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**BY ELECTRONIC MAIL**

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Re: Defendants' Non-Compliance with MCD Provisions on Placements

Dear David, Steve, Judy, Kathleen, and Elissa:

We write on behalf of Plaintiffs pursuant to Section IV, Paragraph A in Part One of the *L.J.* Modified Consent Decree ("MCD") to inform Defendants and the Forum Facilitators that Defendants are not in compliance with multiple requirements concerning placements set forth in Section II and education in Section IV of Part Two of the MCD.

**Section II: Placements**

- **DHR/BCDSS Responsibility**: DHR/BCDSS shall establish and maintain a continuum of out-of-home placements and caregiver supports that is reasonably calculated to ensure that each child in OHP is placed in a stable, less restrictive, and appropriate placement.

- **Outcome 1**: Each child shall be placed in the least restrictive appropriate placement type for that child's needs.

- **Outcome 2**: No child under the age of thirteen shall be placed in congregate care unless it is medically or therapeutically necessary and the child is placed in a program that has services specifically designed to meet that child's needs.

- **Outcome 3**: DHR/BCDSS shall maintain a continuum of placements reasonably calculated to assure that each child is placed in the least restrictive placement for that child.

- **Outcome 7**. Each child's placement shall meet all safety, health, sanitation, licensing, and other legal requirements for that placement.

- **Outcome 10**: No child may be placed in an office, motel, hotel, or other unlicensed facility.

    - If any child is so housed, BCDSS shall notify Plaintiffs' counsel within one working day of the reasons for the placement, the name of the child's CINA attorney, and the steps that BCDSS is taking to find an appropriate placement. Barring extraordinary circumstances, no child may be housed in an office for consecutive nights.

- **Additional Commitment 1**: Biennial needs assessment "of the range of placements and placement supports required to meet the needs of children in OHP by determining the placement resource needs of children in OHP, the availability of current placements to meet those needs, and the array of placement resources and services that DHR/BCDSS needs to develop to meet those needs in the least restrictive most appropriate setting, including sufficient family placements for each child who does not have a clinical need for a non-family placement, family placements available for emergency placement needs, placements appropriate to meet the needs of children with serious mental health problems and children with developmental disabilities, and appropriate facilities and programs for semi-independent and supportive independent living."

- **Additional Commitment 2**: "The DHR Secretary shall include in the DHR budget proposal funds that are sufficient, in the Secretary's judgment, to secure and maintain the array of placement resources and supports needed for children and youth served by BCDSS (including those needed to support the stability of placements and the ability of caregivers to meet the needs of children in OHP and to avoid placement of children in congregate care) and, if included in the Governor's budget, shall advocate for the appropriation of such funds by the General Assembly."

- **Additional Commitment 3**: "BCDSS shall provide stipends to emergency shelter care homes even in months in which children are not provided care to assure that such homes remain available for emergency placements. Should BCDSS determine that this provision is not necessary to achieve the outcomes of this Consent Decree,

BCDSS will propose a modification to this Consent Decree about which the parties will negotiate in good faith. The Secretary shall include funds annually in the DHR budget proposal that are sufficient, in the Secretary's judgment, to meet these requirements and, if included in the Governor's budget, shall advocate for the appropriation of such funds by the General Assembly."

**Section IV: Education:**

- **DHR/BCDSS Responsibility: "**Defendants shall ensure that all children and youth in OHP are provided with appropriate assistance to attend and succeed in school, including having the opportunity for school choice and to participate in school and school-related activities. Where appropriate, i.e., where the child's caregiver knows the child and the child's needs and is capable of advocating effectively for the child, BCDSS should encourage the child's caregiver, particularly if the child is in a foster or kinship care home, to take primary responsibility for communication with the child's school and meeting the child's day-to-day educational needs. BCDSS shall:

  1. Monitor educational progress, work with school personnel and caregivers to ensure that educational problems are identified and addressed, and maintain an educational plan for each child;

  2. Take all reasonable steps to obtain from the school system or third parties all necessary educational services for the child to support the child's educational achievement and to ensure that all goals and tasks in the child's educational plan are accomplished; and…."

We discuss each of these violations in detail in Part II of this letter. In Part I, we discuss the overall placement shortage as reflected by the persistent use of hospital overstays.

In addition to the violations above, which all are clear and substantial, Defendants *might* be in violation of Placement Outcome 4, regarding services to support placement stability. That Outcome adds the following requirements:

- **Outcome 4**: Each child in OHP and the child's caregiver shall be provided those services necessary and sufficient (1) to meet the child's immediate and long-term needs; (2) to support the stability of the child's placement and to support the caregiver's ability to meet the child's needs; (3) to avoid placement of the child in a more restrictive setting; and (4) to move the child, if appropriate given the child's needs, to a less restrictive setting.

Plaintiffs' position as to Defendants' compliance with Outcome 4 is qualified and conditional because Defendants have not performed or arranged for a compliant needs assessment mandated by Additional Commitment 1, which includes an assessment of unmet service needs. That said, as discussed below, the most recent needs assessment issued a year ago indicates significant shortfalls in certain areas. We discuss the service issues in Part III.

**Part I: Defendants' Ongoing Use of Illegal Hospital Overstays, DSS's Office, and Hotels.**

The focus of our concern is the persistent use of hospitals (including emergency departments, psychiatric wings of general hospitals, psychiatric hospitals, and other hospital units) as unlicensed placements to board Plaintiffs who do not clinically require hospital placements (*i.e.*, are medically ready for discharge), but who lack non-hospital placements and thus are not removed by BCDSS from the hospitals. These "overstays" are illegal (hospitals are not licensed residential child-care facilities), discriminatory, unconstitutional, and violative of the MCD. In addition to hospitals, Defendants also are housing children in hotels and their Calvert St. office in Baltimore.

Outcome 10 of the Placement Section (Sect. II) expressly prohibits housing children in unlicensed placements, which include hospitals: "No child may be housed in an office, motel, hotel, or other unlicensed facility." This requirement is binding upon Defendants and is fully enforceable. Moreover, "housed" is defined as a stay of "four hours or longer." Thus, a hospital overstay of four hours or longer violates the MCD. Such placements are inappropriate by definition because the medical providers caring for the children have determined that they should be removed from the hospital and do not require that level of care. Indeed, Medicaid and private insurers typically will not pay for hospital overstays precisely because they are not medically necessary.

Hospital overstays are just the most extreme tip of the iceberg of a chronic placement shortage that has existed for several years. Beyond hospital overstays, other Plaintiffs sit on waiting lists for more appropriate placements for many weeks and months. BCDSS continues to use its Calvert Street office for overnight placements of children who have nowhere else to go. And other children are in hotels or motels. All of these placements in unlicensed locations or other temporary settings violate the MCD.

This placement shortage is statewide, and primary responsibility for fixing it rests with DHS and SSA, not BCDSS. The Maryland Department of Health ("MDH") needs to be part of the solution as well.

DHS, SSA, MDH, three agencies of MDH (developmental disabilities, behavioral health, and Medicaid), and three local departments of social services (not BCDSS) were sued on May 30, 2023 over their use of hospital overstays for foster children outside of Baltimore City and for

children who are stuck in hospitals without medical necessity awaiting voluntary placement agreements. *See T.G., et al. v. Md. Dep't of Hum. Servs., et al.*, No. 8:23-cv-01433-PJM. A copy of the complaint is attached. Most of the issues outlined there pertain to the issues addressed here, with the principal difference that BCDSS has its own "Wellness Project" providing behavioral health and mental health for many of the children involved in overstays and waiting lists and also utilizes the BCARS mobile crisis-intervention service. In particular, the complaint provides an extensive account of the history of the problems, the terrible effects and consequences for the children, and the failure of DHS, MDH, and their respective agencies to take the curative measures needed to solve the placement crisis. Also, in recent years, we have not seen Baltimore City foster children shuttled from E.D. to E.D., as has occurred in other jurisdictions. With those caveats, the issues and facts alleged in the *T.G.* complaint are incorporated by reference here. The case was brought by Disability Rights Maryland ("DRM"), the authorized Protection & Advocacy organization for Maryland, and by one of the undersigned Plaintiffs' counsel. The issues in *T.G.* substantially overlap with the issues raised here.

The placement shortage, its causes, the insufficient efforts to address it, and the consequent violations of the MCD are discussed at length in the *L.J. v. Massinga* Independent Verification Agent's Certification Report for Defendants' 68th Compliance Report (Apr. 17, 2023) ("IVA Cert. Rep.") 24-32. Plaintiffs concur with this analysis in its entirety, incorporate it by reference, and rely upon it as a principal basis for Plaintiffs' request for dispute resolution under MCD Section IV, Paragraph A.

Plaintiffs first raised the placement shortage with Defendants during the summer of 2018, urging Defendants to take concerted action to plan for the projected need. *See* attached letters to Mr. Beller in July 2018 and May 2019 that complained about recurrent use of offices and hospitals. Much time has been spent on the subject in biweekly calls and in the quarterly Forums, addressing such root-cause concerns such as rate reform. Bills have been introduced in the General Assembly, much to the State's consternation. Defendants have had years to develop a comprehensive plan and have failed to do so.

In January 2021, Defendants advised Plaintiffs and the IVA that DHS had "reconfigured" its funds to obtain eight new "high-intensity" beds at the Board of Child Care (a group-home provider); ten such beds at the Children's Home (another group-home provider); 27 new treatment beds at Arrow Ministries (a diagnostic group-home provider), along with seven new psychiatric respite beds. Moreover, MDH had obtained funds for up to 18 new beds, most likely at an RTC-level residential child-care facility and would issue a "request for interest" ("RFI") solicitation. This total of 63 new beds, DHS asserted, should be enough to solve the hospital overstay problem. Accordingly, DRM and other attorneys shelved their work on an imminent lawsuit similar to *T.G.* outside of Baltimore City. (*T.G.* Compl. ¶ 156).

The plan was, for the most part, illusory. Instead of gaining 27 new beds at Arrow, those beds *replaced* 35 diagnostic beds that were being *closed—a net loss of eight beds*. Instead of gaining seven new psychiatric respite beds at Maple Shade, the sole provider of psychiatric respite care for foster children in the state, Maple Shade terminated its contract and *closed all 14 existing beds*—a total net loss of 22 beds from what had been promised. This net loss of beds was compounded by staffing shortages caused by Covid-19 and by the closure of two RTCs. MDH's RFI for 18 new beds generated no positive responses. All told, instead of gaining 63 new beds, the state, which had already started out with an insufficient number of beds and was losing beds due to COVID and RTC closures, *lost* four additional beds. *Id.* at ¶ 157.

In the fall of 2021, DHS and MDH announced another new Cabinet-level initiative. DHS would issue an RFP for 65 new beds (25 psychiatric respite beds and 40 new diagnostic, treatment, and evaluation beds in group-home-level facilities). MDH would issue an RFP for approximately 16 new beds (RTC or group-home, probably the former). This initiative also was unsuccessful. *No providers submitted proposals to DHS*. One provider, Salem Children's Trust, submitted a proposal to MDH, which was accepted, to develop twelve high-intensity group-home beds for dually diagnosed (developmental and mental-health disabilities) children at its closed facility in Frostburg in Western Maryland, under the supervision of Grafton, the Virginia-based RTC provider. Another group-home provider, the Board of Child Care, agreed to develop a new four-bed RTC on its group-home campus in Baltimore County with a projected opening date in June 2022. Salem began accepting children on a limited basis in January 2022. On information and belief, only one foster child in BCDSS custody in an overstay situation was placed at Salem (D.L., whose case is discussed below), as a temporary holding location until a bed would open for him at a state psychiatric facility, two weeks later. Salem opened only one of its two 6-person cottages, and it ultimately shuttered its doors entirely several months ago. The Board of Child Care RTC facility is not yet open, even though it was scheduled to open last June, and will house only 3-4 children.

DHS and MDH have most recently reported taking the following steps: (a) centralizing the reporting of bed availability in hospitals (MDH); (b) rolling out a new emergency-response system for mental-health emergencies; (c) frequent regular meetings between DHS and MDH officials to discuss the individual cases of children in overstays; and (d) possible expansion of beds at one of MDH's Regional Institute for Children and Adolescents ("RICA") RTC facilities. And, of course, BCDSS has implemented its "Youth Wellness Program" of focused evidenced-based clinical therapy for Plaintiffs with moderate to severe behavioral health issues.

These efforts have focused on the creation of new RTC or high-intensity group beds. Indeed, MDH has made clear that increased RTC capacity is its top priority. But relatively few of the children in hospital overstays (only 7.5% of all incidents since January 1, 2021) actually went to RTCs upon leaving the hospital. It is true that they languished in hospitals while RTC

placements were being sought, but in most of the cases where RTC applications were submitted, the RTCs rejected the children, who eventually were placed in less restrictive settings. And in many of these cases, the 818 packets also were sent to group homes and treatment foster care programs—signaling that the priority was finding an open available bed, not that the child's condition was so challenging that an RTC placement was necessary to stabilize the child.

As discussed in the *T.G.* complaint, Plaintiffs in hospital overstays languish in the hospitals for days, weeks, and even months largely confined to their beds. In examining the BCDSS overstay reports since January 2021 (when Defendants advised that they were proposing initiatives that they believed would solve the problem), the magnitude of the problem comes into better focus:

- ***245 overstay incidents*** reportedly occurred in Jan. 1, 2021 through June 7, 2023.
- ***132 different children*** experienced hospital overstays during this period.
- ***Over 100 overstays*** [have] lasted for at least a week.
- The mean length of overstay is ***14.4 days.***
- Only ***7.5%*** of the overstays (18 of 239 reported specific dispositions) concluded with placements in RTCs.[1] Only ***34.7%*** (83 of 239) ended with admission into psych hospitals or psych wings for treatment.
- ***Half (52.7%) of the overstays ended through community-based placements*** (group homes (26.5%, 63 of 239 incidents with dispositions); foster homes (17.1%, 41 incidents); and relatives and other individuals plus independent-living, ALUs, and "return to placements" (10.0%, 24 incidents)).

A significant number of the children (20%) were reported as returning to their original pre-hospital placement, which begs the question of why the overstay needed to occur in the first place. Of course, sometimes that option is not immediately available, but the relatively high incidence of returns signals significant room for improved coordination and effort.

Moreover, sometimes the data are even worse than they appear because the hospitals holding the children readmit them for administrative purposes (and reestablishing Medicaid eligibility), even though, essentially nothing has changed. For example, C.C., a 16-year-old

[1] The RTC total might be lower, as the overstay lists typically do not say whether a child has been placed in the diagnostic group-home facility for St. Vincent's Villa or its RTC facility. Unless the diagnostic group home facility is specified, our tally conservatively assumes that the child was discharged to the RTC program.

foster child, had severe injuries from being hit by an automobile and spent approximately 206 days in a pediatric orthopedic hospital before being technically readmitted by that same hospital to "wean" from treatment prior to an eventual discharge to a community setting. That additional time did not, as a practical matter, change the fact that she was waiting many months for placement in the community. Another youth, D.L., was kept in a state psychiatric hospital for *six months after* he was ready for discharge, but most his period of overstay (possibly 190 days or so), from mid-September 2022 to March 24, 2023 was not listed and counted as an overstay because the hospital accommodated Defendants and kept re-admitting him for a series of "assessments" and "evaluations" for placements, and then multiple "extensions," even though, *before* he went to the hospital, he was on a waiting list for a group home (Board of Child Care) as his planned placement. He ultimately went to this same group home when staffing conditions allowed a bed to open some seven months after his hospitalization. The IVA described this case in detail in their most recent court report filed this spring:

> *DL is a 17-year-old male. He re-entered the foster care/ system on June 29, 2021 after he was unable to remain with his caregiver. DL has been diagnosed with Mild Intellectual Disability; Trauma and Stressor Related Disorder; Disruptive Mood Dysregulation Disorder; Reactive Attachment Disorder; and Attention Deficit Hyperactivity Disorder. Because no licensed facility in Maryland would accept DL, he was placed out of state in a program in Michigan. He was discharged from that program after seven months (7/8/21 - 2/22/22) when they said they were unable to meet his needs. After his return to Baltimore, DL experienced significant placement instability, including more than 60 nights spent in a BCDSS office building. DL was admitted to Spring Grove Hospital Center (SGHC) on August 25, 2022 for inpatient neuropsychological testing. On September 15, 2022. SGHC recommended a therapeutic group home with 1:1 support for a period of time. Despite this recommendation, he remained at SGHC through the end of 2022 and well into 2023, still awaiting placement. DL was on the BCDSS Overstay/Waitlist for ten months - from May 27, 2022 until he finally was placed in a congregate care facility on March 24, 2023.*

(IVA Cert. Rep. at 27-28). Yet, despite all this, D.L.'s hospital overstay reportedly lasted less than a month. And, whatever it's classification, his case illustrates all too vividly how dysfunctional and limited the State's placement system remains.

As C.C.'s case illustrates, not all of the children needing placements are "challenging" pre-teens and teens as Defendants often portray it. H.N., a medically fragile 15-year-old youth with spina bifida, VP shunt, Von Willebrand Disease and other medical complications limiting her to a wheelchair, lived in a Residence Inn with 1:1 aides (except in school hours) from October 2022 to February 2023. while awaiting a DDA placement which was delayed for many

weeks for bureaucratic reasons (and would have been delayed even further had the IVA not intervened). The IVA discussed the case in detail in their most recent report:

> *HN, a medically fragile and developmentally disabled 15-year-old girl with a history of a bleeding disorder, spina bifida, neurogenic bowel/bladder, and end-stage renal disease, was removed, along with her siblings, from the care of her mother and other family members in October 2022 due to severe neglect. HN is also dialysis dependent and in need of a kidney transplant. However, upon removal a placement for HN could not be found, and she was placed in a hotel with nursing care. Even after a placement was identified, there were multiple delays and miscommunication between the Defendants and the provider. As a result, HN spent more than three months (10/27/22-2/6/23) in a hotel room after being removed from her family for neglect.*

(IVA Cert. Rep. 25-26). K.L., a medically fragile 12-year-old girl who uses a walker and wheelchair, spent 5-6 months (August 2022 to February 2023) to find an appropriate handicapped accessible therapeutic placement through DDA, but at least she was in a regular foster home (even though, reportedly, it lacked adequate accessibility). M.H., a previously non-compliant Type 1 diabetic youth, spent 130 days in overstay in a Virginia psychiatric hospital (July until November 2022) until a DDA-approved ALU (alternative living unit) was created for her. During the fall of 2022, cases were reported of foster youth with children who were on the waiting list for parent-child joint placements; at least two of these were living in hotels. L.M., a medically fragile one-year-old infant, spent 83 days in a hospital overstay awaiting the development of a foster home to care for her special needs, even though 24:7 nursing would be provided and was available. J.N. spent 37 days in a hospital overstay following an auto accident.

The overstay problem extends beyond hospitals. Plaintiff children continue to be housed overnight in BCDSS's Calvert St. office and others are housed in hotels. The incidence is increasing here as well. According to Defendants' most recent (68th) Compliance Report:

- The number of children who had to be placed in all forms of unlicensed facilities increased by ***more than a third***, from 41 during the 67th reporting period to 56 during the 68th reporting period.

- The ***total number of incidents*** ***doubled*** from 96 to 196 during that time.

- The Exit Standard for Outcome 10 is set at 98.8% of all Plaintiffs not having an incident during the reporting period. During the 68th reporting period, the compliance level fell from 98.06%--itself a violation—to only 97.26%, meaning that ***almost 3% of all Plaintiffs*** experienced an overstay in an unlicensed facility during the most recent reporting period.

(Defs. 68th Comp. Rep. 113-14, Measures 67 & 68A). H.N.'s case illustrates how children with serious medical conditions can languish in hotels without presenting any behavioral challenges. Another example is provided by the IVA:

> *KM, a 7-year-old male, entered foster care in March 2018 at the age of 2. According to court records, he is diagnosed with Autism Spectrum Disorder, Associated Language Impairment, Global Development Delay, Speech Delay, Other Personality and Behavioral Disorders, Cognitive and Neurobehavioral Dysfunction, Insomnia, Unspecified Feeding Disorder, ADHD and dermatitis. KM is receiving speech and language therapy which includes feeding and occupational therapy in his school. KM is prescribed multiple medications including Clonidine, Risperidone, and Trazodone daily. For nearly four years (March 2018 - February 2022), KM resided in the same therapeutic foster home until his foster parent became ill and was hospitalized and the provider did not have another foster parent available as a placement resource. KM was moved to a hotel with 24-hour nursing coverage where he stayed for more than two months until he was moved to a group home for medically fragile children in another jurisdiction in Maryland.*

(IVA Cert. Rep. 25). Sometimes, the children bounce from hotels to the DSS office to hospitals and vice-versa:

> *JB is a 15-year-old male, diagnosed with ADHD-combined type, Major Depressive Disorder and Anxiety Disorder. He spent 15 nights in a DSS office building in December 2021 followed by a month-long stay, including Christmas, in a hotel with a one-to-one provider from December 23, 2021 to January 24, 2022. Following more failed placements, time at an RTC and psychiatric hospitalizations, JB again spent many nights in a DSS office building and in hotels. From October 25, 2022 through December 6, 2022, JB resided in eight different hotel locations provided by BCDSS under one-to-one supervision. Placement in these hotels put JB at risk for interaction with law enforcement due to his behavior problems with hotel staff and guests, which seemed to become more erratic with each move to a new hotel. Long before the nights spent in an office building and hotels, JB was well known to the Defendants and had experienced multiple inpatient psychiatric stays and significant placement instability including multiple therapeutic foster homes, therapeutic group homes and a residential treatment center since he entered foster care in 2018. JB has a significant trauma history including the death of his father and grandmother, incarceration of his mother and neglect. JB was finally placed in a therapeutic group home in December 2022.*

*Id.* at 26. Even when this youth finally was placed in the group home, he was not placed in school, missing all classes from December 12, 2022 to January 18, 2023. *Id.* at 26 n.34.

During the fall of 2022, after formal notice had been delivered to DHS and MDH in *T.G., et al.*, the number of reported hospital overstays declined substantially, both for Plaintiffs and across the state. At the same time, MDH and DHS commenced regular frequent meetings to discuss individual cases along with other administrative steps. But, while the overstays declined, the number of children on the BCDSS waiting list increased, rising to an all-time high of 22 per BCDSS's December 9, 2022 weekly report. The use of hotels and extensive use of 1:1 aides (or even 2:1's) also has increased, which is a good step inasmuch as hotels are the lesser of two evils compared to confinement to a hospital bed or spending nights in a BCDSS office. On May 31, 2023, six Plaintiffs were reported as being housed in hotels, at the same time that six youths reportedly were boarding in hospitals without medical necessity. But hotels do not constitute compliance with the MCD, let alone a legally permissible placement, and their cost is very high.

Moreover, the dip in overstays that occurred in late 2022 and early 2023 appears to have ended. Per the most recent weekly reports of May 19 and 26, 2023, six Plaintiffs were in hospital overstays as of the respective Fridays and two more had been placed or admitted during the respective prior weeks. Weekly overstay/waitlist reports throughout 2023 have had double-digit lists of Plaintiffs on waiting lists for placements.

In discussing the problem, Defendants' most recent 68th compliance report puts much of the onus on the children themselves. For example, they assert, "[t]o summarize, BCDSS has not had difficulties placing children or youth other than the population of older youth described as having trauma behaviors that present a risk to self or others." (Defs. 68th Ct. Rep. 60). This is simply wrong. As the IVA explains in their report,

> In fact, DHS data on placement stability for children in even their first year in foster care, shows that of the 327 children under the age of 13 who entered foster care in 2022, nearly half (157) had one or more placement moves during that same year. (SSA 2022 Placement Stability Report, provided to IVA on February 8, 2023.) While chronic instability might primarily be an issue for older youth, BCDSS' younger children clearly are not exempted from the problem.

(IVA Cert. Rep. 24 n.32). Later, the IVA provides a chilling case example of an 8-year-old child spent 47 days in a hospital overstay after a minor altercation with a foster parent's child immediately upon entering foster care as a new entrant. Upon his eventual discharge, he went to a foster home and not to a clinically intensive setting. This case had previously been discussed in a prior Forum, but the IVA has provided compelling additional information about the case and the aftermath of the overstay:

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> *JS, 8-years-old at the time, was removed from his mother's care on April 26, 2022. Shortly after entering foster care, JS was taken to University of Maryland Medical Center following an outburst over a television remote at the foster parent's home. University of Maryland did not recommend inpatient admission and JS was considered on overstay status as of April 30, 2022. BCDSS was unable to locate a placement for JS so he remained at University of Maryland, in violation of both the MCD and Maryland law, and he was placed on a waiting list for St. Vincent Villa Group Home. St. Vincent was willing to accept JS but did not anticipate having a bed available for him until mid-June. JS remained at University of Maryland where he had limited opportunities for activities outside the unit and limited schooling. More than a month and a half after being ready for discharge from University of Maryland, JS was placed in a regular (non-therapeutic) foster home on June 16, 2022. JS remained with this foster parent for more than a month with the foster mother's only recorded concern about JS' behavior being that he was very picky about his choice of food. After a short interim placement with a kin caregiver, the court, on July 29, 2022, found that JS was not a Child in Need of Assistance and placed him in the custody of his father.*

(IVA Cert. Rep. 27). Despite such cases (the list also includes children aged 5-7 years old), the Defendants portray the children as the worst of the worst, describing extreme behaviors such as compulsively ingesting any dangerous object within reach such as lightbulbs and razor blades or uncontrolled sexual behavior directed at other children, adults, or themselves, or aggression and violence. (Defs. 68th Ct. Rep. 60). Defendants complain about dually diagnosed children with autism and other developmental disabilities, *see id.*, apparently suggesting that such children are not placeable at all. They state that they send out "818" packets to scores of providers, both in-state and out-of-state, and get rejections due to these behaviors. *See id.* This is no excuse. If more than half of the children in hospital overstays eventually do leave for community placements, they are placeable—even if their presenting behaviors were half as alarming as described by Defendants. And, at least as described in the weekly reports, the behaviors do not rise to Defendants' dire portrayal. The issue is supply, not impossibility.

Leading state officials have acknowledged as much. MDH Secretary Herrera Scott testified to the General Assembly this past February, "We don't have enough beds. Full stop." She added that "it's not just the number of beds, it's also the bed type and having the clinicians to cover those beds." These statements echo former Comptroller Peter Franchot's prior acknowledgement last summer that "[i]t is not a lack of money, it is a lack of political will to implement what is needed to take care of these severely disabled kids." Indeed, as described in the *T.G.* complaint, Defendants have failed to develop evidence-based programs that have been proven successful in avoiding hospitalizations of dually diagnosed children, despite efforts by DRM to convince Defendants to utilize this approach (known as "START") dating back to 2017,

or wraparound programs that were supposed to have been in development as early as 2008 under Medicaid waiver provisions. *See T.G. v. Md. DHS* Compl. ¶¶ 18, 133, 145.

But even if, for the sake of argument, the cohort of children were as extreme as Defendants contend, they have had many years to plan and to develop accommodations for the children. Defendants do not, and cannot, show that the mix of children has suddenly changed or that they have not had to deal with challenging behaviors in some children in the past. It is their obligation to plan for the children, which is precisely the purpose of the placement needs assessment required by Additional Commitment 1. But, as has been discussed in numerous prior Fora, no viable compliant needs assessment has been conducted. The weekly overstay/waitlists and daily in-the-office and hotel reports provide an ample basis for Defendants to engage in such planning: the children are remarkably consistent in their presenting profile. Again, the IVA has gleaned the following shortfalls from these reports:

- Therapeutic foster care agencies, group homes and therapeutic group homes are not accepting placements of children and youth for a multitude of reasons, including a lack of beds, lack of foster families, an inability to meet the needs of the child referred to them, and lack of resources to monitor placements.

- Many placements, including therapeutic foster care providers and group homes, will not accept a child/youth with behavior problems or a history of running away.

- Many decline to accept teenagers saying that they have no placements available for them.

- Many private providers are now telling BCDSS that they do not accept emergency placements, despite the consistent need for them to do so, given that children enter foster care at all hours and on all days of the week. This leaves a child entering foster care in the evening or on the weekend to remain in office buildings or hotels until their cases can be reviewed by provider staff during "regular business hours" for acceptance or rejection.

(IVA Cert. Rep. 30). So, yes, "Form 818" referrals often get rejected. Agencies reject children who meet their criteria for admission. But they are licensed by the State, and it is up to the State to make the agencies adhere to their licenses. Conversely, the providers have sought major substantive reform in rates for more than a decade, without success. As the IVA points out, the latest deadline for rate reform has been pushed back to 2026. *See id.* at 28-29 (describing "inexcusable" and "unacceptable" delays and broken promises for rate reform).

The failure to plan is epitomized by Defendants' failure produce a viable assessment of their projected placement needs as required by /Additional Commitment 1. Their prior attempts

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were mere surveys of what Defendants already had available (which invariably was declared sufficient to meet the need). More recently, as the IVA explains, SSA contracted with researchers at the University of Maryland School of Social Work to conduct an assessment, but, while a marked improvement with useful findings about the children and their needs, it, too, focused on analyzing the child population for stability and failed to analyze what Defendants need in the way of placements for this "challenging" population. Instead, it concluded that all of these children should and can be placed in the community and not placed in congregate care at all—a finding that the State Defendants have rejected. Thus, it, too, has had little value for planning purposes. Plaintiffs submitted a comprehensive letter explaining the serious and many flaws of this assessment (not to mention the extensive efforts by Plaintiffs' counsel and the IVA to correct the flaws before the assessment was conducted), which is attached and incorporated by reference. Until Defendants comply with Additional Commitment 1 and develop a proper plan to fix the placement shortage, their overall lack of compliance with the placement provisions of the MCD, as illustrated by the violations of Outcome 10, will continue apace.

Plaintiffs' counsel have urged Defendants to engage in planning in tandem with the provider community since 2018. These initial efforts were summarized in Plaintiffs' 2019 letter, which is attached and incorporated by reference. Subsequent efforts have failed as well—DHS, SSA, and MDH have insisted on addressing the issues by themselves, without genuine outside participation. As discussed above and as demonstrated by the IVA, the results have been disastrous for many scores of foster children.

For the Plaintiff children, hospital overstays are horrific experiences. They children are confined to beds most of the time. With rare exceptions, they do not go outside and have access to fresh air and ordinary recreation activities. The children are isolated: peer contact is very limited, socialization opportunities are scant, and family visits sporadic. They typically do not receive individual therapy, and clinicians report that the children regress as the overstays persist. It may take weeks before a referral is made for educational services, and, even when provided, the home-and-hospital tutoring is very limited (usually a maximum of six hours of instruction per week). For all practical purposes, a hospital overstay results in significant educational deprivation without any medical justification. As the IVA sums up the practice:

> These overstays are a clear violation of the MCD. Children and youth should not be placed in, nor left in, a more restrictive placement than they need. Even a short but unnecessary hospital stay can be traumatizing to a child.

(IVA Cert. Rep. 28). For these reasons and those discussed below, the persistent use of hospital overstays, the BCDSS office, and hotels substantially violate multiple provisions of the MCD.

**Part II: Specific MCD Violations.**

With the advent of hospital overstays and recurrence of office overnights and the utilization of hotels as an alternative, Defendants have been in clear violation of multiple provisions of the MCD regarding placements and, as a secondary matter, education.

**A. DHR/BCDSS Responsibility**: The above facts make it clear that Defendants have failed their core responsibility of establishing and maintaining a continuum of out-of-home placements and caregiver supports that is reasonably calculated to ensure that each child in OHP is placed in a stable, less restrictive, and appropriate placement. The total of 243 separate incidents of hospital overstays over a 29-month period speaks for itself. So, too, does the failure to develop and implement intensive clinical intervention and case-management services like wraparound and START for the dual diagnosed children that Defendants complain about in their 68th compliance report. *See* Defs. 68th Rep. 60 (discussing challenge of caring for children "diagnosed with developmental disabilities and/or autism with psychiatric features"). Again, the presence of such children in the foster-care system is nothing new and nothing that Defendants should not be required to address through planning and careful development of services and placements.

**B. Outcome 1**: **Least restrictive setting**. The MCD requires that "[e]ach child shall be placed in the least restrictive appropriate placement type for that child's needs." But a hospital is the most restrictive setting possible short of prison, and, by definition, a hospital overstay (or office or hotel) is not an "appropriate placement type for that child's needs." Plainly, the persistent use of hospitals, offices, and hotels violates Outcome 1. The latest "needs assessment" procured by Defendants as their asserted compliance with Additional Commitment 1 makes this clear. The researchers at the Institute for Innovation and Implementation at the University of Maryland School of Social Work researchers that the children stuck on the overstay/waitlist could and should be placed in the community if less restrictive placements were widely available and supported by appropriate services. Despite its flaws (*see* discussion below for Additional Commitment 1), the assessment did make important findings regarding existing deficiencies in Defendants' placement array:

- "[G]roup home placements are over-utilized in Maryland…." (Inst. for Innovations, Univ. of Md. Sch. of Soc. Work, Baltimore City Placement Rev. ("Needs Assessment") at 4).

- "In Baltimore City and across Maryland, more family placements are needed for the children who do not have a clinical need to be in a non-family setting." *Id.* at 20

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- "A small number of children are placed in a treatment foster home as their first out-of-home placement; this intensive therapeutic intervention typically would not be expected for a child who has never been in out-of-home placement." *Id.*

- Contrary to Defendants' preference for more RTCs and high-intensity group home beds, "BCDSS should not develop additional residential treatment center or group home beds for children in the care of BCDSS. *There are children in these settings who should be in family settings*. Supporting these children to move to the most appropriate, least restrictive setting will make beds available for those children who have a clinical need for a residential intervention that cannot be met in the community due to the intensity of treatment and requirement for 24/7 supervision." *Id.* (emphasis added).

Again, the Defendants cannot credibly question the sufficiency of their supply of placements given the extremes that they have had to use throughout the past five years. They have had ample opportunity to develop these. More worrisome, they have not put any plan on the table since their prior efforts failed in 2021 and early 2022. The new Administration has not put any new proposals on the table, either. After five years, Plaintiffs cannot wait any further.

**C. Outcome 2**: **Limitation on congregate care for children under 13.** Hospital overstays constitute a form of congregate care, as the children are supervised by shift workers. (Outcome 2 Definition). Nearly 60 of the hospital overstays (almost 25%) occurring since January 1, 2021 involved children age 12 and under. That is a huge and unacceptable number. By definition, no child in a hospital overstay is there because the placement "is medically or therapeutically necessary and the child is placed in a program that has services specifically designed to meet that child's needs." Thus, Defendants' prevalent use of hospital overstays clearly violates Outcome 2.

**D. Outcome 3**: **Continuum of placements reasonably calculated to assure that each child is placed in the least restrictive placement**. The supply of placements, and the diversity of placement types plainly is insufficient. If a proper continuum existed, hospital overstays, overnight office stays, and/or use of hotels would not occur except in rare circumstances. But they have been occurring for the last five years, and, according to Defendants' data, the problem is getting worse, not better. Five years ago, psychiatric respite homes existed. The contract with the lone provider ended two years ago, and no replacement has been found. Other respite is scarce. Staffing shortages related to Covid-19 have not been eliminated, further limiting available beds. The lack of rate reform has inhibited the recruitment of new programs. Closed RTCs have not been replaced with new community-based programs. As discussed below, Defendants refuse to fund emergency foster homes notwithstanding the express mandate of the MCD that they do so, nor have they developed what, in their view, is a

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superior and more clinically sound alternative to handle emergencies. And these shortcomings do not even address other problems, such as sibling separation and insufficient parent-child joint placements for Plaintiffs who are parents. Here, too, the undisputed or undisputable facts demonstrate substantial violations of Outcome 3.

**E. Outcome 7: Placements must meet all safety, licensing, and other legal requirements.** Overstays, hotels, and office overnights are illegal, as they are not licensed child care facilities. Once hospitalization is no longer medically necessary, continued placement of the child in a hospital also is illegal. *See, e.g.*, Code of Md. Regs. ("COMAR") 07.02.11.06.B(5)(g) (affirming that, for children with disabilities seeking voluntary placement, psychiatric hospitals are *never* a recognized placement, let alone an *appropriate* and *least restrictive* placement). Hospitals are not licensed to provide foster-care or residential child-care services and therefore may not be utilized for those purposes. *See* COMAR 07.02.11.11.I ("Any residential child care facility used by the local department shall meet the requirements for licensure for the facilities established in COMAR 14.31.05.").

**F. Outcome 10**: **No child may be placed in an office, motel, hotel, or other unlicensed facility.** And no use of office for consecutive nights absent extraordinary circumstances. Defendants' persistent and chronic violation of this provision is indisputable. No week has gone by for years without at least one violation, and usually several. The discussion above amply addresses the violations here.

**G Additional Commitment 1**: **Biennial needs assessment of the range of placements and placement supports required to meet the needs of children in OHP**. Additional Commitment 1 *requires* Defendants to *plan* for current and anticipated future needs. This requirement is critical for Defendants' compliance with the other placement and service requirements of the MCD. The assessment must determine the placement resource and service needs, assess their current availability, and determine the array of both that must be developed to meet those needs in the least restrictive, most appropriate setting. The first such assessment was due to be completed by December 31, 2009, over 13 years ago. To date, no *compliant* assessment has been conducted; instead, Defendants twice produced surveys of where children are located and deemed this evidence of a sufficient array. Both were deemed non-compliant by the IVA. The third, and most recent, needs assessment, procured by contract with the Innovations Institute at the University of Maryland School of Social Work, at least attempted to look at a sampling of case files, and it did find that the existing array of placements and services is insufficient to meet the need. But as outlined in the analysis accompanying Plaintiffs' September 22, 2022 letter (attached), which is incorporated by reference, it focused on analyzing whether placements comply with agency policies, which is not what Additional Commitment 1 mandates, and did not do what is required: determine what is needed, and how much. SSA approved this scope of work, so ultimate responsibility for the lack of compliance rests with

SSA. (In this regard, BCDSS provided numerous opportunities for the IVA and Plaintiffs' counsel to discuss the shortcomings with the UMSW researchers, and some improvements were made such as adding cases taken from the weekly overstay/waitlist cases. But the overall problems with the assessment were baked into the scope of work, and the discussions and meetings were largely for naught.)

The IVA found this third assessment to be non-compliant, giving three reasons:

> (1) It fails to identify the placement needs of children in foster care in a quantifiable way. (2) It lacks specificity regarding placement and service needs which does not allow for a determination to be made as to whether the availability of current placements and services meets those needs. (3) It does not address specific components of the Additional Commitment including least restrictive placements, family placements for all youth who do not have a clinical need for a non-family placement; emergency family placements; placements for children with serious mental health problems and/or developmental disabilities; and programs for semi-independent and supportive independent living.

(IVA Cert. Rep. 9-10). Plaintiffs' September 22, 2023 submission elaborated on these and other problems. We incorporate by reference and reassert here the many specific deficiencies outlined in the appended September 22, 2022 analysis. More than a half year later, those deficiencies have not been addressed with a new plan for a compliant assessment.

On September 30, 2022, Defendants responded to the fourteen specific recommendations in the needs assessment. They did not address Plaintiffs' September 22, 2022 letter. For most of the assessment recommendations, Defendants agreed that the item in question was important but then assert that such efforts already are policy and are being implemented: (1) (comprehensive and frequent family team decision-making meetings); (2) (recruitment of foster homes, which BCDSS is complementing with Trust Based Relational Intervention training); (3) (better use of CANS); (4) (quarterly reviews of children in congregate care); (6) QSRI participation; (7) ensuring all children in RTCs have documented CONs; (8) participation in youth transition planning process; (10) CJAMS access for MATCH staff; (11) replication of the needs assessment; (12) expansion of evidence-based treatment availability. Thus, for all practical purposes, Defendants' response to the assessment is that 10 of the 14 recommendations are redundant of current practice policy.

For the remaining four items, Defendants' answers are evasive or unresponsive.

Recommendation 5 calls for DHS to work with MDH "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." This is an important recommendation. Medicaid's "1915(i)" program is intended to prevent unnecessary hospitalization and institutionalization with intensive services and "targeted case management." Defendants' response does not even address the 1915(i) amendment (sometimes termed a waiver) and instead proclaims in conclusory terms that Defendants and MDH closely collaborate on all possible options: "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." Without saying so expressly, this conclusory response effectively rejects the recommendation. Not surprisingly, to Plaintiffs' knowledge no progress has been made on 1915(i), notwithstanding the dire need and the opportunities presented by a new Administration. As discussed in the *T.G.* complaint, even though MDH projected that the 1915(i) program would serve 200 children annually, but, in FY 2019-21, it served only 10 to 40 children per year. (*T.G.* Compl. ¶ 133).

Recommendation 9 calls for every child in BCDSS foster care to have a review of psychotropic medications. Defendants do not address this recommendation and instead say that a new SOP will be finalized soon that complies with state policy. Thus, it is highly unlikely that the recommended classwide review will occur.

Recommendation 13 calls for BCDSS to "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." Here, too, the response is conclusory, evasive, and without meaningful substance: "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." The lack of responsiveness here is telling. The frequent recycling of children through the overstay and wait lists suggests that residential programming does not meet the clinical need in a significant number of cases. Whether it is the needs assessment or some other review process that examines the failures, it is imperative that this effort be undertaken quickly.

Recommendation 14 calls for BCDSS and DHS to "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." The response here is dismissive as well, reiterating that BCDSS works "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." But of course, the type of wraparound services discussed in the assessment are not widely available. The response also projects that the Youth Wellness

Program "will also provide much of the service provision described in this recommendation." We share BCDSS's optimism about the Youth Wellness Program and discuss it in Part III below. But whether it will meet the scope of a true wraparound crisis intervention seems unlikely.

Finally, Defendants report that the next assessment will focus on the "hard to place children" as suggested in last summer's Forum. To date, nothing further has occurred to Plaintiffs' knowledge and yet the placement crisis continues unabated. One year has now elapsed since the last assessment was distributed. The next assessment is due in just one year. Unless something is underway that has not been disclosed, there is no reason to expect that this deadline will be met.

At the last Forum, all agreed that BCDSS, the IVA, and Plaintiffs' counsel would try to work together to design an assessment and to select the person. After some deliberation, we all concluded that this had to be done under the aegis of DHS, as placements are such a state-dominant issue. Moreover, an individual proposed by BCDSS has since developed a conflict of interest that precludes her from conducting the work even if she were the right candidate (which was not clear). Since that discussion in January, no update has been provided on how DHS proposes (or intends) to proceed.

This is not an impossible task. The number of children who end up on the overstay/wait lists is not so large to preclude careful analysis of their needs, both for placements and services, and to project back to better serve and place the children at risk of placement disruption. Even a review of the weekly reports provides significant information about the children and their needs. The provider community can be canvassed to determine their available supply. Placement patterns of the other jurisdictions can be determined as well.

Defendants' avoidance of forward planning for placements is not tenable, and it certainly is not acceptable. The foster-care system will never comply with the MCD or eliminate Defendants' recourse to costly illegal unlicensed holding-arrangements that harm children until Defendants engage in realistic planning for future needs. After five years of a dire placement shortage, we must ask: will Defendants do the hard vital work to determine what the children need?

**H. Additional Commitment 2**: **Budgeted funds to secure and maintain the array of needed placement resources and services.** The IVA has determined that Defendants are not in compliance. (IVA Cert. Rep. 11). Defendants contend that they are in compliance because they procured a needs assessment. (Defs. 68th Compl. Rep. 59). This is circular: if the programs and services are insufficient, by definition the budget is insufficient as well. The fifteen-year failure to implement the State's promise for comprehensive wraparound services is ample evidence of the budget's insufficiency.

**I. Additional Commitment 3: Emergency shelter care homes.** The IVA has determined that Defendants are not in compliance. (IVA Cert. Rep. 11-12). In their 68th compliance report, Defendants acknowledge their persistent violation of this requirement. Indeed, Defendants have never complied with it, and they frankly acknowledge that they have no intention of complying with it. *See* Defs. 68th Compl. Rep. 59. They assert that emergency homes "are an outdated concept" and that the preferred practice is for existing placements to accept emergency placements. *Id.* But emergency placement of children in regular foster homes is not the same because such placements do not occur for just a few days while an appropriate placement is found. Defendants' reliance on hospitals, offices, and hotels proves that Defendants' alternative approach either is not working or is not sufficient. Dedicated emergency placements are needed because not enough foster home beds exist. Defendants also say that "children with high intensity physical, emotional or behavioral issues require services that foster homes are ill equipped to provide," and that Defendants' answer for those children is addressed in their response to the needs assessment recommendations. *Id.* But, as discussed above, that response evades the issue and offers no specific measures to address an emergency that is now *five years old.* Defendants essentially concede by their silence that they have no immediate solution for these children. Plaintiffs with supposedly "high-intensity" issues are entitled to emergency placements short of hospitals, offices, and hotels: if regular foster homes are not appropriate, then develop appropriate community-based placements that Defendants contend are more appropriate.

Instead, Defendants' 68th report justifies their willful violation by portraying the children as uncontrollable and dangerous, with extreme behaviors that no reasonable responsible parent would want in their home. *Id.* at 60. This portrayal is grossly exaggerated and unfair, to say the least. A youth with cutting behavior (probably the most common presenting issue in hospital overstays) is not incorrigible and does not need to be locked away in a hospital for days, weeks, or months. And for children who are experiencing a meltdown, even a violent meltdown, crisis intervention such as BCARS and respite care are designed to deescalate and allow placement in the community without institutionalization. Instead of building out a network of emergency homes, Defendants have compounded the lack of emergency foster homes by losing *all* psychiatric respite beds in Maryland. That occurred in 2021.

In fact, even Defendants seem to be equivocating on the issue. As the IVA points out in their response, Defendants' report elsewhere states with regard to Measure 38, "[t]he Resource Unit Program manager is currently surveying and engaging foster parents to become emergency placement providers." (Defs. 68th Rep. 96).

These "high-intensity children" are far from the only children who need emergency placements. The unfortunate fact is that the children who are not (yet) exhibiting those challenges also lack emergency homes. As discussed above, 27% of all *hospital overstays*

(presumably the highest intensity children in the system) result in placements in non-restrictive settings (foster homes, relatives, independent living). Many of these overstays could have been avoided if Defendants had the required emergency homes available.

The MCD prohibits Defendants from simply refusing to comply because they do not agree with the requirement. Additional Commitment 1 provides that, "[s]hould BCDSS determine that this provision is not necessary to achieve the outcomes of this Consent Decree, BCDSS will propose a modification to this Consent Decree about which the parties will negotiate in good faith." Defendants have never utilized this express remedy. Now, with several years of grievous harm resulting from the lack of emergency placements, it is time for Defendants to accept and abide by their obligation or to develop and implement a proper plan.

**I. Education (DHR/BCDSS Responsibility): Ensure that all children and youth are provided with appropriate assistance to attend and succeed in school.** Plaintiffs assert that Defendants are not in compliance with regard to children in hospital overstays, and, possibly, in other unlicensed settings. Children who are in hospital overstays typically do not receive prompt referrals to their local schools. Sometimes, it may take weeks for the referral to be made. Even when the child is accepted for "home and hospital" services from the school, the child typically receives only up to 6 hours/week of tutoring instruction. Thus, for many hospital overstays, Defendants are also not in compliance with the MCD's educational provisions.

**Part III: Supportive Services**

**Outcome 4** of the Placements section (II) of the MCD requires **supports to the caregivers and children** to sustain or allow placements in less restrictive settings and to meet the children's needs. In this regard, BCDSS has taken important steps to meet children's mental and behavioral health needs: its groundbreaking Youth Wellness Program is now underway and is now working with a number of the children who are in overstays or waitlists for placement. BCDSS has created a new position (assistant director for wellness) to oversee the program and other behavioral/mental health needs. Two mental health navigators (3 slots were created) also are on board to help with referrals. BCARS was expanded to provide up to 5 weeks of in-home clinical support and crisis intervention. BCDSS-licensed foster homes are receiving Trust Based Relational Intervention®, which includes trauma-informed training. These are very important steps, and Plaintiffs commend Defendants for aggressively addressing the issue.

That said, more needs to be done. The same service shortfalls discussed above (lack of respite, wraparound, START or comparable programs for dually diagnosed children, etc.) apply to Outcome 4 as well. Defendants do use 1:1s or even 2:1s liberally, despite their high cost, and those have helped make many community placements possible or salvageable. (There is a serious concern about qualifications and lack of oversight and credentialing for these aides, but that is a separate matter.) The system would be in a state of collapse without them. But more is

needed. The 2022 needs assessment made important findings regarding existing deficiencies in services and placements and found that children could be moved out of intensive congregate-care settings and into family settings if supportive services were available.:

- "*Most children with intensive needs can be safely and appropriately served in a family setting* with the provision of necessary clinical and supportive services. However, *such resources are not always available*." (Needs Assessment at 7) (emphasis added).

- "Children who were identified as having behavioral health challenges or who had a history of being missing from a living situation often were placed in more restrictive settings. *These children often can have their needs met in family settings with the appropriate clinical interventions and in-home supports and supervision. This is a population that could be supported through additional home- and community-based services, as recommended below*." *Id.* at 21 (emphasis added).

- "The same strategies—tailored, individualized, evidence-based, or informed services; support for current and new foster parents; provision of one-on-one supports in homes when needed; access to quality and intensive care coordination; providing sufficient rates for services to meet the expectations of BCDSS; ensuring medically and clinically appropriate diagnoses; providing services that address complex trauma—apply to all the populations outlined." *Id.* at 21.

- "If children appear to be unable to remain in a family setting or move into a family setting due to concerns about behavior management or supervision, BCDSS should use short-term (2-12 weeks) in-home supports, such as a one-on-one or behavioral specialist, to provide supervision, structure, and/or supportive services, particularly during key periods during the day or night when increased supervision would enable the child to remain in the home." *Id.* at 22.

- "Children and families should be supported to access and engage in evidence-based and promising practices currently available in Baltimore City and across the state, including Functional Family Therapy (FFT), Multisystemic Therapy (MST), Parent Child Interactional Therapy (PCIT), Dialectical Behavioral Therapy (DBT), Aggression Replacement Training (ART), and Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Children who meet medical necessity criteria should be enrolled in the 1915(i) State Plan Amendment to receive access to peer support, care coordination, and other services, in coordination with the child's team and, as needed, the local behavioral health authority." *Id.* at 22.

- ”BCDSS should continue to provide mobile response services and should explore opportunities to expand its use and its capacity to provide stabilization services. BCDSS should connect and align this work with the mobile crisis work happening in other parts of the state to meet the needs of children, youth, young adults, and families, including collecting continuous quality improvement and outcomes data. Mobile response should be provided when children and youth first enter an out-of-home placement or experience a placement change and be available ongoingly for any self- or family-defined crisis.” *Id.* at 23.

- “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.” *Id.* at 23.

Again, the new Youth Wellness Program should help provide some of the evidence-based treatment modalities and improved clinical care that the needs assessment found lacking. Plaintiffs are optimistic about its potential benefit to the children.

In light of the various new initiatives, Plaintiffs are not at this time asserting non-compliance with Outcome 4. More investigation is needed to determine whether (a) Defendants' assertions that the needs assessment is wrong about more services being needed, and (b) children who end up in hospital overstays and other unlicensed placements could have avoided these disruptions or had their overstays shortened if the services were available. This is too important an issue to leave to conjecture.

The most important marker, however, is the placement crisis itself. There continues to be placement instability and reliance on unlicensed placements. The overstay reports confirm that children in crisis still get taken to the hospital instead of diverted to respite or intensive crisis intervention through BCARS or a wraparound program. Once there, they get admitted or languish in overstays.

For these reasons, Plaintiffs' position on Outcome 4 is qualified. There may be a service shortage (the UMSW researchers surely thought so), but much work *is* being done. Plaintiffs urge Defendants, the Forum, and the IVA to make this issue a priority area for focus so that a clear determination can be made.

Very truly yours,

/s/ Mitchell Y. Mirviss
/s/ Stephanie S. Franklin

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