RESPONSE TO UMSSW RECOMMENDATIONS FROM THE L.J. PLACEMENT ASSESSMENT

DHS and BCDSS have benefitted from the Biennial Needs Assessment. BCDSS has aligned its strategies with the Institute's recommendations and is working to increase family based placements through recruitment efforts and to stabilize these placements with the implementation of its new Behavioral Health Initiative and other support services that may be available.

The Assessment shows that most children in care are placed in family settings. This confirms the Department's understanding that it has a sufficient range of family placement options to meet the needs of a large majority of the children in its care. However, the Department is responsible for a small group of youth with high intensity needs that present significant placement challenges as evidenced by the Overstay/Waitlist and the agency recommends that the next biennial assessment focus on these youth.

The following is of BCDSS' response to each of the UMSSW Recommendations resulting from the Assessment:

Short-Term (within the next year)

1) Children in the care of BCDSS or any local department of social services across Maryland who are at-risk of out-of-home placement or a non-family placement should have comprehensive and frequent (at least monthly) FTDM that encourage the use of flexible strategies and natural supports. All children in out-of-home placement should be having FTDM consistent with policy.

BCDSS and SSA agree on the importance of FTDMs and Family Teaming. They have substantially revised their FTDM policies and procedures during the last two years in order to emphasize their use at all critical decision-making points during a child's case beginning with the child's likely removal and during possible changes in placement or permanency plan. This work is reflected in SSA Policy 21-02 issued October 1, 2021, and BCDSS SOP released on August 16, 2021 and revised for release on October 3, 2022. The SSA Policy and BCDSS SOP provide that FTDMs and other forms of Family Team Meetings are the platform for all problem solving and critical decisions that need to be made in order to service the children and families that become involved with BCDSS. BCDSS conducted training in conjunction with the Annie E. Casey Foundation for case managers and supervisors in order to familiarize them with the new procedures. As a result of these new policies, a continuum of family focused and driven meetings have been established to address problems and make the critical decisions necessary to achieve permanency for the children in care. Ongoing review of the policies and procedures continues as does continuing hands-on training for case managers, supervisors, and stakeholders to ensure the best possible outcomes resulting from the use of Family Teaming.

2) BCDSS should continue to engage in recruitment and retention activities to increase the number of foster homes to meet the placement needs of children who cannot remain safely in their own homes. DHS should support a comprehensive statewide recruitment and retention plan for resource homes, in collaboration with local departments of social services and child placing agencies, to support utilization of best practices and reduce duplication of efforts.

BCDSS recruits foster homes on a regular basis and every year, updates its plan for recruitment and retention. In particular, BCDSS has committed to implementing the Trust Based Relational Intervention (TBRI) model for our resource homes in order to ensure that our resource families have the skills to service our children appropriately. Furthermore, BCDSS is hiring another staff member to recruit resource families. The incoming staff member has a wealth of resource home knowledge and is experienced in community engagement.

3) BCDSS should improve the meaningful use of the CANS, in partnership with DHS. CANS should be completed at a frequency consistent with policy and needs and strengths should be documented and consistent with placement and other decisions. If children appear to be unable to remain in a family setting or move into a family setting due to concerns about behavior management or supervision, BCDSS should use short-term (2-12 weeks) in-home supports, such as a behavioral specialist, to provide supervision, structure, and/or supportive services, particularly during key periods during the day or night when increased supervision would enable the child to remain in the home.

BCDSS, in partnership with UMSSW, continues to train the workforce on the proper use of the CANS tool and agrees that completion of the CANS at the intervals required by SSA Policy 12-14 assists with decision-making, communication, and care planning throughout a child's placement. The agency is emphasizing to staff the importance of documenting needs and strengths and using the tool when developing placements.

BCDSS recognizes the children with behavioral health issues may require additional supports to find and stabilize a placement. It maintains a Mental Health Navigator team that regularly consults with the case management team in order to plan for appropriate mental health intervention for children and youth who demonstrate extreme behavioral issues.

Additionally, on October 1, BCDSS is launching the BCDSS Mental Health Initiative, the first of its kind in the country! This exciting and innovative program will provide 20 therapists specially trained and certified to work with children and youth in foster care in order to understand and meet their specific mental health needs. The training curriculum is a collaboration among the agency and those involved in or familiar with the needs of the families and children. The initiative is structured to promote consistency in the therapeutic relationship by requiring the therapists to follow the child regardless of any change in placement, an innovation that will eliminate a flaw in current practice. The

therapists will be able to work with bio-families and caretakers with the goal of creating behavioral stability and diminishing placement disruption and change.

4)BCDSS should conduct at least quarterly reviews of all children in a non-family based out-of home setting who have been in those placements for at least six months. This review should be done collaboratively with the child, family, and team to include a review of the child's goals, transition plan, and steps needed to move into a family setting. It should be done in a manner consistent with the review process for Qualified Residential Treatment Programs (QRTP). Children and families should be supported to access and engage in evidence-based and promising practices currently available in Baltimore City and across the state, including Functional Family Therapy (FFT), Multisystemic Therapy (MST), Parent Child Interactional Therapy (PCIT), Dialectical Behavioral Therapy (DBT), Aggression Replacement Training (ART), and TraumaFocused Cognitive Behavioral Therapy (TF-CBT).

BCDSS agrees that children in congregate care require special monitoring to ensure that they are being prepared for step down as soon as they are therapeutically ready and will be issuing an SOP that minimally will include the quarterly Family Team meetings as recommended here by the Institute. BCDSS already has policies concerning the placement of children under thirteen in congregate care. In keeping with L.J. and good practice, the policy requires that the placement be medically or therapeutically necessary and approved by the BCDSS Deputy Director prior to the placement and every 180 days thereafter that the child or youth is to remain in the placement.

BCDSS is also developing procedures for placement of any child or youth in a state approved QRTP Placement that will include an assessment and Family Teaming prior to the placement occurring with continued oversight during the placement and discharge planning, again through the process of Family Teaming.

Additionally, BCDSS requires staffings for every child or youth who remains in an out of home placement after 24 months in care. This process will begin at 27 months and the staffing will be held every 90 days thereafter to review the barriers in achieving permanency for the child or youth.

5)DHS should work with the Maryland Department of Health to ensure that children who meet medical necessity criteria can be enrolled in the 1915(i) State Plan Amendment and are able to access to peer support, care coordination, and other services, in coordination with the child's team and, as needed, the local behavioral health authority.

BCDSS has worked closely with DHS and MDH to explore all possible collaborative placements and support service options that can be used or created to support the children and youth in out of home placement that have serious behavioral health needs.

6) BCDSS should continue to participate in Maryland's Quality Service Reform Initiative (QSRI) and be prepared to partner with providers, workers, and families on the implementation of QRTP and the new residential intervention structure and associated rates.
In anticipation of these new structures, BCDSS should utilize the QRTP documentation and review process for any child recommended for a non-family setting to ensure the child's team identifies the prioritized treatment goals, confirms that the placement is necessary for the intensity of treatment and supervisory requirements, and has a plan for transitioning the child back to a family setting within 6-9 months.

BCDSS continues to participate in the QSRI. In order to have qualified individuals to serve as QIs in the QRTP process, BCDSS staff have been identified and training has been initiated. Meetings are occurring between the State and all LDSS in Maryland to have questions answered at the state level to ensure proper use of the QRTP process. BCDSS has a work group that is developing appropriate procedures to implement the QRTP process so that all legal and policy requirements are being followed.

BCDSS has revised its Family Teaming policies and created an appropriate continuum of Family Teaming Meetings for use when a change in placement is anticipated. This includes decisions to place a child in a non-family setting, and to the step down and discharge of the child into less restrictive placements to include continued out of home care, reunification with parents, or placement with another family member.

7) Every child placed in a residential treatment center should have a documented CON within CJAMS.

BCDSS continues to work on the transition from CHESSIE to CJAMS. Making sure that all documents are uploaded into the electronic record is a mandatory directive to all staff. Policy dictates that all medical documentation is provided to the MATCH assigned case manager and all is appropriately placed in CJAMS.

8) BCDSS should implement the revised DHS Youth Transition Planning Process to partner with transition aged youth in care in planning for their future. The Enhanced-Youth Transition Planning Model informed this process to support older youth in foster care, including those planning for or placed in semi-independent living or independent living.

BCDSS has implemented the YTP. BCDSS is currently working on a CJAMS tip sheet to assist staff with documenting the Youth Transition Plan. The Youth Transition Planning Meeting and the resulting signed Youth Transition Plan is an L.J. requirement and the process is integrated into the Family Team Meetings that occur every six months after a youth in care reaches the age of 14.

9) All children who are receiving psychotropic medications or other medications to address behavioral health needs should be reviewed to ensure that they are receiving medication

management and that it is documented in their files. Children should be assessed for overutilization of one or more.

BCDSS is in the process of finalizing a SOP on the appropriate use of Psychotropic Medication for all children in out of home care. The SOP comports with SSA Policy 15-08 Oversight and Monitoring Psychotropic Medications.

Medium-Term Recommendations (2-3 years)

10) DHS should continue to ensure MATCH staff have access to CJAMS, particularly regarding clinical histories and medication use, and that workers are given training on how to access these documents

All MATCH staff have full access to CJAMS and have been trained on the process for inputting all data and documents. The staff has also been provided an instruction manual.

11) BCDSS should replicate the needs assessment to determine if strategies are effective and what needs should be prioritized.

BCDSS is initiating a new contract and scope of work for the next Biennial Needs Assessment. As expressed at the most recent L.J. Forum, BCDSS wants to concentrate this placement needs assessment on the hard to place children and youth in care that are on hospital overstay status and are on the waitlist seeking a more appropriate type of placement that will meet their special needs.

12) BCDSS should expand access to evidence-based and promising practices, particularly those that can be provided in-home and within clinic or community-based settings, including FFT, MST, PCIT, DBT, ART, TF-CBT, and peer support. This should be done in partnership with the Maryland Department of Juvenile Services, local management boards, local behavioral health authorities, the local school system, and other local departments of social services.

As mentioned above, BCDSS is launching its first in the nation Behavioral Health Initiative in October 2022. This program will bring improved behavioral health services to the children and youth in its care and enhance placement stability.

BCDSS is committed to bringing promising evidence-based practices to the families and children that it serves. It will work with other child serving agencies and organizations to this end.

13) BCDSS should be an active participant in continuous quality improvement and implementation activities associated with the new QSRI/residential intervention structures to ensure that contracted residential services meet the identified needs of children being served.

BCDSS will continue to work with DHS to ensure that all of the children and youth in its care receive appropriate services to meet their identified needs.

Long-Term Recommendation (3-5 Years)

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

As previously stated, BCDSS has worked closely with DHS and MDH to explore all possible collaborative placement and support service options that can be used or created to support the children and youth in out of home placement that have serious behavioral health needs.

Additionally, the new Behavioral Health Initiative will also provide much of the service provision described in this recommendation.