

- 176 (33%) of the 534 youth reviewed were between 14-16 years old.
- 245 (46%) of the 534 youth reviewed were between 17-19 years old.
- 113 (21%) of the 534 youth reviewed were 20 years old.

Independent Living skills (534 cases)

- The local boards agreed that 324 (70%) of the 463 eligible youths were receiving appropriate services to prepare for independent living.

Employment (534 cases)

- The local boards found that 175 (33%) of the 534 eligible youths were employed or participating in paid or unpaid work experience.
- The local boards agreed that 235 (44%) of the 534 eligible youths were being appropriately prepared to meet employment goals.

Housing (113 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 59 (52%) of the 113 youths had a housing plan specified.
- The local boards agreed that 85 (75%) of the 113 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 116 cases had a concurrent permanency plan identified by the local juvenile courts.

- The local boards found that for 114 (98%) of the 116 cases with concurrent permanency plans the local department was implementing the concurrent plans identified by the local juvenile courts.

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.

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 and competitive compensation.

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 health needs being met and outcomes for children 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. Ensure that concurrent planning occurs 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. Increase 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 rather than as 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 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 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
(*)CRBC FY2018 Annual Report

Acknowledgements

CRBC would like to acknowledge the commitment, dedication, passion and service of all stakeholders on behalf of Maryland's most vulnerable children 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, conducting 871 on site case reviews and interviews, and 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)

★ The Local Juvenile Courts of Maryland

★ All Community Partners who strive to improve outcomes for children and youth involved with child welfare

Special Acknowledgements

CRBC would like to thank the following for their leadership, service, attention and efforts to promote safety and well-being for children and youth during Fiscal Year 2020:

★ Delegate CT Wilson for sponsoring bills during the legislative session that promote well-being and the prevention of maltreatment including the prevention of child sexual abuse.

★ Claudia Remington, SCCAN Executive Director for her advocacy regarding safety, well-being and prevention of child maltreatment, for promoting and supporting ACES education.

★ Wendy Lane, MD MPH for her advocacy and supporting recommendations for improvements in health care for children involved with the child welfare system.

★ Pat Cronin, Executive Director of The Family Tree, Board and Staff for providing ACES training and community education and for promoting safety, well-being, child protection and prevention of child maltreatment.

SSA Response to the CRBC FY2019 Annual Report

(Reprinted for inclusion in Annual Report)

MARYLAND DEPARTMENT OF HUMAN SERVICES

Larry Hogan, Governor | Boyd K. Rutherford, Lt. Governor | Lourdes R. Padilla, Secretary

June 1, 2020

Nettie Anderson-Burrs, Chairperson
Citizens Review Board for Children
1100 Eastern Avenue
Baltimore, Maryland 21221

Dear Ms. Anderson-Burrs:

The Maryland Department of Human Services (DHS) extends its appreciation for the work of the Citizens Review Board for Children (CRBC). The CRBC annual report provides information that is necessary for DHS/SSA to improve our services to Maryland's children and families. The feedback and observations found in the report, as well as the information received in meetings with the CRBC leadership, contribute a great deal to our Continuous Quality Improvement (CQI) efforts.

The CRBC recommendations to expand our service array, particularly for youth with intensive needs; as well as those around supporting the LDSS workforce, modernization efforts, and the needs around older youth transition planning, including housing and other independent living skills, are being considered within our implementation team structure. The fact that CRBC's recommendations are based on extensive case reviews is invaluable to the process of developing targeted strategies that are data-driven.

The Families First Prevention Services Act (FFPSA) provides additional opportunities for DHS/SSA to expand the use of evidence-based practices designed to increase prevention services and offer increased support to transitioning foster youth. DHS/SSA's Family First Prevention Plan was approved in February 2020 and we are working toward full implementation of the provisions included in the plan. In addition to the Prevention Plan, DHS/SSA is moving toward the implementation of Qualified Residential Treatment Providers (QRTP) as outlined in FFPSA.

During the development of our Child and Family Services Review (CFSR) Program Improvement Plan (PIP), DHS/SSA developed, in partnership with our stakeholders, the following cross-cutting thematic areas for investment:

- ***Authentic family and youth partnerships*.** Evidence points to the need for stronger engagement and partnership between the workforce and families. This is a critical aspect of practice and is foundational to the Integrated Practice Model currently being deployed across Maryland. DHS/SSA is also improving the accuracy of assessments of safety and family needs, increasing effective service provision, and focusing on the identification of potential relative resources.

- *Workforce development and skill building.* Maryland's workforce needs quality preparation and support throughout an intensely challenging job; therefore DHS/SSA is investing in deeper and more innovative workforce development strategies.

- *Authentic partnerships with stakeholders***.** Due to the diverse and interconnected array of needs that lead families to child welfare involvement, Maryland's staff and stakeholders surfaced the need to seamlessly engage with sister agencies and community-based service providers to collaboratively support and intervene with our families.

Two specific strategies that DHS/SSA is moving forward include the integration of a Safety Culture approach and the implementation of a model to support resource parents. The Safety Culture approach utilizes foundational habits and activities from safety science principles to promote psychological safety in the workplace and a culture of learning, create tests of change, and mitigate the impact of secondary trauma. In addition, DHS/SSA was awarded a federal Center for Excellence grant. Through this opportunity, DHS/SSA will implement a model program for the selection, development, and support of resource families that focuses on collaborating with birth families to preserve and nurture critical parent-child relationships, support reunification, and to provide resource parents and birth families with the stability and enhanced well-being supports needed by children transitioning from congregate care. DHS/SSA is also continuing our modernization efforts and will assist in supporting effective collaborations with a variety of public and private providers and agencies. The implementation of the Child, Juvenile, and Adult Management System (CJAMS) will allow DHS/SSA to better track services, ensure timeliness of key activities, and provide reminders to workers regarding necessary tasks and services.

To specifically address the needs of older youth, DHS/SSA and DJS are collaborating to implement the Crossover Youth Practice Model (CYPM) in Prince George's, Montgomery, Howard, Harford, Carroll, Allegany, Frederick, and Washington Counties. In 2020, Baltimore City and Baltimore County will begin their implementation. DHS/SSA and DDA collaborate prior to emancipation to ensure continuity of disability services and housing options for youth who require significant support to live independently.

DHS continues to utilize the Medical Director and Wellbeing unit to bridge services between DHS, the Maryland Health Department (MHD) and Maryland State Department of Education (MSDE). The Wellbeing unit oversees the quality and access to physical, educational, and wellbeing services and identifies gaps in such services and develops plans to fill those gaps.

DHS/SSA understands the recommendations for improving permanency outcomes for youth in foster care and increasing the support networks for children and families. DHS/SSA is addressing these areas through its implementation structure by developing policies and strategies that redefine the concept of family to be more inclusive of kinship resources, including fictive kin. In addition, our focus is to help older youth and resource parents understand that adoption is an achievable goal and partnering with families to develop supportive networks is a viable option to maintaining permanency.

We appreciate CRBC's careful review and recognize the barriers identified as issues that require our ongoing attention. We are committed to continuing to address these concerns and enhance our efforts to effectively serve the children and families within our system. We look forward to our ongoing partnership on behalf of children, youth, and families.

Sincerely,

Michelle L. Farr, LCSW-C, LICSW
Executive Director, Social Services Administration

311 W. Saratoga Street. Baltimore. MD 21201-3500 Tel: 1-800-332-63471TTY: 1-800-735-22581 www.dhs.maryland.gov

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). There are currently 155 volunteers serving on local boards, 1 pending appointment by the Governor and 3 applicants pending submission for appointment. CRBC reviews cases of children in Out-of-Home Placement, 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.

Retention, Recruitment and Training Activities

During FY2020, recruitment of local Out-of-Home Placement review board members remained a CRBC priority in order to ensure that reviews were conducted 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. In efforts to support the vision and mission of CRBC and reach the goals of the agency, the Volunteer Activities Coordinators working with the Recruitment, Retention and Training Committee strategized to recruit new members to serve across the state with Recruitment efforts focused on the areas of critical need including Baltimore City, Allegany, Garrett, Prince George's, St. Mary's, and Somerset counties. In addition passive recruitment efforts continued for those boards that were not yet full but were stable. In FY2020, 13 members were selected by a selection committee and appointed by the Governor to local out-of home placement review boards in jurisdictions where they reside.

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's priorities remained the safety and well being of Maryland's most vulnerable children and youth. CRBC facilitated virtual meetings with local department of social services administrators in Anne Arundel County on July 9, 2020, Baltimore City on May 5, 2020, Baltimore County on June 9, 2020, Charles and Prince George's Counties on June 8, 2020, Montgomery County on June 11, 2020 Wicomico County on June 17, 2020 and Worcester County on June 15, 2020.

CRBC advocated for resources and support for children and youth, child welfare staff, caregivers and providers and participated in virtual meetings with members of the Department of Human Services, Social Services Administration, child welfare advocates and stakeholders. Advocacy efforts included safety, well-being and preventive measures for child welfare staff, providers and caregivers, housing for aging out youth, extending care for aging out youth turning 21, COVID-19 guidance and access to information regarding COVID-19, and placement resources for youth with intensive needs.

CRBC also participated in virtual meetings with Department of Human Services and Social Services Administration staff to discuss CRBC health findings and concerns. Discussions included the lack of shared health information and documentation, and the potential impact on case management, planning, decision making, placement stability and permanency.

Denise Wheeler (CRBC Administrator) facilitated a virtual meeting with Michelle Farr (SSA Executive Director) to discuss CRBC conducting virtual out-of-home placement reviews and working collaboratively.

Promoting Well-Being and Prevention of Maltreatment

Pam Dorsey, Harford County Local Review Board Member and Denise E. Wheeler, Administrator continued to participate with Maryland's other CAPTA citizen panels, the State Council on Child Abuse and Neglect (SCCAN) and the State Child Fatality Review Team (SCFRT) on the Maryland Child Abuse & Neglect Fatalities (MCANF) Work Group. The purpose of the work group is to make recommendations to prevent future child abuse and neglect fatalities and near fatalities. Goals include:

- Reviewing child death cases in order to develop accurate cross-system aggregate data to understand causes (risk factors, substance abuse, domestic violence, mental illness, etc.) of child abuse and neglect fatalities.

Developing recommendations to improve policies, programs, practices and training within child and family serving agencies (health care providers, hospitals, WIC, Early Care and Learning, parental mental health and substance abuse services, law enforcement, CPS, schools, etc.) to prevent child abuse and neglect and related fatalities and near fatalities.

Community Activities

August 17, 2019 - Alpha Kappa Alpha Community Health Fair and School Supply Giveaway

CRBC is one of 20+ organizations and agencies that participated in this event in Easton, MD. This provided an opportunity to raise awareness of CRBC in the region and for recruitment of potential new members.

September 7, 2019 - The Family Tree FamFest

CRBC participated in this event and provided information and activities for children. The event takes place in Baltimore City annually and serves as an opportunity to support a community partner and families, to promote safety and well-being for children, youth and families in Baltimore City, to raise awareness of CRBC and to recruit new members.

October 30, 2019 - Prince George's County Information Session

CRBC collaborated with the Family Tree, Central Region to provide an information session to the community around child welfare issues and ways in which the community can be involved in advocating for children in Prince George's County. Prince George's County Local Department of Social Services also presented at this event.

November 6, 2019 – Adverse Childhood Experiences(ACES) Interface Training

The training was provided by The Family Tree to interested CRBC members. The focus of the training was being trauma informed and understanding ACES in relation to case reviews, assessments and recommendations.

Rhonda Watties, Volunteer Activities Coordinator attended and participated in several community meetings and events in Baltimore City to spread awareness of CRBC and to support CRBC's recruitment efforts and goals from January 2020 - February 2020 until in person recruitment was suspended. They included the following:

January 8, 2020 - Consent Decree Monitoring Team for Baltimore City Meeting

Attended a community meeting that included representatives from the Consent Decree Monitoring Team for the Baltimore City Police Department's Consent Decree. The team discussed progress regarding addressing public safety concerns and included discussion on and the affect on the health, well-being, and safety of children in the local community.

January 30, 2020

Attended the Youth Town Hall Mayoral Candidate Forum hosted by Heart Smiles at the Johns Hopkins Bloomberg School of Public Health. The youth facilitated and hosted the event. This was a mixed audience of varying age groups and differing interests. The purpose of attending was to promote awareness of CRBC and for opportunities to engage former foster youth as part of CRBC's efforts to advocate and support improved outcomes for older and aging out youth.

February 3, 2020

Attended the CADCA (Community Anti-Drug Coalition of America) to network with Maryland Drug Free Community Coalition members and stay current on topics affecting youth alcohol, substance, and drug use. This was the annual SAMHSA (Substance Abuse and Mental Health Services Administration) Prevention Day. Their mission is "to reduce the impact of substance abuse and mental illness on America's communities." Attended the Gen Z Marketing: Engaging the Next Generation and the School Mental Health and Safety: Policies and Best Practices sessions.

February 7, 2020 - February 9, 2020

Attended the weekend long Healing City Baltimore events. On Friday February 7, 2020, attended youth event at Morgan State University. On Sunday, February 9, attended the Bill signing ceremony for the Elijah Cummings Healing Act. Attending these events provided opportunities to promote awareness of CRBC, for recruitment and to support efforts to promote safety and wellness in Baltimore City communities.

February 11, 2020

Attended the Community Discussion on Human and Social Services sponsored by Leaders of a Beautiful Struggle which is a local Baltimore City community group. Presented a brief overview of CRBC to the group. This outreach resulted in the recruitment of a new member who was appointed to the CRBC board later in November 2020.

February 18, 2020

Attended the Community conversations with Baltimore City Schools CEO Sonja Santelises at the ACCE School and met the President of the PTA Council of Baltimore City. This resulted in an invitation to speak at the next meeting and to promote awareness of CRBC.

February 26, 2020

Presented at the PTA Council of Baltimore City. This outreach resulted in the recruitment of a new member who was appointed later in November 2020.

March 2020

Additional recruitment activities in early March included social media posting and information sharing. These resulted in the recruitment of two members who were both appointed later in November 2020.

CRBC 2020 Legislative Activities

The 2020 Legislative session ended abruptly due to the COVID-19 pandemic in March 2020.

During the 2020 session CRBC reviewed and weighed in on 38 pieces of legislation and supported 14 of them.

Some of the bills that CRBC supported included SB585-Family Law-Children in Out of Home Placement Concurrent Planning, SB 0452-Family Investment Program Temporary Cash Assistance Funding, HB974 The Hidden Predator Act. These bills promoted safety, well-being and prevention of ACES.

CRBC advocated with child welfare advocates, stakeholders and legislative representatives for extending the moratorium on extending foster care placements for aging out youth turning 21 during fiscal year 2020.

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.

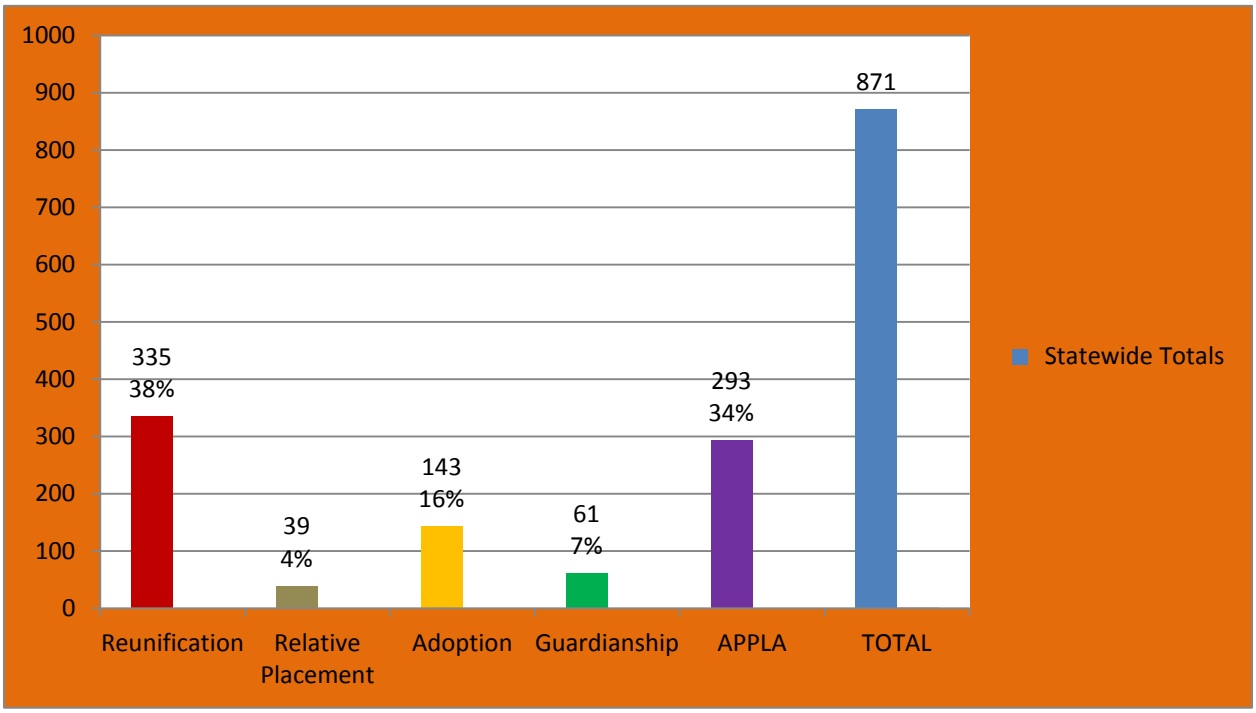
Older Youth Aging Out

- 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 Review Findings Percentages by Permanency Plan



Gender Totals (871)

Male	Female
427 (49%)	444 (51%)

Male

Reunification	Relative Placement(*)	Adoption	Guardianship	APPLA
170 (51%)	20 (51%)	80 (56%)	33 (54%)	124 (42%)

Female

Reunification	Relative Placement(*)	Adoption	Guardianship	APPLA
165 (49%)	19 (49%)	63 (44%)	28 (46%)	169 (58%)

*(Note: Relative Placement is the combined total of Relative Placement for Adoption (10) and Relative Placement for Custody/Guardianship (29))

Ethnicity Overall (871)

African American	Caucasian	Asian	Other
521 (60%)	266 (31%)	9 (1%)	75 (9%)

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	41	6	4	70	8	0	129
age 6 thru 10	48	3	3	32	8	0	94
age 11 thru 13	77	0	7	20	13	0	117
age 14 thru 16	113	1	11	16	24	11	176
age 17 thru 19	52	0	4	4	8	177	245
age 20	4	0	0	1	0	105	110
Totals	335	10	29	143	61	293	871

CRBC Case Reviews by Jurisdiction

Jurn #	County	Reunification	Relative Placement	Adoption	Custody Guardianship	APPLA	TOTAL
01	Allegany	2	1	3	0	1	7
02	Anne Arundel	13	0	11	2	22	48
03	Baltimore County	56	1	15	5	45	122
04	Calvert	2	1	4	3	6	16
05	Caroline	5	0	3	0	0	8
06	Carroll	4	0	0	0	2	6
07	Cecil	11	2	10	1	5	29
08	Charles	5	0	2	8	9	24
09	Dorchester	0	0	1	1	9	11
10	Frederick	5	1	6	3	5	20
11	Garrett	0	0	0	0	0	0
12	Harford	23	0	14	2	17	56
13	Howard	9	0	1	0	6	16
14	Kent	1	0	1	0	2	4
15	Montgomery	45	12	23	6	27	113
16	Prince Georges	36	3	14	4	24	81
17	Queen Anne	2	0	0	0	2	4
18	Saint Mary's	6	2	1	2	0	11
19	Somerset	1	0	1	0	1	3
20	Talbot	0	0	0	0	0	0
21	Washington	12	0	5	1	6	24
22	Wicomico	3	0	2	0	1	6
23	Worcester	0	1	4	1	2	8
49	Baltimore City	94	15	22	22	101	254
24	Statewide Totals	335	39*	143	61	293	871**
24	Percentages	38%	4%	16%	7%	34%	100%

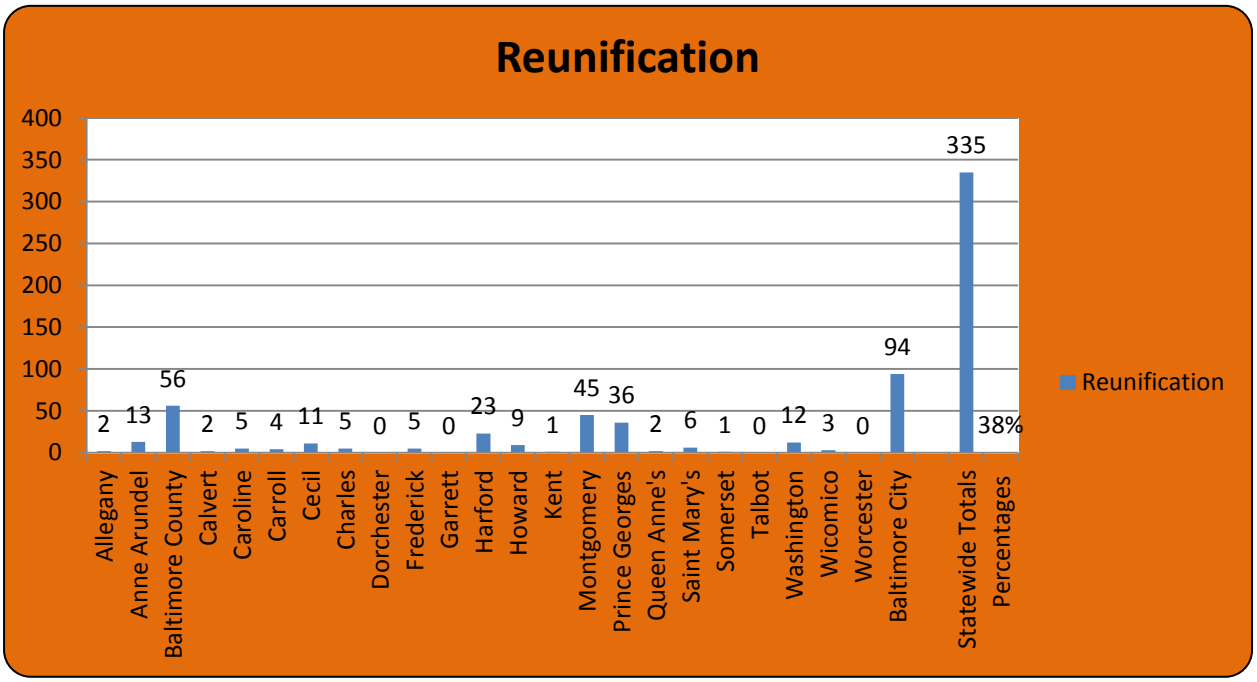
* Relative Placement is the combined total of Relative Placement for Adoption = 10 and Relative Placement for Custody/Guardianship = 29

CRBC conducted a total of 871 individual out-of-home case reviews (each case reviewed represents 1 child/youth) in 22 Jurisdictions on 123 boards that held reviews during fiscal year 2020.

** Due to the COVID-19 pandemic and the Governor of Maryland issuing a mandatory teleworking order effective March 13th 2020, some case reviews scheduled for March 2020 and all of the case reviews scheduled the fourth quarter were not held.

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	129	41	32%
Age 6 thru 10	94	48	51%
Age 11 thru 13	117	77	66%
Age 14 thru 16	176	113	64%
Age 17 thru 19	245	52	21%
Age 20	110	4	4%
Total	871	335	38%

Permanency

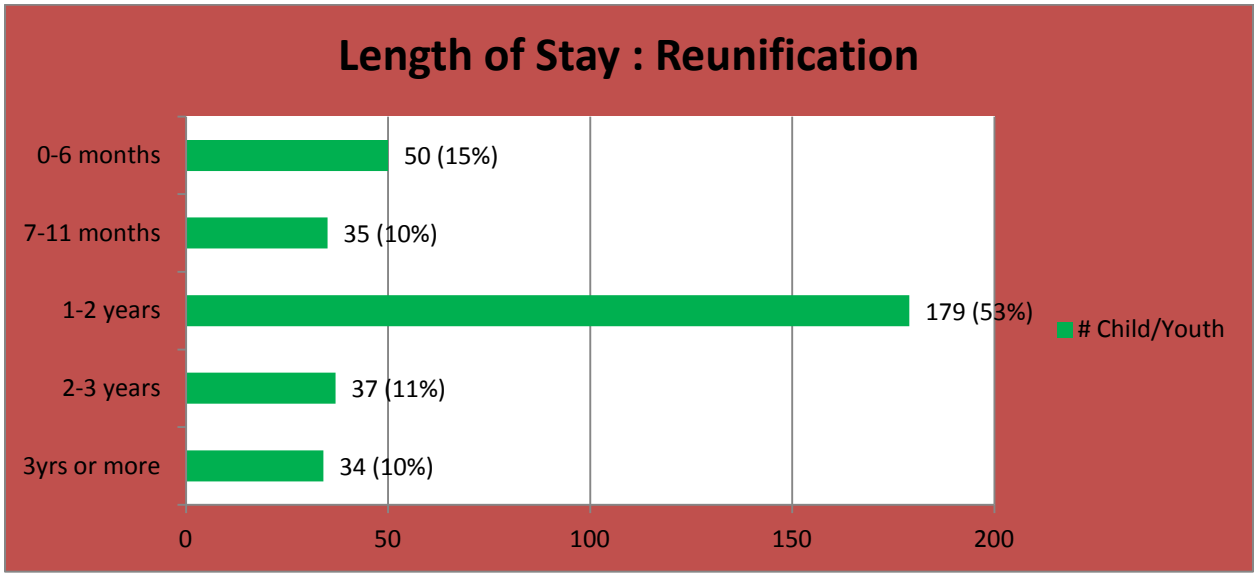
The local boards agreed with the permanency plan of reunification for 227 (68%) of the 335 cases reviewed.

The local juvenile courts identified concurrent permanency plans for 65 (20%) of the 335 cases reviewed.

The local departments were implementing the concurrent plans set by the local juvenile courts for 64 (99%) of the 65 cases.

Length of Time a Child/Youth had a plan of Reunification

Of the 335 Reunification cases reviewed the local boards found that the length of time the child/youth had 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 213 (64%) of the 335 cases reviewed.

Service Agreements: The local departments had signed service agreements for 151 (45%) of the 334 eligible cases and 1 case was a Post-TPR child under the age of 14. Efforts to involve the families in the service agreement process were made for 230 (69%) of the 334 cases.

The local boards agreed that the service agreements were appropriate for 148 (98%) of the 151 signed cases.

Placement/Living Arrangement (LA)

Number of Cases	Placement/ Living Arrangement (LA)
40	Formal Kinship Care
2	Intermediate Foster Care
30	Regular Foster Care
16	Restricted (Relative) Foster Care
38	Treatment Foster Care
71	Treatment Foster Care (Private)
20	Residential Group Home
26	Therapeutic Group Home
3	Independent Living Residential Program
34	Residential Treatment Center
3	Own Dwelling
5	Psychiatric Respite
12	Diagnostic Center
1	College (LA)
5	Inpatient Psychiatric Care (LA)
12	Inpatient Medical Care (LA)
7	Runaway (LA)
2	Secure Detention Facility (LA)
24	Trial Home Visit (LA)
1	Unapproved Living Arrangement (LA)

In 160 (48%) of the 335 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 316 (94%) of the 335 cases reviewed.

Placement Stability

The local boards found that in 162 (48%) of the cases reviewed there were changes in placement within the 12 months prior to the review. 49 (30%) of the 162 cases had 1 placement change, 61 (38%) had 2 placement changes, 24 (15%) had 3 placement changes and 28 (17%) had 4 or more placement changes.

A family involvement meeting took place with the most recent placement changes for 75 (46%) of the 162 cases.

The following levels of care were found for the 162 most recent placement changes:

- 50 (31%) were in less restrictive placements
- 49 (30%) were in more restrictive placements
- 56 (35%) had the same level of care
- 6 (4%) child on runaway
- 1 (0.6%) unknown, information not available

The local boards found that the primary positive reasons for the 162 most recent placement changes were:

- Transition towards a permanency goal: 53 cases
- Placement with relatives: 5 cases

Provider specific issues for the most recent placement changes were:

- Provider home closed: 1 case
- Provider requests: 11 cases
- Allegation of provider abuse/neglect: 4 cases
- Founded incident of provider abuse/neglect: 2 cases
- Incompatible match: 9 cases

Child/youth specific issues for the most recent placement changes were:

- Behavioral: 58 cases
- Threats of harm to self/others: 2 cases
- Delinquent behavior: 3 cases
- Runaway: 6 cases
- Hospitalization: 3 cases

While child/youth was in the placement from which they were removed, were placement specific services adequate to support the provider:

a) Yes, for 155 cases

For the current placement, is there a match between the child/youth's needs and the provider's ability to meet those needs?

a) Yes, for 153 cases

<u>Health/Mental Health</u>

- Developmental/Special Needs: The local departments reported that 83 (25%) of the 335 children/youths reviewed had developmental or special needs.

- Current Physical: 240 (72%) children/youths had a current physical exam.

- Current Vision: 193 (58%) children/youths had a current vision exam.
- Current Dental: 200 (60%) 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 52 (72%) of 72 children/youths.
- Completed Medical Records: The local departments reported that 139 (42%) children/youths had completed medical records in their case files.
- Prescription Medication: 190 (57%) children/youths were taking prescription medication.
- Prescription Medication Monitored: Prescription medication was being monitored regularly for all 190 (100%) children/youths.
- Psychotropic Medication: 166 (50%) children/youths were taking psychotropic medication.
- Psychotropic Medication Monitored: Psychotropic medication was being monitored at least quarterly for all 166 (100%) children/youths.
- Mental Health Issues: 260 (78%) children/youths had mental health issues.
- Mental Health Diagnosis: 256 (76%) children/youths had a mental health diagnosis.
- Mental Health Issues Addressed: Yes, for 237 (91%) of the 260 children/youths.
- Mental Health Issues/Transitioning/Services: 4 of the 260 youths with mental health issues who were transitioning out of care, had an identified plan to receive services in the adult mental health system.
- Substance Abuse: 48 (14%) children/youths had a substance abuse problem.
- Substance Abuse Addressed: Yes for 21 (44%) of the 48 children/youths.
- Behavioral Issues: 208 (62%) children/youths had behavioral issues.
- Behavioral Issues Addressed: Yes, for 193 (93%) of the 208 children/youths.

The local boards found that the health needs of 137 (41%) of the 335 children/youths had been met and 14 children/youths refused to comply with standard health exams.

Education

291 (87%) of the 335 children/youths reviewed were enrolled in school or another educational/vocational program. 288 of the 291 children/youths were in Pre-K thru 12th grade. 1 of the 291 was in college and 2 were enrolled in a GED program. 3 of the 44 children/youths not

enrolled in school or another educational/vocational program had already graduated high school, 12 refused to attend school and 29 were under the age of 5.

156 (54%) of the 291 children/youths enrolled in school or another educational/vocational program had a 504 or IEP plan. 112 (72%) of the 156 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 154 (53%) of the 291 children/youths enrolled in school or another educational/vocational program.

The local boards agreed that 273 (94%) of the 291 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 – 172 cases)

  23 (13%) of the 172 youths were employed or participating in paid or unpaid work experience. 2 youths were unable to work due to being medically fragile, 28 were unable to work due to mental health issues and 1 was in a correctional facility.

  The local boards agreed that the youths were being appropriately prepared to meet employment goals.

- Independent Living Services (age 14 and older – 172 cases)

  The local boards agreed that 69 (40%) of the 172 youths were receiving appropriate services to prepare for independent living.

  2 youths were unable to participate due to being medically fragile, 28 due to mental health issues and 1 due to being in a correctional facility.

- Housing (Transitioning Youth – 4 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 2 of the 4 youths transitioning out of care. Alternative housing options were also provided for 2 youths.

  The local boards agreed that 2 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 314 (94%) of the 335 children/youths.

CASA (Court Appointed Special Advocate)

The local boards found that for 89 (27%) of the 335 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	213	111
No	122	224

Frequency of Visits	With Parents	With Relatives
Daily	3	9
Once a week	90	40
More than once a week	22	6
Once a month	24	16
More than once a month	44	16
Quarterly	11	5
Yes, but undocumented	19	19

Supervision of Visits	With Parents	With Relatives
Supervised	95	27
Unsupervised	118	84

Who Supervises Visits	With Parents	With Relatives
LDSS Agency Representative	63	18
Other Agency Representative	6	
Biological Family Member	8	4
Foster Parent	6	2
Other	13	3

Where do Visits Occur ?	With Parents	With Relatives
Parent/Relative Home	56	60
LDSS Visitation Center	21	2
Public Area	47	12
Child's/Youth's Placement	62	20
Other	27	17

Overnight Stays	With Parents	With Relatives
Yes	62	28

No	151	83

The local boards found that 174 (52%) of the 335 children/youths had siblings in care. 132 (76%) of the 174 children/youths had visits with siblings in care who did not reside with them.

Barriers/Issues

The local boards identified the following barriers to permanency/issues:

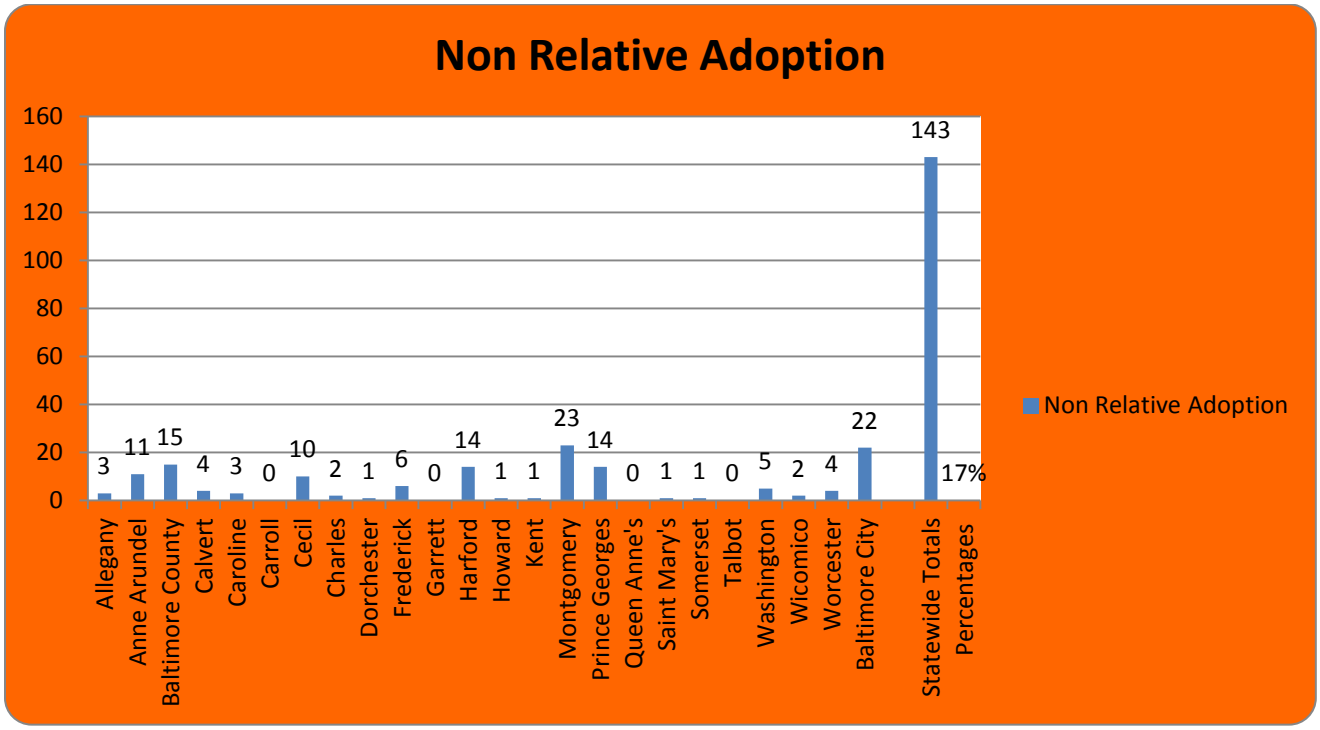
- No service agreement with parents.
- No service agreement with youth.
- Missing or lack of documentation.
- Annual physicals not current.
- Board does not agree with current permanency plan.
- Dentals not current.
- Vision not current.
- No current IEP.
- Other child/youth related barrier.
- Other 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 286 (85%) of the 335 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	129	70	49%
Age 6 thru 10	94	32	22%
Age 11 thru 13	117	20	14%
Age 14 thru 16	176	16	11%
Age 17 thru 19	245	4	3%
Age 20	110	1	< 1%
Total	871	143	16%

Permanency

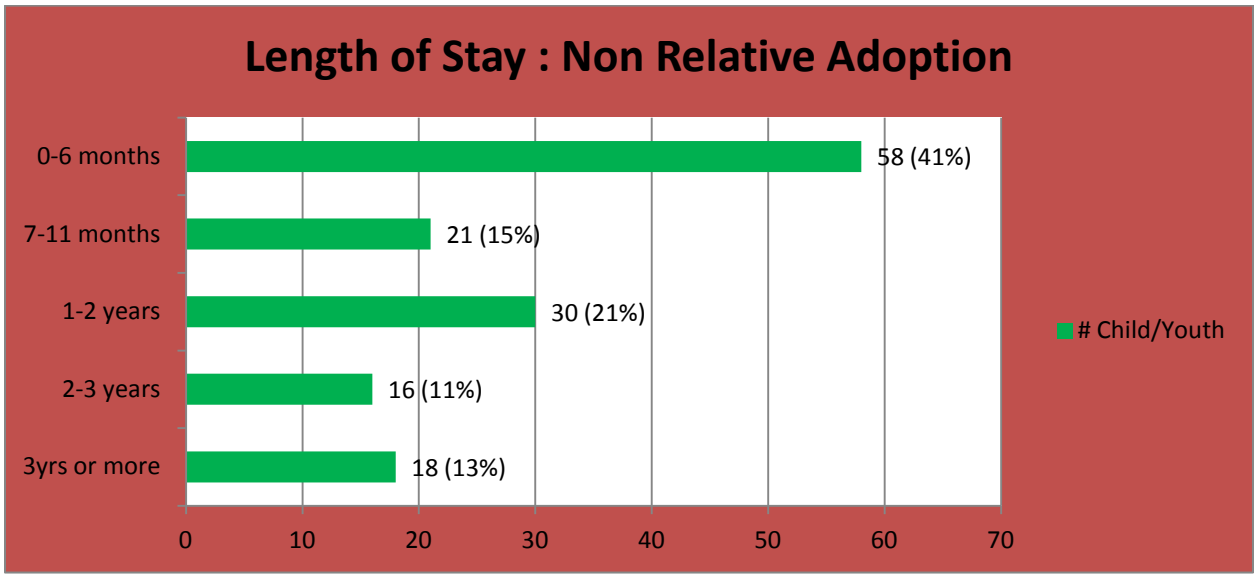
The local boards agreed with the permanency plan of Non Relative Adoption for 138 (97%) of the 143 cases reviewed.

The local juvenile courts identified concurrent permanency plans for 18 (13%) of the 143 cases reviewed.

The local departments were implementing the concurrent plans set by the local juvenile courts for all 18 cases.

Length of time Child/Youth had a plan of Adoption

Of the 143 Non Relative Adoption cases reviewed the local boards found that the length of time the child/youth had a plan of Adoption were as follows:



Case Planning/Service Agreements

Family Involvement Meetings (prior to entry): The local departments held family involvement meetings prior to entry for 102 (71%) of the 143 cases reviewed.

Service Agreements: The local departments had signed service agreements for 18 (21%) of the 84 eligible cases and 59 cases were Post-TPR children under the age of 14. Efforts to involve the families in the service agreement process were made for 44 (52%) of the 84 cases.

The local boards agreed that the service agreements were appropriate for all 18 signed cases.

Placement/Living Arrangement (LA)

Number of Cases	Placement/Living Arrangement (LA)
2	Formal Kinship Care
94	Pre-Finalized Adoptive Home
17	Regular Foster Care
4	Treatment Foster Care
16	Treatment Foster Care (Private)
3	Residential Group Home
5	Therapeutic Group Home
2	Residential Treatment Center

In 103 (72%) of the 143 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 141 (99%) of the 143 cases reviewed.

Placement Stability

The local boards found that in 27 (19%) of the 143 cases reviewed there was a change in placement within the 12 months prior to the review. 15 (56%) of the 27 cases had 1 placement change, 5 (19%) had 2 placement changes, 6 (22%) had 3 placement changes and 1 case had 4 or more placement changes.

A family involvement meeting took place with the most recent placement changes for 13 (48%) of the 27 cases.

The following levels of care were found for the 27 most recent placement changes:

- 4 (15%) were in less restrictive placements
- 5 (19%) were in more restrictive placements
- 17 (63%) had the same level of care
- 2 (7%) child/youth on runaway
- 1 was unknown, info not available

The local boards found that the primary positive reasons for the 27 most recent placement changes were:

- Transition towards a permanency goal: 7 cases
- Placement with relatives: 1 case

Provider specific issues for the most recent placement changes were:

- Provider home closed: 5 cases
- Allegation of provider abuse/neglect: 2 cases
- Founded incident of provider abuse/neglect: 1 case
- Incompatible match: 1 case

Child/youth specific issues for the most recent placement changes were:

- Behavioral: 9 cases
- Runaway: 2 cases

While child/youth was in the placement from which they were removed, were placement specific services adequate to support the provider:

b) Yes, for 26 cases

For the current placement, is there a match between the child/youth's needs and the provider's ability to meet those needs?

b) Yes, for 26 cases

Health/Mental Health

- Developmental/Special Needs: The local departments reported that 33 (23%) of the 143 children/youths reviewed had developmental or special needs.

- Current Physical: 129 (90%) children/youths had a current physical exam.

- Current Vision: 111 (78%) children/youths had a current vision exam.

- Current Dental: 101 (71%) 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 25 (83%) of 30 eligible children/youths.

- Completed Medical Records: The local departments reported that 84 (59%) children/youths had completed medical records in their case files.

- Prescription Medication: 48 (34%) children/youths were taking prescription medication.

- Prescription Medication Monitored: Prescription medication was being monitored regularly for 47 of the 48 children/youths.

- Psychotropic Medication: 34 (24%) children/youths were taking psychotropic medication.

- Psychotropic Medication Monitored: Psychotropic medication was being monitored at least quarterly for all 34 children/youths.
- Mental Health Issues: 68 (48%) children/youths had mental health issues.
- Mental Health Diagnosis: 64 (45%) children/youths had mental health diagnosis.
- Mental Health Issues Addressed: Yes, for 63 (93%) of the 68 children/youths.
- Mental Health Issues/Transitioning/Services: 1 of 2 youths with mental health issues who were transitioning out of care, had an identified plan to receive services in the adult mental health system.
- Substance Abuse: 4 (3%) children/youths had a substance abuse problem.
- Substance Abuse Addressed: Yes for 2 (50%) of the 4 children/youths.
- Behavioral Issues: 50 (35%) children/youths had behavioral issues.
- Behavioral Issues Addressed: Yes, for 49 (98%) of the 50 children/youths.
- The local boards found that the health needs of 88 (62%) of the 143 children/youths had been met and 2 children/youths refused to comply with standard health exams.

Education

85 (59%) of the 143 children/youths reviewed were enrolled in school or another educational/vocational program. All 85 children/youths were in Pre-K thru 12th grade. 2 of the 58 children/youths not enrolled in school or another educational/vocational program had already graduated high school, 2 refused to attend school and 54 were under the age of 5.

47 (55%) of the 85 children/youths enrolled in school or another educational/vocational program had a 504 or IEP plan. 41 (87%) of the 47 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 47 (55%) of the 85 children/youths enrolled in school or another educational/vocational program.

The local boards agreed that 83 (98%) of the 85 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 – 20 cases)

  4 (20%) of the 20 youths were employed or participating in paid or unpaid work experience.

1 youth was unable to participate due mental health issues.

The local boards agreed that the youths were being appropriately prepared to meet employment goals.

- Independent Living Services (age 14 and older – 20 cases)

The local boards agreed that 12 (60%) of the 20 youths were receiving appropriate services to prepare for independent living.

- Housing (Transitioning Youth – 1 case)
(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 the 1 youth transitioning out of care.

The local boards agreed that the youth was being appropriately prepared to transition out of care.

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 30 (21%) of the 143 children/youths consented to adoption and 93 (65%) children/youths were under the age of consent.

Consent to Adoption for Cases Reviewed with Adoption Plans

Child's Consent to Adoption	Cases
Yes	30
Yes, with conditions	2
Child did not want to be Adopted	7
N/A under age of consent	93
No, Medically Fragile, unable to consent	1
No, Mental Health Issues, unable to consent	2
Unknown	8

Pre-Adoptive Services, Placements and Resources

117 (82%) of the 143 children/youths with a plan of adoption were placed in pre-adoptive homes. The family structure was comprised of a married couple for 78 (67%) of the 117 cases, an unmarried couple for 5 (4%), a single female for 33 (28%) and a single male for 1 case. The relationship to the pre-adoptive children/youths was a relative foster parent for 6 (5%) cases, a non-relative foster parent for 108 (92%) and a fictive kin foster parent for 3 (3%) cases.
Lengths of time in the pre-adoptive placements were as follows:

- 5 case(s) from 1 to 3 months

- 4 case(s) from 4 to 6 months
- 4 case(s) from 7 to 9 months
- 14 case(s) from 10 to 12 months
- 21 case(s) from 13 to 15 months
- 7 case(s) from 16 to 20 months
- 62 case(s) 21 months or more

An adoptive home study was completed and approved for 88 (75%) of the 117 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 117 (100%) cases.

The local boards found that the pre-adoptive placements were appropriate for 116 (99%) of the 117 cases.

Adoptive Recruitment (26 cases)

The local boards found that the local department had documented efforts to find an adoptive resource for 15 (58%) of the 26 children/youths not placed in a pre-adoptive home. Some of the adoptive recruitment resources were Adopt Us Kids, Bark Foundation, Digital Me, Heart & Gallery, Wednesdays Child, Adoption Together, Ready and Waiting and Wendy's Wonderful Child.

The local boards agreed that the adoptive recruitment efforts were appropriate for 14 (99%) of the 15 children/youths.

Post-Adoptive Services and Resources

Post-adoptive services were needed for 127 (89%) of the 143 children/youths. The services that were needed were Medical for 108 cases, Mental Health services for 31 cases, Educational services for 22 cases, Respite Services for 3 cases and DDA services for 4 cases.

Post-adoptive subsidies were needed for 102 (71%) of the 143 children/youths.

The local boards agreed that the post-adoptive services and resources were appropriate for 127 (89%) of the 143 children/youths.

Risk and Safety

The local boards agreed that safety and risk protocols were followed for 140 (98%) of the 143 children/youths.

CASA (Court Appointed Special Advocate)

The local boards found that for 57 (40%) of the 143 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	45	27
No	98	116

Frequency of Visits	With Parents	With Relatives
Daily		
Once a week	6	3
More than once a week	1	1
Once a month	20	13
More than once a month	11	5
Quarterly	3	2
Yes, but undocumented	4	3

Supervision of Visits	With Parents	With Relatives
Supervised	43	23
Unsupervised	2	4

Who Supervises Visits	With Parents	With Relatives
LDSS Agency Representative	36	16
Other Agency Representative		
Biological Family Member	1	
Foster Parent	6	5
Other		2

Where do Visits Occur ?	With Parents	With Relatives
Parent/Relative Home	4	3
LDSS Visitation Center	25	9
Public Area	11	11
Child's/Youth's Placement	4	4
Other	1	

Overnight Stays	With Parents	With Relatives
Yes	2	2
No	43	25

The local boards found that 75 (52%) of the 143 children/youths had siblings in care. 43 (57%) of the 75 children/youths had visits with siblings in care who did not reside with them.

Barriers/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.

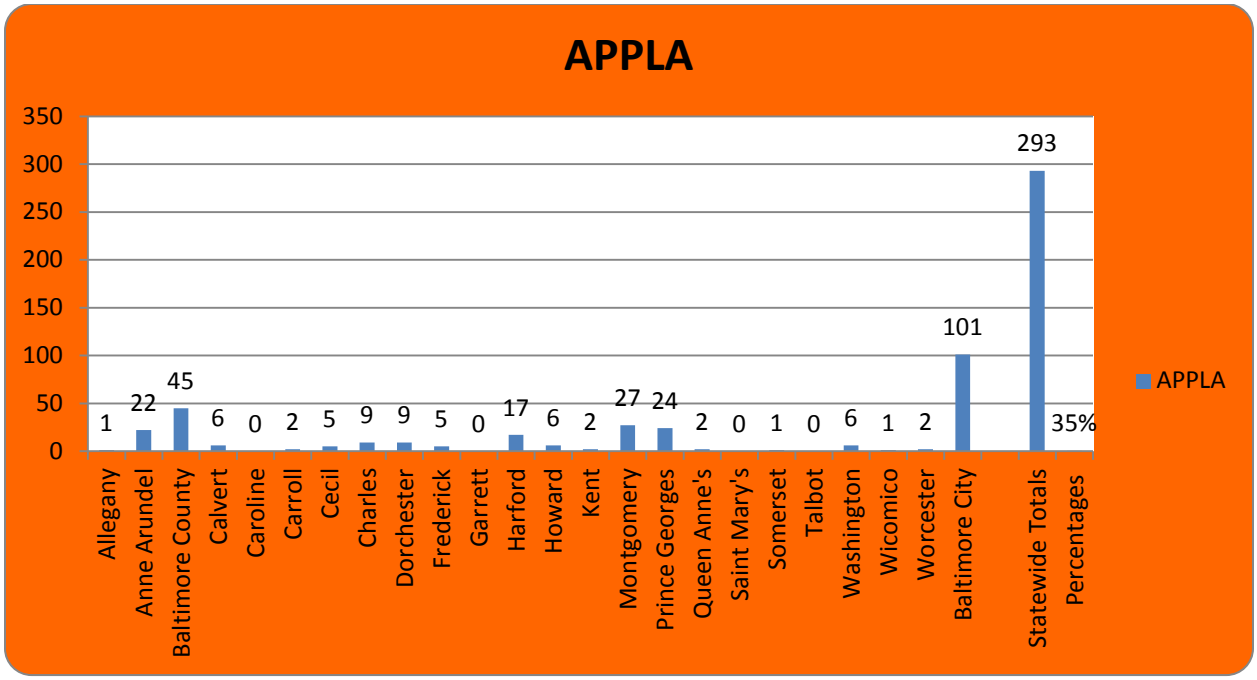
Summary

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 141 (99%) of the 143 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 871 cases reviewed, 293 (34%) of the cases had a plan of APPLA. Baltimore City had the most 101 (34%), Baltimore County 45 (15%), Montgomery County 27 (9%), Prince George's County 24 (8%), Anne Arundel 22 (7%) and Harford 17 (6%). All other counties had three 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	129	0	N/A
Age 6 thru 10	94	0	N/A
Age 11 thru 13	117	0	N/A
Age 14 thru 16	176	11	4%
Age 17 thru 19	245	177	60%

Age 20	110	105	36%
Total	871	293	34%

Permanency

The local boards agreed with the permanency plan of APPLA for 292 (99%) of the 293 cases reviewed.

Category of APPLA plan

The local boards found the following categories for the APPLA plans:

- Emancipation/Independence: 263 (90%) cases
- Transition to an Adult Supportive Living Arrangement: 30 (10%) cases

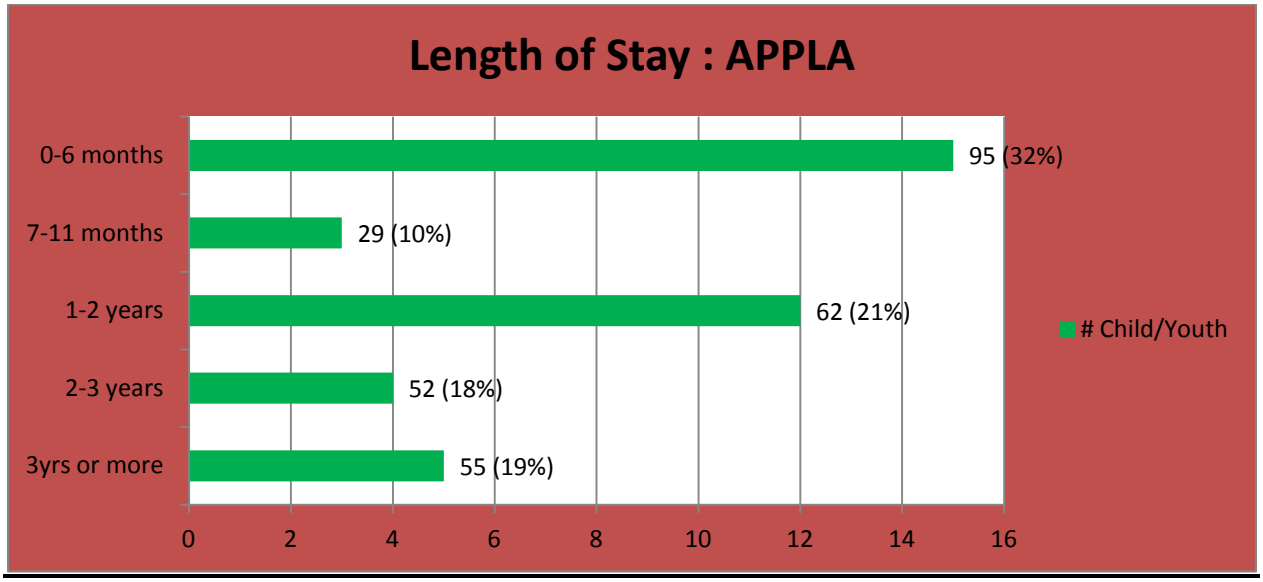
Permanent Connections

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 268 (91%) of the 293 cases reviewed, a permanent connection had been identified for the children/youths by the local departments and that the identified permanent connection was appropriate for 263 (90%) cases.

Length of time Child/Youth had a plan of APPLA

Of the 293 APPLA cases reviewed the local boards found that the length of time the child/youth had 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 156 (53%) of the 293 cases reviewed.

Service Agreements: The local departments had signed service agreements for 190 (65%) of the 291 eligible cases. Efforts to involve the families in the service agreement process were made for 221 (76%) of the 291 eligible cases.

The local boards found that the service agreements were appropriate for 184 (97%) of the 190 signed cases.

Placement/Living Arrangement (LA)

Number of Cases	Placement/ Living Arrangement (LA)
6	Formal Kinship Care
13	Regular Foster Care
2	Restricted (Relative) Foster Care
20	Treatment Foster Care
56	Treatment Foster Care (Private)
15	Residential Group Home
20	Teen Mother Program
35	Therapeutic Group Home
52	Independent Living Residential Program
4	Residential Treatment Center
5	Relative

10	Non Relative
23	Own Dwelling
2	Diagnostic Center
1	Psychiatric Respite
	Living Arrangement (LA)
8	College (LA)*
2	Own Home/Apartment (LA)
2	Inpatient Psychiatric Care (LA)*
2	Inpatient Medical Care (LA)*
6	Runaway (LA)
7	Secure Detention Facility (LA)
13	Unapproved Living Arrangement (LA)

(*These cases have both a living arrangement and a placement)

In 156 (53%) of the 293 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 278 (95%) of the 293 cases reviewed.

Placement Stability

The local boards found that for 145 (50%) cases reviewed there was a change in the placement in the last 12 months prior to being reviewed. 60 (41%) of the 145 cases reviewed had 1 placement change, 57 (39%) had 2 placement changes, 9 (6%) had 3 placement changes and 19 (13%) had 4 or more placement changes.

A family involvement meeting took place with the most recent placement changes for 73 (50%) of the 145 cases.

- 63 (43%) were in less restrictive placements
- 27 (19%) were in more restrictive placements
- 45 (31%) had the same level of care
- 8 (6%) youth on runaway
- 2 (1%) info not available

The local boards found that the primary positive reasons for the 145 most recent placement changes were:

- Transition towards a permanency goal: 60 cases
- Placement with relatives: 3 cases

Provider specific issues for the most recent placement changes were:

- Provider home closed: 7 cases
- Provider request: 2 cases
- Allegation of provider abuse/neglect: 1 case
- Incompatible match: 5 cases

Child/youth specific issues for the most recent placement changes were:

- Behavioral: 49 cases
- Delinquent behavior: 4 cases
- Runaway: 7 cases
- Hospitalization: 1 case
- Child/youth request removal: 2 cases

While child/youth was in the placement from which they were removed, were placement specific services adequate to support the provider:

c) Yes, for 138 cases

For the current placement, is there a match between the child/youth's needs and the provider's ability to meet those needs?

c) Yes, for 134 cases

Health/Mental Health

- Developmental/Special Needs: The local departments reported that 57 (19%) of the 293 children/youths reviewed had developmental or special needs.

- Current Physical: 194 (66%) children/youths had a current physical exam.

- Current Vision: 150 (51%) children/youths had a current vision exam.

- Current Dental: 161 (55%) 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 35 (61%) of 57 eligible children/youths.

- Completed Medical Records: The local departments reported that 101 (34%) children/youths had completed medical records in their case files.

- Prescription Medication: 118 (40%) children/youths were taking prescription medication.

- Prescription Medication Monitored: Prescription medication was being monitored regularly for 115 (97%) of the 118 children/youths.

- Psychotropic Medication: 87 (30%) children/youths were taking psychotropic medication.
- Psychotropic Medication Monitored: Psychotropic medication was being monitored at least quarterly for 85 (98%) of the 87 children/youths.
- Mental Health Issues: 227 (77%) children/youths had mental health issues.
- Mental Health Diagnosis: 224 (76%) children/youths had mental health diagnosis.
- Mental Health Issues Addressed: Yes, for 152 (67%) of the 227 children/youths.
- Mental Health Issues/Transitioning/Services: 18 (8%) of the 227 youths with mental health issues who were transitioning out of care, had an identified plan to receive services in the adult mental health system.
- Substance Abuse: 76 (26%) children/youths had a substance abuse problem.
- Substance Abuse Addressed: Yes for 17 (22%) of the 76 children/youths.
- Behavioral Issues: 141 (48%) children/youths had behavioral issues.
- Behavioral Issues Addressed: Yes, for 105 (74%) of the 141 children/youths.
- The local boards found that the health needs of 107 (37%) of the 293 children/youths had been met and 36 children/youths refused to comply with standard health exams.

Education

171 (58%) of the 293 children/youths reviewed were enrolled in school or another educational/vocational program. 122 (71%) of the 171 were in Pre-K through 12th grade, 8 (5%) were enrolled in a GED program, 36 (21%) were in college and 5 (3%) were in trade school. 90 (74%) of the 122 children/youths not enrolled in school or another educational/vocational program had already graduated high school and 32 (26%) refused to attend school.

65 (38%) of the 171 children/youths enrolled in school or another educational/vocational program had a 504 or IEP plan. 46 (71%) of the 65 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 76 (44%) of the 171 children/youths enrolled in school or another educational/vocational program.

The local boards agreed that 163 (95%) of the 171 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 – 293 cases)

  137 (47%) of the 293 youths were employed or participating in paid or unpaid work experience. 6 youths were unable to participate due to being medically fragile, 16 were unable to participate due to mental health issues and 2 were in a Juvenile Justice Facility.

  The local boards agreed that the youths were being appropriately prepared to meet employment goals.

- Independent Living Services (age 14 and older – 293 cases)

  The local boards agreed that 223 (76%) of the 293 youths were receiving appropriate services to prepare for independent living.

  6 youths were unable to participate in independent living services due to being medically fragile, 16 due to mental health issues and 2 due to being in a Juvenile Justice Facility.

- Housing (Transitioning Youth – 105 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 56 (53%) of the 105 youths transitioning out of care. Alternative housing options were also provided for 80 youths.

  The local boards agreed that 81 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 272 (93%) of the 293 children/youths.

CASA (Court Appointed Special Advocate)

The local boards found that in 92 (31%) of the 293 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	141	91
No	152	202

Frequency of Visits	With Parents	With Relatives
Daily	5	1
Once a week	31	12
More than once a week	11	12
Once a month	17	10
More than once a month	21	14
Quarterly	11	6
Yes, but undocumented	45	36

Supervision of Visits	With Parents	With Relatives
Supervised	8	3
Unsupervised	133	88

Who Supervises Visits	With Parents	With Relatives
LDSS Agency Representative	3	2
Other Agency Representative		
Biological Family Member		
Foster Parent	1	
Other	4	1

Where do Visits Occur ?	With Parents	With Relatives
Parent/Relative Home	65	66
LDSS Visitation Center	3	1
Public Area	39	19
Child's/Youth's Placement	24	4
Other	10	1

Overnight Stays	With Parents	With Relatives
Yes	52	44
No	89	47

The local boards found that 59 (20%) of the 293 children/youths had siblings in care. 37 (63%) of the 59 children/youths had visits with siblings in care who did not reside with them.

Barriers/Issues

The local boards identified the following barriers to permanency/issues:

- No service agreement with parents.
- No service agreement with youth.

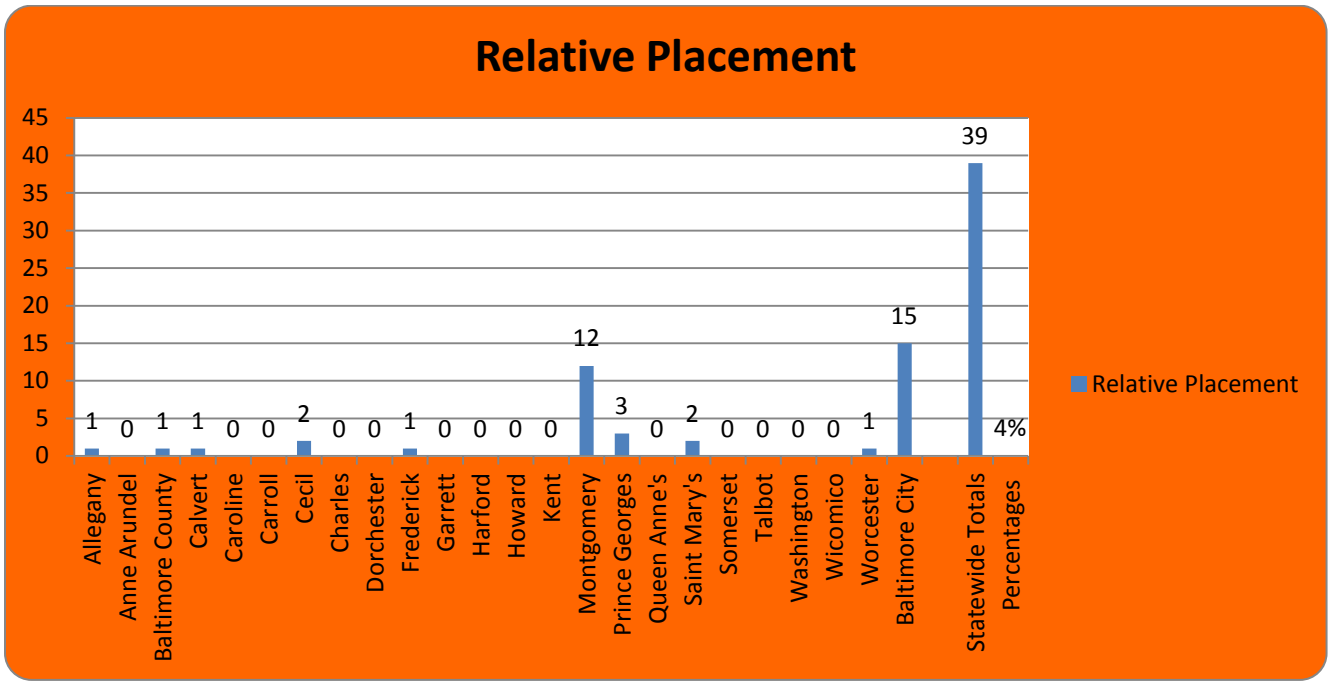
- Youth placed outside of home jurisdiction.
- Missing or lack of documentation.
- Child has behavior problems in the home.
- Issues related to substance abuse.
- Not following up on referrals.
- Youth not enrolled in school.
- Youth not attending school or in GED program.
- Youth not receiving adequate 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 247 (84%) of the 293 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: 10 cases
- Relative Placement for Custody/Guardianship: 29 cases

Age Range	Totals	Relative Placement	Percentage
Age 1 thru 5	129	10	26%
Age 6 thru 10	94	6	15%
Age 11 thru 13	117	7	18%
Age 14 thru 16	176	12	31%
Age 17 thru 19	245	4	10%
Age 20	110	0	N/A
Total	871	39	4%

Permanency

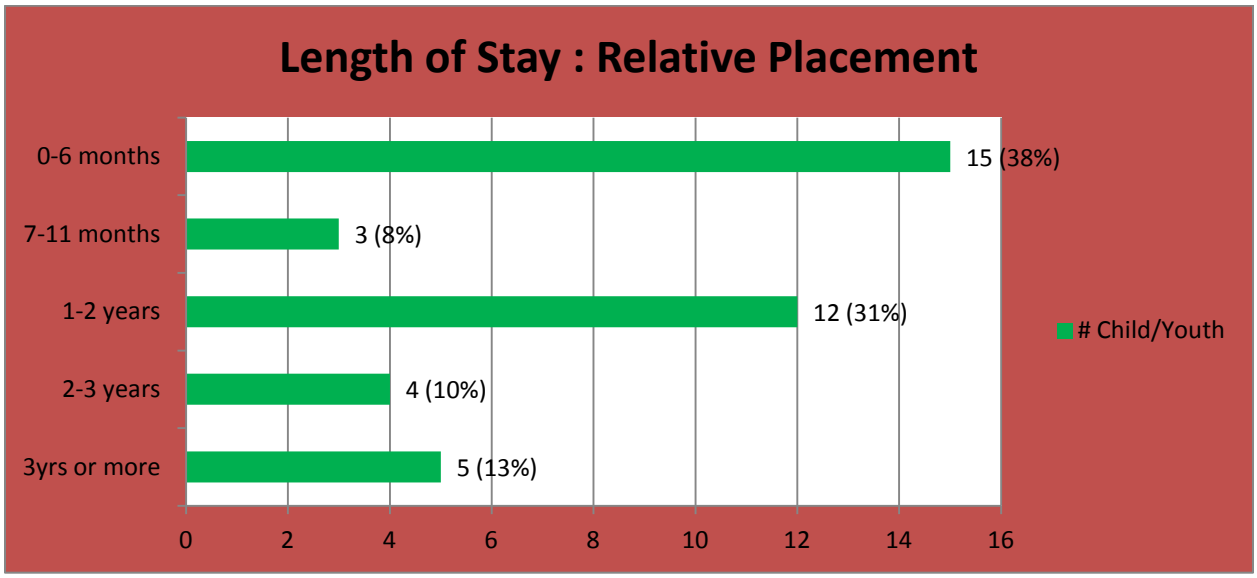
The local boards agreed with the permanency plan of relative placement for 34 (87%) of the 39 cases reviewed.

The local juvenile courts identified concurrent permanency plans for 10 (26%) of the 39 cases reviewed.

The local departments were implementing the concurrent plans set by the local juvenile courts for all 10 cases.

Length of time child/youth had a plan of Relative Placement

Of the 39 cases reviewed the local boards found that the length of time the child/youth had a plan of Relative Placement for Custody/Guardianship or Adoption 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 22 (56%) of the 39 cases reviewed.

Service Agreements: The local departments had signed service agreements for 10 (31%) of the 32 eligible cases and 7 cases were Post-TPR children under the age of 14. Efforts to involve the families in the service agreement process were made for 15 (47%) of the 32 eligible cases reviewed.

The local boards found that the service agreements were appropriate for the 10 signed cases.

Placement

Number of Cases	Placement/Living Arrangement (LA)
4	Formal Kinship Care
1	Intermediate Foster Care
6	Pre-Finalized Adoptive Home
7	Regular Foster Care
7	Restricted (Relative) Foster Care
1	Treatment Foster Care
8	Treatment Foster Care (Private)
1	Residential Group Home
2	Residential Treatment Center
1	Psychiatric Respite
1	Diagnostic Center
1	Inpatient Psychiatric Care (LA)*
1	Inpatient Medical Care (LA)*

(*These cases have both a living arrangement and a placement)

The local boards found that in 24 (62%) of the 39 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 38 (97%) of the 39 cases reviewed.

Placement Stability

The Local boards found that for 13 (33%) of the 39 cases reviewed there was a change in placement within the 12 months prior to the review. 3 (23%) of the 13 cases had 1 placement change, 7 (54%) had 2 placement changes and 3 (23%) had 3 placement changes.

A family involvement meeting took place with the most recent placement changes for 4 (31%) of the 13 cases.

The following levels of care were found for the 13 most recent placement changes:

- 7 (54%) were in less restrictive placements
- 5 (38%) were in more restrictive placements
- 1 child/youth on runaway

The local boards found that the primary positive reasons for the 13 most recent placement changes were:

- Transition towards a permanency goal: 3 cases
- Placement with relatives: 3 cases

Child/youth specific issues for the most recent placement changes were:

- Behavioral: 6 cases
- Hospitalization: 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 12 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 13 cases

Health/Mental Health

- Developmental/Special Needs: The local departments reported that 4 (10%) of the 39 children/youths reviewed had developmental or special needs.

- Current Physical: 28 (72%) children/youths had a current physical exam.

- Current Vision: 20 (51%) children/youths had a current vision exam.

- Current Dental: 19 (49%) 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 3 (75%) of 4 eligible children/youths.

- Completed Medical Records: The local departments reported that 15 (39%) of the children/youths had completed medical records in their case files.

- Prescription Medication: 14 (36%) children/youths were taking prescription medication.

- Prescription Medication Monitored: Prescription medication was being monitored regularly for all 14 children/youths.

- Psychotropic Medication: 10 (26%) children/youths were taking psychotropic medication.

- Psychotropic Medication Monitored: Psychotropic medication was being monitored at least quarterly for all 10 children/youths.

- Mental Health Issues: 23 (59%) children/youths had mental health issues.
- Mental Health Diagnosis: 23 (59%) children/youths had a mental health diagnosis.
- Mental Health Issues Addressed: Yes, for 19 (83%) of the 23 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 (5%) children/youths had a substance abuse problem.
- Substance Abuse Addressed: Yes for 1 of the 2 children/youths.
- Behavioral Issues: 18 (46%) children/youths had behavioral issues.
- Behavioral Issues Addressed: Yes, for 16 (89%) of the 18 children/youths.
- The local boards found that the health needs of 16 (41%) of the 39 children/youths had been met and 4 children/youths refused to comply with standard health exams.

Education

29 (74%) of the 39 children/youths reviewed were enrolled in school or another educational/vocational program. All 29 were in Pre-K through 12th grade. 2 of the 10 children/youths not enrolled in school or another educational/vocational program refused to attend school and 8 were under the age of 5.

13 (45%) of the 29 children/youths enrolled in school or another educational/vocational program had a 504 or IEP plan. 9 (69%) of the 13 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 15 (52%) of the 29 children/youths enrolled in school or another educational/vocational program.

The local boards agreed that 26 (90%) of the 29 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 – 16 cases)

  4 (25%) of the 16 youths were employed or participating in paid or unpaid work experience. 1 youth was unable to participate due to mental health reasons.

  The local boards agreed that 6 youths were being appropriately prepared to meet employment goals.

- Independent Living Services (age 14 and older – 16 cases)

  The local boards agreed that 5 (31%) of the 16 youths were receiving appropriate services to prepare for independent living.

  1 youth was unable to participate in independent living services due to mental health reason.

- Housing (Transitioning Youth – None)

  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 1 of the 10 children/youths with a plan of relative placement for adoption consented.

Consent to Adoption for Cases Reviewed with Adoption Plans

Child's Consent to Adoption	Cases
Yes	1
Yes, with conditions	
Child did not want to be Adopted	
N/A under age of consent	8
No, Medically Fragile/Mental Health	
No, Concurrent Plan is Reunification	
No, Relative Placement	
Unknown	1

Pre-Adoptive Services, Placements and Resources (10)

9 (90%) of the 10 children/youths with a plan of relative placement for adoption were placed in a pre-adoptive home. The family structure was comprised of a married couple for 5 (56%) of the 9 cases, a single female for 3 (33%) of the 10 cases and a single male for 1 case. The relationship to the pre-adoptive children/youths was a relative foster parent for 8 (89%) cases, and a non-relative foster parent for 1 case.

Lengths of time in the pre-adoptive placements were as follows:

- 1 case(s) from 7 to 9 months
- 1 case(s) from 10 to 12 months
- 4 case(s) from 16 to 20 months
- 3 case(s) 21 months or more

An adoptive home study was completed and approved for 6 (67%) of the 9 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 9 cases.

The local boards found that the pre-adoptive placements were appropriate for all 9 cases.

Adoptive Recruitment (1)

The local board found that the local department did not have documented efforts to find an adoptive resource for the 1 child/youth not placed in a pre-adoptive home.

The local board agreed that the adoptive recruitment efforts were not appropriate for the child/youth.

Post-Adoptive Services and Resources (10)

Post-adoptive services were needed for 8 (80%) of the 10 children/youths. The services that were needed for the 8 children/youths were Medical for 5 children/youths, Mental Health services for 2 and Educational services for 1 child/youth.

The local boards agreed that the post-adoptive services and resources were appropriate for the 8 children/youths.

Risk and Safety

The local boards agreed that safety and risk protocols were followed for 37 (95%) of the 39 children/youths.

CASA (Court Appointed Special Advocate)

The local boards found that for 15 (38%) of the 39 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	22	19
No	17	20

Frequency of Visits	With Parents	With Relatives
Daily		1
Once a week	12	10
More than once a week	1	1

Once a month	3	2
More than once a month	1	2
Quarterly	1	
Yes, but undocumented	4	3

Supervision of Visits	With Parents	With Relatives
Supervised	9	4
Unsupervised	13	15

Who Supervises Visits	With Parents	With Relatives
LDSS Agency Representative	6	2
Other Agency Representative	2	
Biological Family Member	1	1
Foster Parent		
Other		1
Where do Visits Occur ?	**With Parents**	**With Relatives**
Parent/Relative Home	1	11
LDSS Visitation Center		
Public Area	6	4
Child's/Youth's Placement	7	4
Other	8	

Overnight Stays	With Parents	With Relatives
Yes	1	3
No	21	16

The local boards found that 19 (49%) of the 39 children/youths had siblings in care. 17 (89%) of the 19 children/youths had visits with siblings in care who did not reside with them.

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.

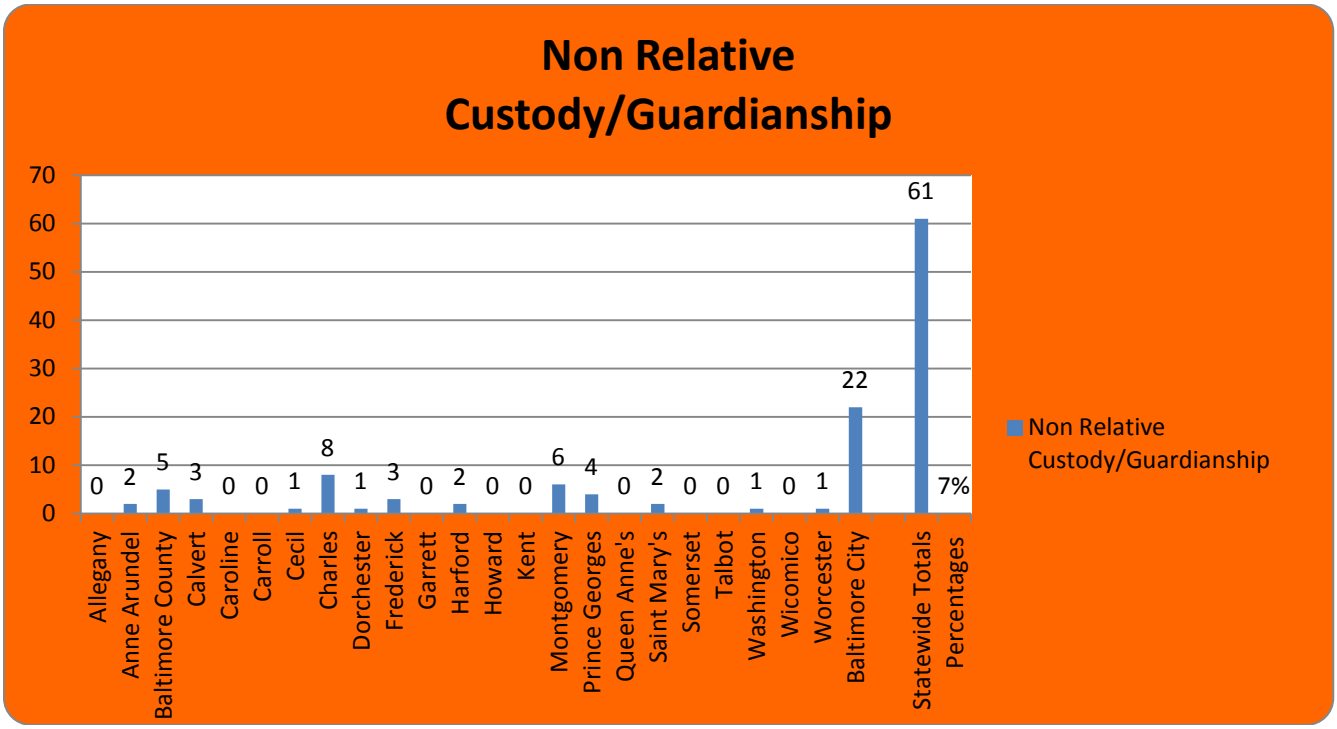
- Not following up on referrals.
- Other child/youth related barrier.
- No follow up on medical referrals.

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 35 (90%) of the 39 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	129	8	13%
Age 6 thru 10	94	8	13%
Age 11 thru 13	117	13	21%
Age 14 thru 16	176	24	39%
Age 17 thru 19	245	8	13%
Age 20	110	0	N/A
Total	871	61	7%

Permanency

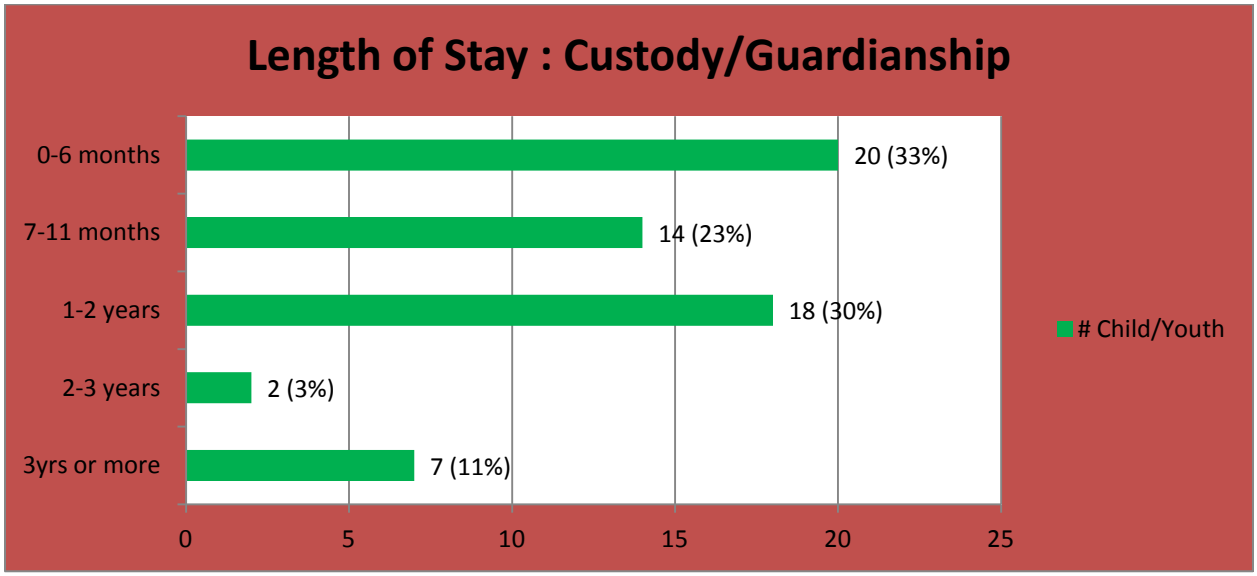
The local boards agreed with the permanency plan of non relative custody/guardianship for 57 (93%) of the 61 cases reviewed.

The local juvenile courts identified a concurrent permanency plan for 23 (38%) of the 61 cases reviewed.

The local departments were implementing the concurrent plans set by the local juvenile courts for 22 (96%) of the 23 cases.

Length of time child/youth had a plan of Non Relative Custody/Guardianship

Of the 61 cases reviewed the local boards found that the length of time the child/youth had a plan of Non Relative Custody/Guardianship were as follows:



Case Planning

Family Involvement Meetings (prior to entry): The local boards found that the local departments held family involvement meetings prior to entry for 37 (61%) of the 61 cases reviewed.

Service Agreements: The local departments had signed service agreement for 14 (23%) of the 60 eligible cases and 1 case was a Post-TPR child/youth under the age of 14. Efforts to involve the families in the service agreement process were made for 29 (48%) of the 60 cases reviewed.

The local boards found that the service agreements were appropriate for 13 of the 14 signed cases.

Placement/Living Arrangement (LA)

Number of Cases	Placement/Living Arrangement (LA)
3	Formal Kinship Care
10	Regular Foster Care
12	Treatment Foster Care
26	Treatment Foster Care (Private)
2	Residential Group Home
1	Teen Mother Program
2	Therapeutic Group Home
2	Residential Treatment Center
1	Diagnostic Center
1	Inpatient Medical Care (LA)*
1	Unapproved Kinship Home (LA)*
1	Unapproved Living Arrangement (LA)*

(*These cases have both a living arrangement and a placement)

The local boards found that for 33 (54%) of the 61 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 59 (97%) of the 61 cases reviewed.

Placement Stability

The Local boards found that for 33 (54%) of the 61 cases reviewed there was a change in placement within the 12 months prior to the review. 10 (30%) of the 33 cases had 1 placement change, 16 (48%) had 2 changes, 4 (12%) had 3 changes and 3 (9%) had 4 or more placement changes.

A family involvement meeting took place with the most recent placement changes for 10 (30%) of the 33 cases.

The following levels of care were found for the 33 most recent placement changes:

- 5 (15%) were in less restrictive placements
- 4 (12%) were in more restrictive placements
- 24 (73%) had the same level of care

The local boards found that the primary positive reasons for the 33 most recent placement changes were:

- Transition towards a permanency goal: 9 cases
- Placement with relatives: 1 case
- Placement with siblings: 1 case

Provider specific issues for the most recent placement changes were:

- Provider home closed: 2 cases
- Allegation of provider abuse/neglect: 1 case
- Incompatible match: 2 cases

Child/youth specific issues for the most recent placement changes were:

- Behavioral: 21 cases

While child/youth was in the placement from which they were removed, were placement specific services adequate to support the provider:

d) Yes, for all 33 cases

For the current placement, is there a match between the child/youth's needs and the provider's ability to meet those needs?

d) Yes, for 31 cases

Health/Mental Health

- Developmental/Special Needs: The local departments reported that 8 (13%) of the 61 children/youths reviewed had developmental or special needs.

- Current Physical: 46 (75%) children/youths had a current physical exam.

- Current Vision: 32 (52%) children/youths had a current vision exam.

- Current Dental: 35 (57%) 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 10 (63%) of 16 eligible children/youths.

- Completed Medical Records: The local departments reported that 21 (34%) children/youths had completed medical records in their case files.

- Prescription Medication: 26 (43%) children/youths were taking prescription medication.

- Prescription Medication Monitored: Prescription medication was being monitored regularly for the 26 children/youths.
- Psychotropic Medication: 26 (43%) children/youths were taking psychotropic medication.
- Psychotropic Medication Monitored: Psychotropic medication was being monitored at least quarterly for all 26 children/youths.
- Mental Health Issues: 48 (79%) children/youths had mental health issues.
- Mental Health Diagnosis: 47 (98%) of the 48 children/youths had a mental health diagnosis.
- Mental Health Issues Addressed: Yes, for 42 (88%) of the 48 children/youths.
- Mental Health Issues/Transitioning/Services: Not applicable. None of the youths with mental health issues, were transitioning out of care.
- Substance Abuse: 5 (8%) children/youths had a substance abuse problem.
- Substance Abuse Addressed: Yes for 3 (60%) of the 5 children/youths.
- Behavioral Issues: 36 (59%) children/youths had behavioral issues.
- Behavioral Issues Addressed: Yes, for 35 (97%) of the 36 children/youths.
- The local boards found that the health needs of 22 (36%) of the 61 children/youths had been met and 4 children/youths refused to comply with standard health exams.

Education

56 (92%) of the 61 children/youths reviewed were enrolled in school or another educational/vocational program. All 56 were in Pre-K through 12th grade. 2 of the 5 children/youths not enrolled in school or another educational/vocational program refused to attend school and 3 were under the age of 5.

33 (59%) of the 56 children/youths enrolled in school or another educational/vocational program had a 504 or IEP plan. 21 (64%) of the 33 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 35 (63%) of the 56 children/youths enrolled in school or another educational/vocational program.

The local boards agreed that 54 (96%) of the 56 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 – 33 cases)

  7 (21%) of the 33 youths were employed or participating in paid or unpaid work experience. 2 youths were unable to participate due to mental health reasons

  The local boards agreed that the youths were being appropriately prepared to meet employment goals.

- Independent Living Services (age 14 and older – 33 cases)

  The local boards agreed that 15 (45%) of the 33 youths were receiving appropriate services to prepare for independent living.

  2 youths were unable to participate in independent living services due to mental health reasons.

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.

Risk and Safety

The local boards agreed that safety and risk protocols were followed for 58 (95%) of the 61 children/youths.

CASA (Court Appointed Special Advocate)

The local boards found that for 15 (25%) of the 61 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	28	21
No	33	40

Frequency of Visits	With Parents	With Relatives
Daily	2	5
Once a week	10	3
More than once a week	1	

Once a month	5	4
More than once a month	5	6
Quarterly		
Yes, but undocumented	5	3

Supervision of Visits	With Parents	With Relatives
Supervised	20	2
Unsupervised	8	19

Who Supervises Visits	With Parents	With Relatives
LDSS Agency Representative	17	2
Other Agency Representative		
Biological Family Member		
Foster Parent	2	
Other	1	

Where do Visits Occur ?	With Parents	With Relatives
Parent/Relative Home	6	17
LDSS Visitation Center	6	1
Public Area	14	1
Child's/Youth's Placement	1	2
Other	1	

Overnight Stays	With Parents	With Relatives
Yes	4	16
No	24	5

The local boards found that 41 (67%) of the 61 children/youths had siblings in care. 35 (85%) of the 41 children/youths had visits with siblings in care who did not reside with them.

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 47 (77%) of the 61 children reviewed.

Child Protection Panels

CRBC became a citizen review panel in response to the Federal Child Abuse Prevention and Treatment Act (CAPTA) and state law requiring citizen oversight of the child protection system. Local child protection panels may be established in each jurisdiction. Panel members are appointed by the local appointing authority and local child protection panels report findings and recommendations to the CRBC State Board.

There are local child protection panels in Baltimore City, Baltimore County and Montgomery County. The following report findings and recommendations were reported to CRBC for the fiscal year 2020.

Baltimore City Child Protection Panel

In FY2020, the Baltimore City Child Protection Panel completed 15 reviews from July 2019 through February 2020 that addressed outcomes as adapted from the DHR/DHS approved Child and Family Services Review (CFSR) review instrument. The panel made some of the same recommendations as previously because concerns and/or issues continue to exist based on the panel's review findings. Reviews were suspended from March 2020 due the COVID-19 Pandemic.

Recommendations:

- The department should improve with documentation regarding involvement with biological fathers in the provision of services, especially when the father is living in the home or is involved with the children.
- The department should ensure appropriate documentation of referrals, especially school or medical records mentioned in Local Department of Social Services (LDSS) records. LDSS frequently fails to follow up on mental health and substance abuse referrals for parents so there is no evidence that the parent actually benefited from the referral.
- The department should ensure that complete medical and educational records are included in the record.
- Ensure that the target child/children in a case are intervened.
- Only actual face to face contacts should be documented as such. Notes by workers indicating contacts when they are actually visits without contact create the appearance that there had been a face to face in person visit.
- The department should document interviews with children and children should be interviewed out of the presence of the parents when home visits occur. Document discussion of case plan goals with children interviewed.
- The panel reported concerns about the cases where the children were not interviewed at all.

Members

Beatrice Lee (CRBC State Board Member), Jackie Donowitz, Joan Little, Sheila Jessup, Carolyn Finney.

Baltimore County Child Protection Panel

Meetings Held

- July 31, 2019
- January 28, 2020
- All other meetings for the year were canceled due to the COVID-19 Pandemic, (meetings resumed in July 2020 which will be reported in the FY2021 annual report)

SFY 2020 Accomplishments

- The Child Protection Panel focused on Substance Exposed Newborns for much of this year. The Panel received a briefing from the Department of Social Services regarding the SENs program and response process.
- The Panel reviewed data related to substance abuse in Baltimore County.
- The Panel conducted a preliminary review of three cases involving SENs and selected two to complete a thorough case review. These case reviews did not take place due to the onset of the COVID-19 pandemic and resulting changes.

Members:

Mark Millspaugh, Deputy Director, Baltimore County Department of Social Services, (Chair)
Brynez Roane (Baxter), Arrow Child & Family Ministries
April Lewis, Baltimore County Public Schools
Pat Cronin, Executive Director, Family Tree
Bambi Glenn, Assistant County Attorney
Dr. Scott Krugman, Vice Chair, Department of Pediatrics, Herman & Walter Samuelson Children's Hospital at Sinai
Lisa Fox Dever, Office of the State's Attorney
Laura S. Steele, M.A.M.S., State Citizens Review Board
Lt. Michael Peterson, Baltimore County Police Department

Montgomery County Child Protection Panel

The Mission of the Montgomery County Citizen's Advisory Panel is to examine the extent to which the County Child Welfare Agency effectively implements the child protection standards and State plan under Child Abuse and Neglect Federal legislation, 42 USC section 5106a(b).

The Panel is a multidisciplinary group of expert professionals and private citizens whose responsibility is to ensure that maltreated children receive the services and support they need. The panel has members with varied backgrounds, all committed to the safety and welfare of children and they work collaboratively with the County's Child Welfare Agency.

FY2020 Priorities:

- Data Analysis: Provide oversight of new State information system (CHESSIE to CJAMS) and recommend types of reports that might be used to enhance practice.
- Alcohol and Drug Abuse issues affecting child welfare system: Provide oversight of the START (Evidence Based) model.
- Mental Health: Focus on mental health issues of foster care youth.
- Foster Family Recruitment: Analyze foster parent recruitment and training policies and procedures.

Members

Ronna Cook (Chair), Marci Roth, Jennifer Carson, Lawrence Washington, Laura Coyle, George Gable, Pam Littlewood, Jane Steinberg, Sarah Stanton, Kay Farley (CRBC State Board Member), Deanna McCray-James, Stacy McNeely, Lisa Merkin & Angela English (agency staff)

CRBC FY2020 Review Metrics

Total # of Children - Scheduled on the Preliminary:	1725
Total # of Children - Closed (adopted, reunified, exited care), Non Submission:	447
Total # of Children - Rescheduled (DSS caseworker requests, board overload):	331
Total # of Children - Eligible for Review:	947
Total # of Children - Reviewed at the Board:	871
Total # of Children - Not Reviewed at the Board (worker no shows, closed):	76
Percentage of Children Reviewed for the Period:	92%
Percentage of Children Not Reviewed for the Period:	8%
Recommendation Reports to DSS - Number Sent:	871
Recommendation Reports to DSS - Number Sent on Time:[2]	813
Recommendation Reports to DSS - Percentage Sent on Time:	93%
Recommendation Reports from DSS - Number of Responses Received:[3]	410
Recommendation Reports from DSS - Percentage of DSS Responses:	47%
Recommendation Reports from DSS - Number Received on Time:	125
Recommendation Reports from DSS - Percentage Received on Time	30%
Number of Boards Held	123
Recommendation Reports - Number of DSS Agreement:	404
Recommendation Reports - Percentage of DSS Agreement:	99%
Recommendation Reports - Number of DSS Disagreement:	6
Recommendation Reports - Percentage of DSS Disagreement:	1%
Recommendation Reports - Number of Blank/Unanswered:[4]	0
Recommendation Reports - Percentage of Blank/Unanswered:	0%
Percentage of REUNIFICATION Children Reviewed for the Period:	38%
Percentage of RELATIVE PLACEMENT - Adoption Children Reviewed:	1%
Percentage of RELATIVE PLACEMENT - C & G Children Reviewed:	3%
Percentage of ADOPTION Children Reviewed for the Period:	16%
Percentage of CUSTODY/GUARDIANSHIP Children Reviewed for the Period:	7%
Percentage of APPLA Children Reviewed for the Period:	34%

[2] Due to the COVID-19 pandemic and the Governor of Maryland issuing a mandatory teleworking order effective March 13th 2020, 58 recommendation reports from 5 board reviews were not sent on time in March 2020.

[3] 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 recommendation(s) within 10 days of receipt of the report.

[4] 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 FY2020 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-Shick
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 FY2020 Members

Ms. Carmen Jackson
Ms. Shirley Struck *
Mrs. Mary Ann Bleeke
Ms. Heidi Busch
Mrs. Catherine Gonzalez
Mrs. Denise Messineo
Mrs. Linda Robeson
Ms. Delores Alexander
Ms. Melissa Parkins-Tabron
Ms. Laura Steele
Ms. Patricia Sudina
Ms. Rosina Watkins
Ms. Juanita Bellamy
Ms. Beverly Corporal
Mrs. Ernestine Jackson-Dunston
Mrs. Charlotte Williams
Ms. Norma Lee Young
Mr. Wesley Hordge
Mrs. Gwendolyn Statham
Mrs. Jean West
Ms. Cherryllynn Williams
Ms. Gail McCloud *
Mrs Anita Fishbein
Mrs. Jennifer Gill
Mr. Edwin Green Jr.
Mrs. Eunice Johnson
Mrs. Stephanie Lansey-Delgado
Ms. Gabrielle Shirley *
Ms. Niurka Calcano
Ms. Nicole Cooksey
Ms. Allyn Fitzgerald
Ms. Denise Lienesch
Mr. Reginald Groce Sr.
Mrs. Wanda Molock
Ms. Janet Fountain *
Mr. Harris Freedman
Ms. Adelaide Lagnese *
Ms. Carmen Shanholtz
Ms. Courtney Edwards *
Ms. Adelaide Lagnese
Ms. Dianne Fox
Mrs. Nechelle Kopernacki
Ms. Mary MacClelland
Mrs. Velma Walton
Mrs. Roberta Berry
Mr. John Coller
Mr. Robert Foster Jr.
Ms. Brandy Hunter
Mrs. Denise Joseph
Ms. Gail Radcliff
Mrs. Kamilah Way
Mrs. Katrena Batson Bailey
Mrs. Shirley Greene
Mrs. Barbara Hubbard
Mrs. Portia Johnson-Ennels
Dr. Norby Lee
Dr. Theresa Stafford
Mrs. Vatice Walker
Mrs. Jennifer Grimes
Ms. Helen Johnson
Mrs. Barbara Poucher-Wagner
Mrs. Nancy Wiley
Ms. Katie Sillex *
Mrs. Sharde Twyman
Mrs. Debra Stephens
Mrs. Pamela Dorsey
Mr. Russell Ebright
Mrs. Virginia Heidenreich
Ms. Janet Ramsey
Ms. Manolya Bayar *
Ms. Maureen North *
Dr. Kathy Boyer-Shick
Mr. John Kelly
Mr. Donald Pressler
Mrs. Patricia Soffen
Mr. Kyle Kirby Esq.
Mrs. Susan Gross
Ms. Florence Webber
Ms. Edith Williams
Ms. Alison O'Brien *
Ms. Sandra "Kay" Farley
Mrs. Susan Fensterheim
Ms. Ruth Hayn
Ms. Margaret Rafner
Ms. Phyllis Rand
Ms. LaShanda Adams
Mrs. Susan Haberman
Ms. Sandra Dee Hoffman
Mrs. Claire McLaughlin
Ms. Cheryl Keeney *
Mr. David Schardt *
Mr. Erwin Brown Jr.
Ms. Melissa Daniels *
Ms. Iris Pierce
Ms. Carol Rahbar
Mrs. Davina Richardson
Mrs. Linda Love McCormick
Ms. Mildred Stewart
Dr. Jessica Denny
Mrs. Terry Perkins-Black
Dr. Corinne Vinpool
Mrs. Patricia Duncan
Mrs. Treasea Johnson
Mr. Kirkland Hall Sr.
Dr. Sharon Washington
Ms. Stephanie Chester
Mrs. Brenda Gaines-Blake
Mrs. Phyllis Hubbard
Mrs. Mary Taylor-Acree
Ms. Nettie Anderson-Burrs
Mrs. Jean Harries
Ms. Judith Niedzielski
Mrs. Karen Nugent
Mrs. Yvonne Armwood
Ms. Doretha Henry
Mr. Robert Horsey
Ms. Sarah McCabe
Mrs. Helen Lockwood
Mrs. Terry Smith
Mrs. Valerie Turner
Ms. Otanya Brown
Dr. Thomas Dorsett
Ms. Sharon Guertler
Mr. Reed Hutner
Mrs. Tara Alderman
Ms. Charmika Burton
Ms. Jackie Donowitz
Mr. Leon Henry
Ms. Beatrice Lee
Mrs. Rasheeda Peppers
Ms. Elizabeth Williams
Ms. Sharon Buie

Mrs. Rita Jones
Ms. Sabine Oishi
Mrs. Helene Goldberg
Ms. Rosemarie Mensuphu-Bey
Ms. Ella Pope
Ms. Valerie Sampson
Mrs. Roslyn Chester
Dr. Walter Gill
Ms. Suzanne Parejo
Ms. Benia Richardson
Dr. Patricia Whitmore-Kendall
Ms. Barbara Crosby
Ms. Britonya Jackson
Ms. Deanna Miles-Brown
Ms. Terri Howard

*** New Members appointed by the Governor in fiscal year 2020.**

CRBC FY2020 Staff Members

Denise E. Wheeler
Administrator

Crystal Young, MSW
Assistant Administrator

Agnes Smith
Executive Assistant

Jerome Findlay
Information Technology Officer

Hope Smith
IT Functional Analyst

Fran Barrow
Child Welfare Specialist

Michele Foster, MSW
Child Welfare Specialist

Marlo Palmer-Dixon, M.P.A
Child Welfare Specialist

Sandy Colea, CVA
Volunteer Activities Coordinator Supervisor

Rhonda Watties,
Volunteer Activities Coordinator II

Cindy Hunter-Gray
Lead Secretary

Lakira Whitaker
Office Clerk

References

Citizens Review Board for Children (2013). Policy and Procedures Manual. Baltimore, MD: Department of Human Services (formerly Dept. of Human Resources).

COMAR 07.01.06.05. Procedures for Conducting the Citizen Review of Out-of-Home Placement. Title 07 Department of Human Services (formerly Dept. of Human Resources).

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),

Maryland Code, Family Law § 5-539

Maryland Code, Family Law § 5-545

Maryland Department of Human Resources (FY2015). State Stats. Place Matters Statewide Summary Department of Human Services (formerly Dept. of Human Resources).

Social Services Administration (2016). Out of Home Placement Services – Ready By 21 Manual (FY2017 Edition). Baltimore, MD: Department of Human Services (formerly Dept. of Human Resources).

Social Services Administration cw#16-10 (September 15th 2015). Another Planned Permanent Living Arrangement (APPLA). Baltimore, MD: Department of Human Services (formerly Dept. of Human Resources).

Social Services Administration cw#14-17 (April 15, 2014). Oversight and Monitoring of Health Care Services. Baltimore, MD: Department of Human Services (formerly Dept. of Human Resources).

Social Services Administration (2010). Out of Home Placement Program Manual. Baltimore, MD: Department of Human Services (formerly Dept. of Human Resources).

Social Services Administration cw#10-08 (August 14, 2009). Family Involvement Meetings (FIM). Baltimore, MD: Department of Human Services (formerly Dept. of Human Resources).

June 21, 2021

Nettie Anderson-Burrs, Chairperson
Citizens Review Board for Children
1100 Eastern Avenue
Baltimore, Maryland 21221

Dear Ms. Anderson-Burrs:

The Maryland Department of Human Services, Social Services Administration (DHS/SSA) greatly appreciates the work of the Citizens Review Board for Children (CRBC). The CRBC annual report contains significant analytics and qualitative data useful to inform practice improvement and service innovation to enhance outcomes for Maryland's children, youth and families.

The CRBC recommendations to review and develop policies and practices to ensure they are trauma informed, expand our service array, particularly for youth with multifaceted needs are being addressed within our implementation team structure. Through the implementation structure, we are enhancing our concurrent planning strategies, coordination of services and workforce development activities to integrate our Youth Transition Planning (YTP). The case reviews the CRBC utilizes to offer recommendations makes the process invaluable for all.

To specifically address the needs of the older youth population, DHS/SSA is expanding efforts to improve and implement a YTP process that embraces authentic youth engagement and youth-driven plans. DHS/SSA and transitional independent living providers collaborate quarterly to discuss the needs of youth and young adults prior to emancipation to ensure the continuity of experiential learning activities and life skills that lead to successful independence. In addition, SSA has created a workgroup consisting of DHS, services partners and technical assistance partners to draft educational and training strategies for youth and our workforce as youth move through the transitional planning process.

Youth engagement is continually pursued in activities to include the development of Youth Transitional Planning. Youth input and feedback is essential and quite innovative. Among the various forums that promotes authentic youth voice, include but are not limited to local Youth Advisory Boards, State Youth Advisory Board, Family Team Decision Making Meetings, and Local Independent Living Work Groups. Most recently, over 75 youth participated in a Pandemic Relief Virtual Listening Session to identify supportive services and optimal usage of COVID-19 resources for thoughtful immediate access.

DHS/SSA endorses the recommendations for improving permanency outcomes for youth in care and increasing the support networks for children and families. DHS/SSA is developing policies and strategies that redefine the concept of family as more inclusive of kinship resources (including fictive kin) and placing emphasis on relational permanency for older youth, who have a plan of Another Planned Permanent Living Arrangement (APPLA).

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 and families.

We look forward to our ongoing partnership with the CRBC on behalf of children, youth, and families across Maryland.

Respectfully,

Michelle L. Farr, LCSW-C, LICSW
Executive Director, Social Services Administration

Maryland's Statewide Recruitment and Retention Goals

Goal 1: Increase the number of resource parents in Maryland to meet the needs of the state. **(See Item #33 for data update)** Target by 2024: 85% of Maryland's resource parents will be identified by their racial composition. Target by 2024: Ensure the percentage of racial composition of resource parents to foster care youth will be 85%.	Objective 1: Recruit and retain resource families appropriate for local department children in care.

Strategy 1: DHS will provide technical assistance to local departments to assist with recruitment and retention efforts. (Strategy 1,4)

#	Action step	Person or people responsible	Start date	Complete date
1	Reach out to Prince George's County, Montgomery County and Baltimore City who have the highest number of children in care and highest number of African American children to provide technical assistance as needed around the recruitment/retention of resource parents. **(See item #33 for data update)**	SSA Resource Home Team, LDSS Resource Home Recruiters	August 2019	June 2024

2	Reach out to all local departments to ensure their racial demographic data is correct and their recruitment efforts for their population are appropriate. Specifically looking at those jurisdictions that have Hispanic and Native American youth. **(See item #33 for data update)**	LDSS Resource Home Recruiters, SSA Resource Home Supervisor, National Center for Indian Affairs,	August 2019	Continuous
Goal 2: Increase certification pre-service rate of eligible applicants to 95% statewide. Target by 2024: Maryland will increase the percentage of resource home pre-service training to 95% (Current rate CY2018, 90%, data source: MDCHESSIE).		Objective 1: Promote timely and diligent recruitment efforts in order to meet the needs of youth in Maryland's foster care system.		
#	Action step	Person or people responsible	Start date	Complete date
1	Revise the annual statewide recruitment and retention plan reporting form and quarterly analysis tool in order to trend data and give appropriate feedback to LDSS regarding recruitment and retention efforts.	SSA Resource Home Supervisor/Analyst, Chapin Hall Technical Assistance Partner	May 2019	June 2019 **Update: June 2022, this activity has been delayed due to lack of resource home staff.**

2	Utilizing the statewide recruitment and retention data, track the LDSS home study rate and provide technical assistance to eliminate barriers to home study approval.	LDSS Resource Home Caseworker, SSA Resource Home Supervisor/Analyst,	July 2019	June 2024
Strategy 2: Engage current/experienced Resource Parents and previous foster care youth in assisting with LDSS recruitment and retention efforts. (Strategy 1, 4)				
#	Action step	Person or people responsible	Start date	Complete date
1	Invite LDSS resource parents, previous foster youth to statewide resource parent engagement workgroups.	LDSS Resource Home Caseworkers, SSA Resource Home Supervisor/Analyst, Maryland Resource Parent Association, Capacity Center for States, State Youth Advisory Board	October 2020	Continuous **2020 Progress: Resource Parents are currently active in the Resource Parent Engagement Workgroup**
2	Identify experienced resource parents and connect them to prospective parents for support groups and peer to peer support options.	LDSS Resource Home Caseworker SSA Resource Home Supervisor/Analyst, Maryland Resource Parent Association	July 2019	June 2024

2	Identify previous foster youth to assist LDSS with recruitment and retention efforts.	LDSS Resource Home Caseworkers, SSA Resource Home Supervisor/Analyst, Maryland Resource Parent Association, Capacity Center for States, State Youth Advisory Board	July 2019	June 2024
Strategy 3: Facilitate focus groups with prospective parents to discuss barriers to completing certification. (Strategy 1, 2, 3)				
#	Action step	Person or people responsible	Start date	Complete date
1	Survey LDSS applicants who have not completed the home study process to determine barriers to completion.	LDSS Resource Home Caseworker, SSA Resource Home Analyst, MRPA, State foster parent ombudsman	July 2019	June 2024
Strategy 4: Increase the pre-service training at times and locations that are convenient to prospective families. (Strategy 3)				
#	Action step	Person or people responsible	Start date	Complete date
1	Ensure LDSS compliance with on-line foster parent training and the offering of in-person training if applicable for the pre-service training modules.	LDSS Resource Home Caseworker SSA Resource Home Supervisor/Analyst	July 2019	December 2019 Completed
2	Assess the current on-line hybrid foster parent training and evaluate its effectiveness since	LDSS Resource Home Caseworker SSA Resource Home Supervisor/Analyst	July 2019	December 2019 Completed

	statewide implementation.			
Strategy 5: Provide timely responses to resource home inquiries within the LDSS. (Strategy 2, 3)				
#	Action step	Person or people responsible	Start date	Complete date
1	Cross train foster and adoption staff with talking points on how to respond to inquiries.	LDSS Resource Home/Permanency Caseworker, SSA Resource Home Supervisor/Analyst, Maryland Resource Parent Association, State Foster Parent Ombudsman, Capacity Center for States, Current Resource Parents	July 2019	June 2024
2	Establish procedures for immediate response to inquiries. This will include providing information to work with diverse communities including cultural, racial, and socio-economic variations. This will also address linguistic barriers in those jurisdictions in which this is identified as a need.	LDSS Resource Home/Permanency Caseworker SSA Resource Home Supervisor/Analyst, Maryland Resource Parent Association, State Foster Parent Ombudsman, Capacity Center for States, Current Resource Parents	July 2019	June 2024
Goal # 3: Public resource home placement stability will improve to 4.2 or less.		Objective: Preserve willingness and strengthen the abilities of current foster parents.		

Placement Stability - current CY2018 rate is 4.38, data source: MD CHESSIE)	

Strategy 1: Enhance visibility of resources and accessibility of training and support services to foster parents. (Strategy 1, 3)

#	Action step	Person or people responsible	Start date	Complete date
1	Provide resource parents with ongoing access to on-site and on-line training calendars. This will allow for information to be disseminated in regards to both general and child-specific information.	LDSS Resource Home Caseworker, SSA Resource Home Supervisor/Analyst, Maryland Resource Parent Association, State Foster Parent Ombudsman, University of Maryland Child Welfare Academy	July 2019	June 2024
2	Provide Maryland Resource Parent Association with access to all current resource parents across the state.	LDSS Resource Home Caseworker, SSA Resource Home Supervisor/Analyst, Maryland Resource Parent Association.	June 2019	June 2024
3	Arrange for panel presentations by the State Youth Advisory Board of trainings and events	LDSS Resource Home Caseworker, State Independent Living Coordinator, SSA Resource Home and Older Youth Supervisor/Analyst	June 2019	June 2024

Strategy 2: Ensure resource parents are present at Family Involvement meetings whenever possible to discuss placement options of youth and be included in the conversation. (Strategy 6)

#	Action step	Person or people responsible	Start date	Complete date

1	Upon revision of the FIM policy, SSA will monitor resource parent presence at FIM meetings by looking at the statewide CFSR, FIM data and LDSS resource parent surveys to assess whether they are at the table during the FIM meeting.	SSA Resource Home Supervisor/Analyst, SSA CQI Analyst, LDSS FIM facilitators and staff.	July 2019	January 2021 **2020 Progress:: Goal Updated to June 2022**. **SSA is currently awaiting approval of Family Teaming Policy**
2	Ensure resource parent, LDSS casework staff, and biological parents are knowledgeable about FIM meetings and have access to participate.	SSA Resource Home, Outcomes Improvement Supervisor/Analyst, LDSS FIM casework staff, State Court Improvement Project	July 2019	June 2024
Strategy 4: Increase the availability of resource homes that are able to provide care for sibling groups. (Strategy 5)				
#	Action step	Person or people responsible	Start date	Complete date
1	Assess the current resource parent pool for potential kinship providers and/or prospective adoptive homes to potential homes.	LDSS Resource Home Caseworker SSA Resource Home Supervisor/Analyst	July 2019	June 2024
2	Track/Trend state level sibling visitation data and monitor placement stability and provide technical assistance to the LDSS casework staff.	LDSS Resource Home/Permanency Worker, SSA Resource Home Supervisor/Analysts	July 2019	June 2024

Goal # 4: Increase the number of youth placed in a pre-adoptive home. Target: Maryland will increase the number of children placed by 20% by 2024. CY2018 data, monthly average: 26 children are in pre-adoptive homes.		Objective: Increase the number of homes for legally free children.		
Strategy 1: Public Awareness Campaign (Strategy 1,6)				
#	Action step	Person or people responsible	Start date	Complete date
1	Assess LDSS adoption data and contact the LDSs to inquire about barriers to placement.	LDSS Resource Home Caseworker/Permanency Worker SSA Resource Home Supervisor/ Analyst	July 2019	June 2024 **2020 Progress: SSA has issued the quarterly LDSS Adoption Incentive Goals to begin discussion regarding barriers.**
2	Increase the profiling of youth on Adopt-us-Kids website.	LDSS Resource Home Caseworker/Permanency Worker, SSA Resource Home Supervisor/Analyst, AUK SSA Resource Home Supervisor/Analyst	July 2019	June 2024

3	Increase the practice of inter-jurisdictional adoptive placement.	LDSS Resource Home Caseworker/Permanency Worker, SSA Resource Home Supervisor/Analyst	October 2019	September 2020 Update: September 2021 **2020 Progress: SSA has begun work with the LDSS regarding distributing the Adoption/Guardianship Fact Sheet and procured a contract for Adoption Competency within the CW Workforce.**
5				
Strategy 2: Develop public-private partnerships with adoption agencies and other partners in order to increase adoption/guardianship placements within the state.(Strategy 6)				
#	Action step	Person or people responsible	Start date	Complete date
1	Partner with state adoption agencies such as the Center for Adoption Support and Education, Adoptions Together, Contracted CPA providers around adoption education and recruitment.	LDSS Resource Home/Adoption Caseworkers, SSA Resource Home Supervisor/Analyst, CASE, Adoptions Together	September 2019	July 2020 Completed
2	Increase LDSS caseworker adoption competency.	LDSS Resource Home/Permanency worker, SSA Resource Home Supervisor/Analyst	January 2020	*December 2020* **2020 Progress: SSA has procured a contract for Adoption Competency**

				within the CW Workforce.
5	Utilize Adoptions Together and AUK technical assistance for locating placements through inter-jurisdictional matching	LDSS Resource Home/Adoption Staff, SSA Resource Home Analyst/Supervisor, Adoptions Together and AUK liaison.	September 2019	Annual Reviews **2020 Progress: SSA has procured a contract with Adoptions Together and initiated discussions within the Permanency Workgroup regarding technical assistance via the mentioned partners.**

Maryland Department of Human Services-Social Services Administration
Annual Training Report
January-December 2020 (Quarterly Intervals)

January 2020-March 2020
Title IV-E New Workshop Matrix

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
In-Service Course	**Advanced Coaching: Enhancing Your Coaching Skillset and Mindset** In this workshop we will build on the coaching mindsets and skillsets developed in the first course. We will explore the impacts of our wiring - our neurobiology - on how to motivate and coach others. And, we will see how the reality of our complex world can limit our ability to coach and lead effectively.	11 hours	Child Welfare Academy/Regional	Child Welfare Workers and Supervisors	State General Funds
In-Service Course	**Now What? Practical Applications of the Personality Disorders** Many child welfare professionals want to develop skills to help them better interact with individuals with personality disorders to ensure a productive working relationship. In this interactive training, attendees will learn, and practice skills aimed at meeting the needs of such individuals through effective communication and limit-setting, increased cooperation, and conflict resolution. Title IV-E Activities: General Mental Health Awareness; Communication Skills	3 hours	Child Welfare Academy/Regional	Child welfare Supervisors and Workers	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate
In-Service Course	**Raising Disability Awareness in the Child Welfare System**	5.5 hours	Child Welfare Academy/Regional	Child welfare Supervisors	Title IV-E Training at 75% FFP

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	This training will focus on children, youth and parents with disabilities by addressing the scope of the issue, risk factors, strategies for assessment, engagement tools and best practice recommendations. Participants will increase their capacity to engage with individuals with disabilities in a manner that is individualized, strengths-based, family-centered and culturally responsive. Title IV-E Activities: Cultural Diversity			and Workers	after applying Title IV-E penetration rate
In-Service Course	**Refining Service Planning Skills** This half-day refresher training for Safety/Service Planning will provide a review and opportunity for focus on the successful implementation of new skills utilized when working with families to develop appropriate service plans. Title IV-E Activities: Job Performance Enhancement, Development of Case Plan	3 hours	Child Welfare Academy/Regional	Child welfare Supervisors and Workers	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate
	Substance Use Trends Among Youth & the Effects of Substances on Families This training will look at how biological, environmental and genetic factors influence drug use among adolescents and teens. Participants will understand the current trends of substance use among this group and the reasons young people are attracted to certain drugs. This training will also identify special considerations to be aware of when working	5.5 hours	Child Welfare Academy/Regional	Child welfare Supervisors and Workers	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	with families affected by a substance use disorder. Title IV-E Activities: General Substance Abuse				
In-Service Course	**Time Management Primer for Child Welfare Workers** This seminar is designed to help program staff gain control of their time and manage their workload with greater ease and confidence. Through techniques that are easy to understand and implement, participants will learn how to get organized and stay that way, set manageable goals, prioritize tasks, and create more time in their day when there is no time to waste. Title IV-E Activities: Job Performance Enhancement	1.5 hours	Child Welfare Academy Webinar	Child welfare Supervisors and Workers	Title IV-E Training at 50% FFP after applying Title IV-E penetration rate
In-Service Course	**Working with Adolescents to Build a Cooperative Relationship** This seminar is designed to help participants understand the relationship between trauma and adolescent development, with an emphasis upon how the normative developmental tasks of identify development, separation and individuation can be exacerbated for adolescents in care. Participants will gain a better understanding of adolescent brain development through a trauma lens and will be able to differentiate between "typical" adolescent challenges versus behavior that has been negatively shaped by trauma. Workers will be	5.5 hours	Child Welfare Academy/Regional	Child welfare Supervisors and Workers	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	equipped with knowledge and skills to better communicate with and build a positive relationship with the teens support permanency planning. Title IV-E Activities: Trauma Responsive Practice				
Continuing Professional Education					
CPE In-Service Course	**28 C's of Ethics** Approximately 45% of ethics complaints about social workers can be linked directly to social work ethics codes. The majority of complaints are outside the scope of ethics codes and are not directly or adequately articulated in the ethics codes. The focus of this workshop is to aid child welfare workers in avoiding actions or situations that could lead to ethics complaints based on the Maryland Board of Social Work Examiners Code of Ethics and/or the National Association of Social Workers (NASW) Code of Ethics. Title IV-E Activities: Ethics	6 hours	Continuing Professional Education SSW	Child welfare Supervisors and Workers	Title IV-E Training at 50% FFP after applying Title IV-E penetration rate
CPE In-Service Course	**Harnessing the Power of "We"** By bringing professionals, together group supervision enables members to reflect on their work and improve each other's skills and capabilities. Reviewing COMAR requirements for supervision, structures for group supervision, and managing hurdles of the group process.	3 hours	Continuing Professional Education SSW	Child welfare Supervisors	State General Funds
CPE In-Service Course	**It's Not "Taken": Realities of Domestic Trafficking** This workshop will explore the latest data on the overlap between child welfare and sex	6 hours	Continuing Professional Education SSW	Child welfare Supervisors and Workers	Title IV-E Training at 75% FFP after applying

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	trafficking, and will discuss the training needs of child welfare workers to equip themselves with the skills and knowledge necessary to assess if a youth is a victim of sex trafficking and identify appropriate services to support their safety and well-being.. Title IV-E Activities: Assessment and Planning				Title IV-E penetration rate
CPE In-Service Course	**Navigating Ethical Boundaries with Clients and Peers** This three-hour workshop is focused on the development of strategies to address the common, yet complex, ethical issues concerning boundaries child welfare workers face in their practice. Content will cover the following topics: establishing and maintaining ethical boundaries; different types of boundaries, and the impact of boundaries on practice and client outcomes. Current legal references will be provided, concerning relevant statutes and the ethical codes of practice for behavioral health professionals. Title IV-E: Ethics	3 hours	Continuing Professional Education SSW	Child welfare Supervisors and Workers	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate
CPE In-Service Course	**Social- Emotional Development** **How to Partner with Teachers and Parents in Support of Young Children:** Participants will gain a better understanding of the social-emotional behavior of children under the age of five, and how best to support teachers and parents.	3 hours	Continuing Professional Education SSW	Child welfare Supervisors and Workers	State General Funds

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
CPE In-Service Course	**The ABC's of ACEs: An Overview of the Adverse Childhood Experience** As we become more knowledgeable about the effects of trauma and understanding early adversity can have lasting impacts, the Adverse Childhood Experiences Scale is increasingly used to screen for traumatic experiences in childhood. This session will focus on understanding the ACES and utilizing it as a screening tool to help identify risk factors in order to team with individuals to identify services to mitigate those risks. Title IV-E Activities: Trauma Responsive Practice; Assessment, Development of case plan	1.5 hours	Continuing Professional Education SSW	Child welfare Supervisors and Workers	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate
CPE In-Service Course	**Working with Transgender Children, Youth, and Their Families** This workshop increases your skills in supporting transgender children, teens, and their families to make sure professionals feel confident and prepared to partner with the youth to develop an appropriate plan that address their strengths and challenges. Title IV-E Activities: Cultural Competency	3 hours	Continuing Professional Education SSW	Child welfare Supervisors and Workers	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate

Maryland Department of Human Services
April 2020-June 2020
Title IV-E New Workshop Matrix

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
In-Service Course	**CQI, Data and CFSR Training**	5.5 hours	Child Welfare Academy/Regional	Child Welfare Workers	State General Funds

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	This training is an introduction to Continuous Quality Improvement (**CQI**) in Maryland for Child Welfare staff. Participants will gain an understanding of the State's CQI processes, the difference between quantitative (numerical) data and qualitative (narrative) data, and the combined use in improving practice when serving families and children in Maryland. This includes an overview of the Maryland Child and Family Services Review (**CFSR**) and the participants' role as their local department is involved in the many stages of the process.			and Supervisors	
In-Service Course	**Engaging Empathy** This interactive workshop provides participants with the opportunity to learn client conceptualization techniques to improve provider empathy. Using a strengths-based and person-centered approach, participants will also engage in a coaching session where they will learn strategies to employ with all clients.	5.5 hours	Child Welfare Academy/Regional	Child Welfare Workers and Supervisors	State General Funds
In-Service Course	**The Essentials of Clinical Supervision: The Dynamics of Effectiveness:** Today's practice environment is increasingly complex and stressful for social workers	11 hours	Child Welfare Academy/Regional	Child Welfare Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	and their supervisors. Increasing caseloads, funding challenges, budget shortfalls, regulatory and documentation burdens, and a steady push for accountability leave us all exhausted from being asked to do more with less. This new two-day interactive workshop will provide a framework for supervisors, at all experience levels and in all practice settings, to develop their own knowledge, skills, competence, and effectiveness as supervisors in order to help their supervisees develop the same. Title IV-E Activities: Supervisory skills				penetration rate
In-Service Course	**Introduction to Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** This webinar will present an overview of child trauma including common reactions to trauma and an introduction to Trauma-Focused Cognitive Behavioral Therapy, an evidence-based treatment for children and families exposed to traumatic life events. This webinar will highlight the relevant evidence for this approach, format and structure of the model, client criteria and model	1.5 hours	Webinar	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	components. It will also discuss the role caregivers have in treatment and how child welfare workers can best support a child who is participating in TF-CBT. Title IV-E Activities: Trauma Responsive Care				
In-Service Course	**Marijuana Legalization and the Impact on Child Welfare** Marijuana Legalization, both for medical reasons and for personal use, is taking place across the country including in Maryland. Changes in Marijuana laws will affect child welfare workers through its effect on the criminal justice system, prevention messages to youth and rates of Marijuana use, drug treatment access, and health effects on Marijuana users. This class will prepare child welfare workers to understand the public health and criminal justice consequences of reform of Marijuana laws, different types of legal reforms, and how they can advocate for the health and safety of children as the State of Maryland moves toward Marijuana legalization. Title IV-E Activities: Substance abuse	5.5 hours	Child Welfare Academy/Regional	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
In-Service Course	**What Should I Say? Handling Difficult Conversations at Work: A Training for Supervisors** Avoiding difficult conversations at work can grow to become a major barrier and obstacle to excellent performance. Despite our education and training, not having difficult conversations with those we supervise is something that many of us suffer from. When we avoid these conversations, we fail to address the issue at hand with the person who needs to hear it. This can lead to sub-optimal performance. In this interactive and dynamic training, you will learn strategies to overcome these obstacles and learn proven techniques on how to have courageous conversations and how to provide constructive feedback to those you supervise. Title IV-E Activities: Supervisory skills	5.5 hours	Child Welfare Academy/Regional	Child Welfare Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate
In-Service Course	**Working Through Resistance** This workshop will focus on the skills and ideas that are necessary to engage and also support a client presenting with "resistance" An emphasis is placed specifically on the professional examining his or her	3 hours	Child Welfare Academy/Regional	Child Welfare Workers and Supervisors	State General Funds

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	experience and worldview and in turn, how that perspective influences one's interpretation of observable phenomenon.				
Resource Parent Training	Mindfulness: From Chaos to Calm	1-3 Hours	Child Welfare Academy / Online	Maryland Resource Parents licensed through their Local Department	

Maryland Department of Human Services
July 2020 –Sept 2020
Title IV-E New Workshop Matrix

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
In-Service Course	**Ethics, Resiliency and the Pandemic** This seminar explores the ethical imperative we each have to cultivate personal and professional resilience during this time. Participants will learn specific strategies that enhance resiliency for themselves and their clients so that they will have the capacity to deliver services according to best practices. Title IV-E Activities: Ethics	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
In-Service Course	**A Disaster of Uncertainty: Life and Addictions Social Work in the Time of COVID-19**	3 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	The pandemic has heightened awareness of substantial health disparities as well as how the Digital Divide challenges providers and clients. However, we have, of necessity, catapulted 20 years into the future of telehealth and this workshop will also consider the pros and cons of this dramatic leap into the future of telehealth. We will also consider how social workers are uniquely well prepared to help navigate our families and workplaces and communities through this Disaster of Uncertainty on the micro and macro levels. Title IV-E Activities: Substance Abuse				Title IV-E penetration rate
In-Service Course	**Practicing Boundaries During a Time of Telework and Social Distancing** COVID-19 has resulted in unprecedented levels of uncertainty, global stress, and blurring of work and home life. The importance of boundaries is clear, but making decisions and plans to balance work and personal life can be challenging, particularly for those in the helping professions. In this training, attendees will	1.5 hours	Child Welfare Academy/Virtual	Child Welfare Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	discuss the benefits of boundaries a nd identify ways to set limits and reframe the pandemic experience. Title IV-E Activities: Professional Development				
In-Service Course	**Integrating Technology & Child Welfare Services** This live webinar workshop will explore the use of technology for child welfare professionals and social service providers when working with children and families. By examining ethical and legal considerations, best practices, and strategies for increased client engagement; providers will become familiar with techniques to enhance their effectiveness when utilizing tele-behavioral health through live instruction, interactive polling, and breakout sessions. Title IV-E Activities: Professional Development	3 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetratio n rate
In-Service Course	**Healing Centered Engagement** Participants will learn about how to use a healing centered approach to support children in their care in healing from trauma.	3 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetratio n rate

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	Specific strategies will be identified, and challenges will also be discussed. Title IV-E Activities: Trauma Responsive Care				
In-Service Course	**Understanding and Addressing the Complex Web of Childhood Abuse and Trauma** This workshop will explore the effects of medication and how many children have lost the ability to self-sooth and regulate emotions, unless they are given a pill. Participants will gain an understanding regarding the best treatment modalities treating children and adolescent to assist them identify appropriate services. Current literature will be discussed, and participants will be able to articulate the importance of understanding treatmen t modalities to best advocate for children and families. Title IV-E Activities: Child Abuse and Neglect	3 hours	Child Welfare Academy/Virtual	Child Welfare Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetratio n rate
	Attention-Deficit/Hyperactivity Disorder (ADHD) in Substance Use Disorders	3 hours	CPE/ Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	This training will discuss what ADHD is and the neurobiology and etiology that increases the likelihood of someone being diagnosed with ADHD. The training will explore the symptoms and strengths of ADHD and tie in how SUD is linked to this diagnosis. And finally, effective treatment options will be identified to help child welfare workers advocate for clients and stop the trend of people with ADHD being at higher risk for substance abuse, including working to know the facts, the use of medication, and understanding the triggers. Title IV-E Activities: Mental Health				penetration rate
Continuing Professional Education	**Beyond Acknowledging Diversity: Moving Towards Inclusion and Allyship** It is time to move beyond simply acknowledging diversity in our organizations. We must move to creating a more inclusive organizational climate for our organizations. This work is done through allyship and action. In this course, you will assess your organization's diversity and inclusion culture	3 Hours	CPE/ Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	and develop an action plan to build a more inclusive organization. Title IV-E Activities: Cultural Diversity				
Continuing Professional Education	**Collaborative IQ** Collaborative IQ is more critical in today's workplace than ever before. How do you raise the collaborative IQ of your team and enable smart people to be smarter, together? A group of high performing individuals in and of itself does not constitute a successful team. This training will give specific and concrete tools that can easily be used with teams.	3 hours	CPE/Virtual	Child Welfare Workers and Supervisors	State General Funds
	How to Assist Parents in Raising Free People 4 Strategies for Applying Decolonization and De-schooling to The Ways We Raise and Relate to Children This workshop and this practice help adults focus on transitioning from master to partner; embrace collaboration instead of coercion; be willing to listen; and embody compassion as we raise and support confident, happy, community-minded, fully equipped, liberated people. During this session, we will challenge the things we held in our minds as	3 hours	CPE/Virtual	Child Welfare Workers and Supervisors	State General Funds

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	true and begin to unpack the reality of our participating in the oppression of people through parenting, caregiving, and overall relationships with children. This workshop is to help providers support parents in understanding and conveying more emotionally healthy ways to support their children.				
In-Service Course	**Utilizing Technology with Couples, Families, and Groups** Many of the published resources around tele-mental health focus largely on providing care to individuals. For many that serve couples, families, and facilitate groups, there is a collective realization of the difference in needs, assessment, communication, and engagement, when providing support to more than one person simultaneously from a distance. Through live instruction, polling, and a live Q&A, we'll compare HIPAA secure platform features that allow for multi-point connection, review key terminology, explore single-point versus multi-point advantages and challenges,	3 hours	CPE/Virtual	Child Welfare Workers and Supervisors	State General Funds

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	engagement techniques, insurance adjustments, ethical concerns, and online group guidelines when serving multiple participants.				
	Understanding and Preventing Sexual Violence among Communities of Color This workshop will explore and identify risk and protective factors for sexual violence. The culture of silence will be discussed in order to fully understand how breaking the silence of sexual violence can help prevent sexual abuse. Participants will discuss the various forms of sexual trauma and the psychosocial and collateral factors related to sexual violence. Title IV-E Activities: Sexual Abuse	3 hours	CPE/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetratio n rate
In-Service Course	**Talking to Children and Families about Race Strategies for Therapist and Clinicians** This webinar covers information about children's race awareness and racial attitudes and how parents and other adults socialize children regarding race. Specific focus will be on how to talk to children and families about race, and strategies for therapists and clinicians working	3 hours	CPE/Virtual	Child Welfare Workers and Supervisors	State General Funds

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	with diverse clients will be presented.				
	What You Don't Know CAN Hurt You: Links Between Law, Ethics, Risk Management and Social Work Practice This workshop will explore the context and various kinds of requirements social workers are obligated to follow. The workshop will include opportunities to enhance skills for locating and understanding laws and regulations relevant to social work practice. Risk Management strategies will also be explored, and a Policy Guide will be provided. Title IV-E Activities: Ethics	3 hours	CPE/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate
	The Your Money, Your Goals Financial Empowerment Toolkit: Viewing Financial Empowerment in Difficult Times through a Social Work Lens This course explores the CFPB's Financial Empowerment Toolkit and how social workers and other helping professionals can utilize vital tools and build their skills to address financial distress in their	3 hours	CPE/Virtual	Child Welfare Workers and Supervisors	State General Funds

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	clients and communities. Financial Social Work is an important, emerging area of social work practice, and it is more important than ever for social workers and others to be competent and effective as they work with individuals, families, and communities in profound need.				

Maryland Department of Human Services
October 2020 –December 2020
Title IV-E New Workshop Matrix

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
In-Service Course	**Conflict to Collaboration** This workshop focuses on understanding how and why conflict arises and how to negotiate it in order to resolve the conflict. Handling conflict properly is an art and a science; once trained, you can respond professionally and calmly under any conflict related condition In this workshop, you will learn how to manage conflict and how to effectively deal with it. Title IV-E: Job performance and enhancement skills	3 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 50% FFP after applying Title IV-E penetration rate
In-Service Course	**IPM Module One: Authentic Partnership & Engagement**	5.5 hours	Child Welfare Academy/Virtual	Child Welfare Workers	Title IV-E Training at 75% FFP

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	The first in a series of IPM foundational trainings, the Authentic Partnership and Engagement training is a learning exchange that builds upon and magnifies existing effective practice in Maryland, while infusing lived experiences and perspectives of families. The focus will be on building the essential knowledge and skills necessary to authentically engage and partner with children, youth, families and vulnerable adults to catalyze a shift in philosophy and practice state-wide. Title IV-E Activities: Social work practice			and Supervisors	after applying Title IV-E penetration rate
In-Service Course	**IPM Module Two: Teaming** The second module in the Integrated Practice Model training series, Teaming, will reinforce the Authentic Engagement and Partnership module by focusing on the IPM core practice of teaming to support desired outcomes for children, youth, families and vulnerable adults. Teaming is the shared identification of family and community supports to mobilize strengths and resources, as well as maximize protective factors. Moving beyond an isolated meeting or one-time event, teaming is a continuous, collaborative process that lives	5.5 hours	Child Welfare Academy/Virtual	Child Welfare Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	throughout the life of a case and is woven into every aspect of service delivery. Building on a strong foundation, this module will augment teaming best practices in Maryland through an exploration of the benefits, barriers, and practical skills needed to establish and engage teams to achieve safety, permanency and well-being outcomes. Title IV-E: Social work practice				
In-Service Course	**IPM Module Two: Teaming** The second module in the Integrated Practice Model training series, Teaming, will reinforce the Authentic Engagement and Partnership module by focusing on the IPM core practice of teaming to support desired outcomes for children, youth, families and vulnerable adults. Teaming is the shared identification of family and community supports to mobilize strengths and resources, as well as maximize protective factors. Moving beyond an isolated meeting or one-time event, teaming is a continuous, collaborative process that lives throughout the life of a case and is woven into every aspect of service delivery. Building on a strong foundation, this module will augment	5.5 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 75% FFP after applying Title IV-E penetration rate

Training Activity	Course	Duration	Provider/Venue	Audience	Cost Allocation
	teaming best practices in Maryland through an exploration of the benefits, barriers, and practical skills needed to establish and engage teams to achieve safety, permanency and well-being outcomes. Title IV-E: Social work practice				
In-Service Course	**Redefining Resistance** This training aims to discuss challenging individuals presenting with issues such as personality disorders, substance abuse, and domestic violence. Attendees will learn underlying causes for symptoms and their impact on the working relationship and progress towards goals. Attendees will discuss ways to manage interactions with these individuals more effectively through case conceptualization, effective boundary-setting, and healthy conflict resolution to support a family stability or reunification efforts. Title IV-E Activities: Social work practice	3 hours	Child Welfare Academy/Virtual	Child Welfare Workers and Supervisors	Title IV-E Training at 50% FFP after applying Title IV-E penetration rate

APSR Appendix F

Annual Reporting of Education and Training Vouchers Awarded

Name of State/ Tribe: Maryland

	Total ETVs Awarded	**Number of New ETVs**
Final Number: **2019-2020 School Year** (July 1, 2019 to June 30, 2020)	120	38
2020-2021 School Year* (July 1, 2020 to June 30, 2021)	155	60

Comments:

*In some cases, this might be an estimated number since the APSR is due on June 30, the last day of the school year.

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 2022: October 1, 2021 through September 30, 2022

1. Name of State or Indian Tribal Organization and Department/Division:	**3. EIN:**	52-6002033
Maryland Department of Human Services (DHS)	**4. DUNS:**	878358332
2. Address: (insert mailing address for grant award notices in the two rows below)	**5. Submission Type:** New	
311 W. Saratoga St.		
Baltimore, Maryland 21201		
a) **Email address** for grant award notices: stafford.chipungu@maryland.gov		

REQUEST FOR FUNDING for FY 2022:

The annual budget request demonstrates a grantee's application for funding under each program and provides estimates on the planned use of funds. Final allotments will be determined by formula.

Hardcode all numbers; no formulas or linked cells.

6. Requested title IV-B Subpart 1, Child Welfare Services (CWS) funds:		$3,981,262
a) Total administrative costs (not to exceed 10% of the CWS request)		$398,126
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%	$923,534
b) Family Support Services	20.0%	$923,534
c) Family Reunification Services	20.0%	$923,534
d) Adoption Promotion and Support Services	20.0%	$923,534
e) Other Service Related Activities (e.g. planning)	10.0%	$461,768
f) Administrative costs (*STATES ONLY: not to exceed 10% of the PSSF request; TRIBES ONLY: no maximum %)*	10.0%	$461,768
g) Total itemized request for title IV-B Subpart 2 funds: *NO ENTRY: Displays the sum of lines 7a-f.*	100.0%	*$4,617,672*
8. Requested Monthly Caseworker Visit (MCV) funds: *(For STATES ONLY)*		$291,386
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*)		$1,628,433
10. Requested John H. Chafee Foster Care Program for Successful Transition to Adulthood:		$1,274,363
a) Indicate the amount to be spent on room and board for eligible youth (not to exceed 30% of Chafee request).		$382,308
11. Requested Education and Training Voucher (ETV) funds:		$386,999

REALLOTMENT REQUEST(S) for FY 2021:

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 2021 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 ***Lourdes R. Padilla*** Lourdes R. Padilla		***Signature of Federal Children's Bureau Official*** Joseph Bock for Aysha E. Schomburg
Secretary, Maryland Department of Human		***Title***
Date 6/30/21		***Date*** 11/10/2021

CFS-101 Part II: Annual Estimated Expenditure Summary of Child and Family Services Funds

Name of State or Indian Tribal Organization: Maryland Department of Human Services (DHS) **For FY 2022: OCTOBER 1, 2021 TO SEPTEMBER 30, 2022**

SERVICES/ACTIVITIES	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)	(L)
1.) PROTECTIVE SERVICES	$ 1,433,254			$ 618,805				$ 72,698,676	19,091		Children	Statewide
2.) CRISIS INTERVENTION	$ -	$ 923,534		$ -				$ 22,823,472	-	1,041	risk of entering foster	Statewide
3.) PREVENTION & SUPPORT	$ -	$ 923,534		$ 602,520				$ 291,508	-	1,041	of entering foster care	Statewide
4.) FAMILY REUNIFICATION	$ 2,149,882	$ 923,534		$ -				$ 1,711,548	1,560	1,034	chidlren in foster care or	statewide
5.) ADOPTION PROMOTION AND	$ -	$ 923,534						$ 253,203	547	815	adoption	statewide
6.) OTHER SERVICE RELATED	$ -	$ 461,768						$ 1,147,354	-	-	-	-
7.) FOSTER CARE MAINTENANCE:	$ -						$ 39,499,715	$ 23,595,486	4,404		Children	statewide
(b) GROUP/INST CARE	$ -						$ 17,321,496	$ 128,692,848	673	-	Children	statewide
8.) ADOPTION SUBSIDY PYMTS.	$ -						$ 28,877,706	$ 16,011,617	11,303	11,303	youth	statewide
9.) GUARDIANSHIP ASSISTANCE	$ -						$ 618,169	$ 29,881,707	2,781	2,781	youth.	statewide
10.) INDEPENDENT LIVING	$ -				$ 1,274,363			$ 225,906	2,185	0	Youth in care 14-21	-
11.) EDUCATION AND TRAINING	$ -				$ -	$ 386,999		$ 77,400	200	-	foster youth agens 14-	statewide
12.) ADMINISTRATIVE COSTS	$ 398,126	$ 461,768	$ -				$ 5,425,828	$ 67,565,798				
13.) FOSTER PARENT RECRUITMENT & TRAINING	$ -	$ -		$ 407,108			$ -	$ 760,146				
14.) ADOPTIVE PARENT RECRUITMENT & TRAINING	$ -	$ -		$ -			$ -	$ 760,146				
15.) CHILD CARE RELATED TO EMPLOYMENT/TRAINING	$ -						$ -	$ -	-	-	-	-
16.) STAFF & EXTERNAL PARTNERS TRAINING	$ -	$ -		$ -	$ -	$ -	$ 1,203,847	$ 3,884,965				
17.) CASEWORKER RETENTION, RECRUITMENT & TRAINING	$ -	$ -	$ 291,386				$ -	$ 62,699				
18.) TOTAL	$ 3,981,262	$ 4,617,672	$ 291,386	$ 1,628,433	$ 1,274,363	$ 386,999	$ 92,946,761	$ 370,444,479				
19.) TOTALS FROM PART I	$3,981,262	$4,617,672	$291,386	$1,628,433	$1,274,363	$386,999	-----	-----	-----	-----	-----	-----
20.) Difference (Part I - Part II)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-----	-----	-----	-----	-----	-----

(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 Part II exceeds request)

21.) Population data required in columns I - L can be found: On this form

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 2019 Grants: October 1, 2018 through September 30, 2020

1. Name of State or Indian Tribal Organization:	**2. Address:**				**3. EIN: 52-6002033**
Maryland Department of Human Services (DHS)	311 W. Saratoga St.				**4. DUNS: 878358332**
5. Submission Type: (select one)	Baltimore, Maryland 21201				
Description of Funds	**(A)**	**(B)**	**(C)**	**(D)**	**(E)**
6. Total title IV-B, subpart 1 (CWS) funds:	$ 3,951,830	6,116		Children	Statewide
a) Administrative Costs *(not to exceed 10% of CWS allotment)*					
7. Total title IV-B, subpart 2 (PSSF) funds: Tribes enter amounts for Estimated and Actuals, or complete 7a-f.	$ -	5,147	3,322	Children and Families	Statewide
a) Family Preservation Services	$ 1,390,620				
b) Family Support Services	$ 930,843				
c) Family Reunification Services	$ 930,843				
d) Adoption Promotion and Support Services	$ 1,123,205				
e) Other Service Related Activities (e.g. planning)	$ 32,949				
f) Administrative Costs *(FOR STATES: not to exceed 10% of PSSF allotment)*	$ 245,756				
g) Total title IV-B, subpart 2 funds: NO ENTRY: This line displays the sum of lines a-f.	*$ 4,654,216*				
8. Total Monthly Caseworker Visit funds: *(STATES ONLY)*	$ 193,280				
a) Administrative Costs *(not to exceed 10% of MCV allotment)*	$ -				
9. Total Chafee Program for Successful Transition to Adulthood Program (Chafee) funds: *(optional)*	$ 1,238,095	-	-		
a) Indicate the amount of allotment spent on room and board for eligible youth *(not to exceed 30% of Chafee allotment)*	$ -	286	-	children and youth (ages 14-21)	Statewide
10. Total Education and Training Voucher (ETV) funds: *(Optional)*	$ 375,864	379	* Number served includes multiple academic school years	Current and Former foster care youth age 14-26 who attend post secondary education programs	statewide

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: Lourdes R. Padilla		***Signature of Federal Children's Bureau Official***	
Lourdes R. Padilla		Joseph Bock for Aysha E. Schomburg	
Title	***Date***	***Title***	***Date***
Secretary Department of Human Services	***6/30/2021***		11/10/2021