Submitted to the U.S. Department of Health and Human Services,
Administration for Children & Families,
Administration on Children, Youth and Families,
Children's Bureau
February 2014

Maryland Department of Human Resources
Title IV-E Child Welfare Waiver

Demonstration Project Application for
Federal Fiscal Year 2014




Martin O'Malley
Governor

Anthony G. Brown
Lt. Governor

Theodore Dallas
Secretary

February 21, 2014

Ms. JooYeun Chang
Associate Commissioner
Children's Bureau
1250 Maryland Avenue SW, 8th Floor
Washington, DC 20024

RE: Child Welfare Demonstration Projects for Fiscal Years (FYs) 2012-2014 (ACYF-CB-IM-12-05)

Dear Associate Commissioner Chang:

It is my pleasure to submit the State of Maryland's application for a Title IV-E Waiver Demonstration Project. Over the past decade, the Department of Human Resources, Maryland's child welfare and human services agency, has implemented reforms that have enabled more children to be served through shorter lengths of stay in out-of-home care and in more family-based settings.

Our proposal builds upon this innovative and collaborative work to continue to move our system to one that is both proactive and responsive to the individualized needs and strengths of each child and family. This Demonstration will serve as the necessary catalyst to move Maryland into its next phase of growth—a trauma-informed system that serves more children and families in their homes and communities, without ever entering out-of-home placement, and does so through cost-effective interventions that are evidence-informed, strengths-based, individualized, and improve the well-being of the entire family unit. Maryland's trauma-informed system will *reduce entries* into out-of-home care, *reduce re-entries* into out-of-home care, and *reduce length of stay* in out-of-home care—while improving the well-being of the children, youth and families we serve.

As the individual authorized to sign the terms and conditions of the Demonstration Project on behalf of the State of Maryland, I have reviewed the proposal and can confirm it meets all of the requirements outlined in the 2012 Information Memorandum (ACYF-CB-IM-12-05). I look forward to partnering with the Children's Bureau on the implementation of a Title IV-E Waiver Demonstration Project to improve outcomes for children, youth and families involved with the child welfare system.

Thank you for this opportunity and I look forward to a positive federal review of the application.

Sincerely,

Theodore Dallas
Secretary

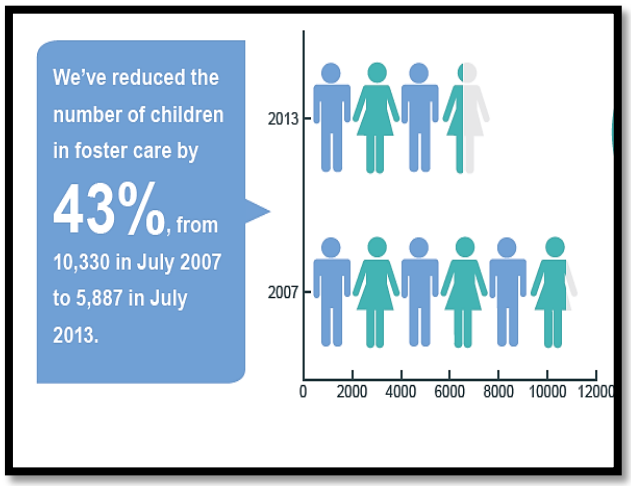
Introduction

The Maryland Department of Human Resources (DHR), Social Services Administration (SSA) envisions a Maryland where all children are safe from abuse and neglect, children have permanent homes, and families are able to meet their own needs. Maryland's 24 local departments of social services (LDSS) employ strategies to prevent child abuse and neglect, protect vulnerable children, and preserve and strengthen families by collaborating with state and community partners. Maryland is building a system that improves family and child well-being through the provision of family-centered, child-focused, community-based services.

DHR, Maryland's human services and child welfare agency, is a member of Maryland's Children's Cabinet which, for more than 30 years, has provided leadership for and commitment to achieving a collaborative system of care for Maryland's children and families. The Children's Cabinet is comprised of the Secretaries of the Department of Budget and Management (DBM), Department of Health and Mental Hygiene (DHMH), DHR, Department of Juvenile Services (DJS), and Maryland Department of Disabilities (MDOD), the Superintendent of the Maryland State Department of Education and the Executive Director of the Governor's Office for Children. The Children's Cabinet provides a vehicle for interagency planning and collaboration on behalf of children and families with the most complex and challenging needs.

In 2007, DHR made a deliberate and focused shift in its practice, policy and service delivery with the launch of its Place Matters initiative. Place Matters promotes safety, family strengthening, permanency and community-based services for children and families in the child welfare system. The proactive direction of Place Matters is designed to improve the continuum of services for children and families, and places emphasis on preventing children from coming into care when possible, while ensuring that children are appropriately placed when they enter care. Place Matters also shortens the length of time youth are placed in out-of-home care. The goals of Place Matters are to:

- **Keep children in families first**: place more children who enter care with relatives or in resource families as appropriate and decrease the numbers of children in congregate care.
- **Maintain children in their communities**: keep children at home with their families and offer more services in their communities, across all levels of care.
- **Reduce reliance on out of home care**: provide more in-home support to help maintain children with their families.
- **Minimize the length of stay**: reduce length of stay in out-of-home care and increase reunification.
- **Manage with data and redirect resources**: ensure that managers have relevant data to improve decision-making, oversight, and accountability.
- **Shift resources** from the back-end to the front-end of services.

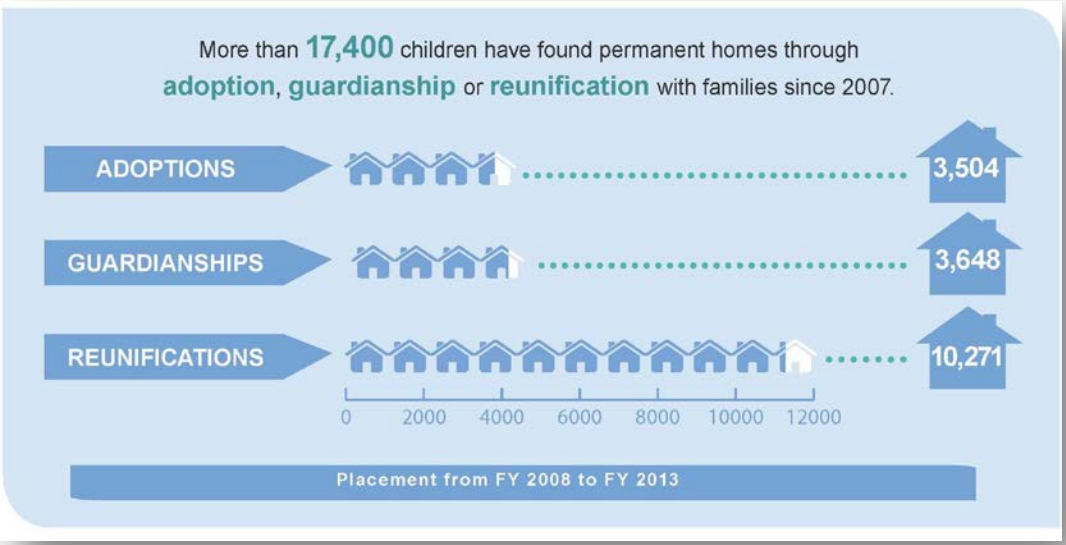


The primary successes of Place Matters are found in the shorter lengths of stay in out-of-home care and the increasing numbers of children and youth exiting from foster care to a permanent placement. Since the start of Place Matters, **the number of children in out-of-home care has decreased by 43%,** and the number of youth in group placements has decreased by more than 50%; the proportion of youth in group home placements

declined from 19% to 11%. **There are fewer children in foster care today in Maryland than at any time in the past twenty-five years.**

In 2008, the Children's Cabinet released the first Maryland Child and Family Services Interagency Strategic Plan in partnership with families, communities and providers. This plan identified a series of strategies and targeted initiatives to improve access, services, and supports for children and families across systems and agencies. The companion implementation plan continues to be updated and serves as a foundation for cross-systems design initiatives, including the implementation of evidence-informed practices and service delivery models, family partnership, and individualized care planning.

DHR attributes much of the success to its Family Centered Practice (FCP) model, which is at the core of Maryland's child welfare model and consistent with the service planning models outlined in the Interagency Strategic Plan. FCP includes the utilization of the Family Involvement Meeting (FIM) to encourage children, family members and community partners to be actively involved in case planning decisions. Maryland has partnered with families, including kin and fictive kin, to move children out of foster care and into permanency. More than 17,400 children have moved to permanent homes through reunification, adoption, or guardianship since 2007.



Maryland's success in reducing foster care through Place Matters is driven by exits exceeding entries from year to year. Entries have generally been consistent over time, with only occasional increases, as illustrated in Figure 1 below.[i]

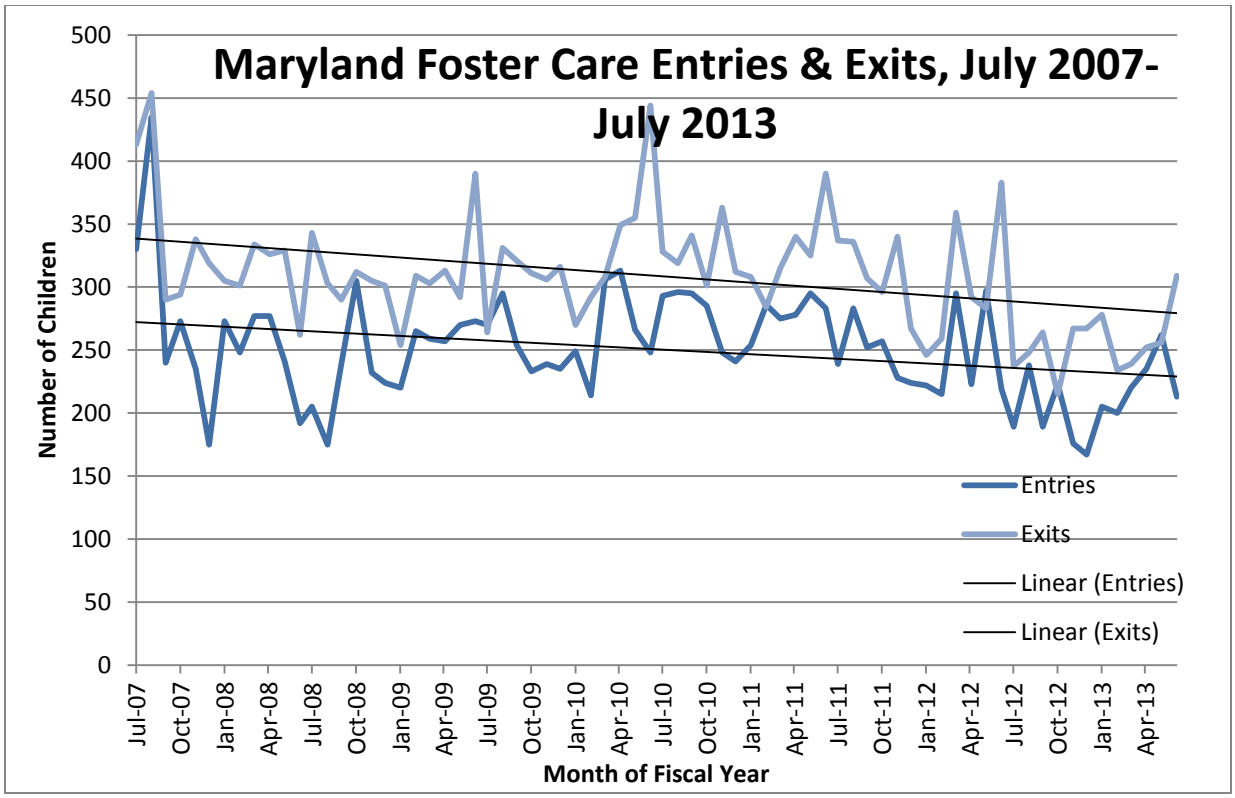


Figure 1: Maryland Foster Care Entries & Exits, July 2007-July 2013

Although Maryland has experienced a decrease in entries in the past two years, the challenge is to focus on a continued reduction of entries into foster care by determining the factors that lead to placement and the services required to prevent placement. Place Matters, therefore, is shifting its focus to narrowing foster care's front door, and Maryland needs to build flexible capacity to make this happen.

In July 2012, Maryland passed landmark legislation permitting the development and implementation of an alternative response system to address low risk cases of child abuse and neglect. **Alternative Response** permits DHR to intervene to ensure safety and address risk without the stigma of a finding of maltreatment being attached to the parent. The cornerstone of Alternative Response is family engagement; families work with DHR to address the issues that place children at-risk. Maryland provides Consolidated In-Home Services to families where risk of maltreatment is identified, and the availability of targeted community services to meet the needs of families and children is integral to the success of Alternative Response. July 2013 marked the beginning of the year-long implementation of Alternative Response. By July 2014, Alternative Response will be available statewide as an alternative to traditional, investigative responses, when appropriate.

Alternative Response marks the next phase in Maryland's efforts to reduce the number of children in out-of-home care. Although full implementation of Alternative Response provides flexibility for each jurisdiction to offer services to families at-risk, this Title IV-E Waiver Demonstration Project will provide the resources to ensure its success as an effective strategy.

As noted above, the successes of Place Matters have led to reductions in the number of children in out-of-home care; however, as Maryland's total population of children in out-of-home care has decreased, the percent of youth over the age of 14 has increased (See Figure 2 below).

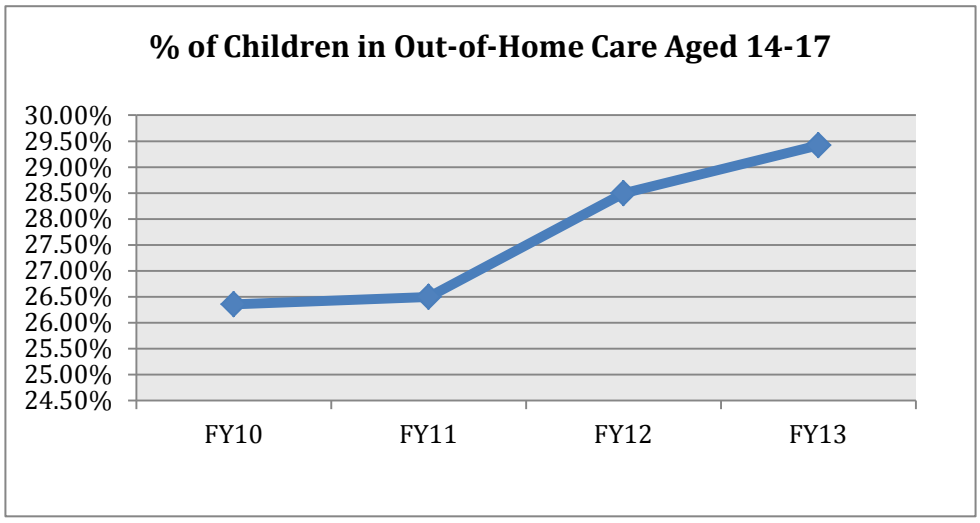


Figure 2: % of Children 14-17 in Out-of-Home Care

Nearly half of the youth in care in Maryland are between the ages of 14-20, with almost 30% of youth in care ages 18-20. This cohort of youth presents unique needs as they prepare to transition from foster care to young adulthood. **Ready by 21** is Maryland's initiative to ensure that youth are prepared for the transition into adulthood. Focusing on the five core areas of housing, education, finances, health, and mentoring, Ready by 21 provides a framework and key strategies that are implemented at the local level by the LDSS and their community partners. Ready by 21 is designed to ensure that youth have the necessary skills and resources to integrate back into their homes and communities when they reunify with the families or to be successful if they emancipate from care at age 21.

Maryland has been innovative in its work with transition-aged youth, recognizing that the supports that are provided to youth ages 14-17 impacts their permanency and well-being as they move into adulthood. While some states are only just starting to consider expanding foster care up through age 21, for several years, Maryland has encouraged youth to remain in care past age 18 if they are not reunifying with their families or being adopted. While the child welfare system is no substitute for a family, the resources and supports that DHR provides to these youth as they move into adulthood serve as a critical safety net. The **Youth Matter** Practice Model is an important piece of Maryland's Ready by 21 initiative, focusing on understanding the process and importance of actively engaging and teaming with youth. LDSS use FIMs, advisory boards, and other local opportunities to engage youth in both the practice and policy levels of the child welfare system.

Since 2007, Maryland has been systematically enhancing and improving its child welfare system through broad initiatives (Place Matters, Ready by 21), practice model improvements (Family Centered Practice, Youth Matter, Alternative Response), program improvement policies (Guardianship Assistance Program, Tuition Waivers, Kinship Navigators), and innovative and evidence-based programmatic improvements (Family Finding, Family Involvement Meetings, Family Unification Program Vouchers). Maryland is poised to utilize these wide-ranging initiatives under the Demonstration to reduce entries and re-entries into out-of-home care and reduce lengths

of stay for youth in out-of-home care, ultimately achieving greater safety, permanency, and well-being for Maryland's children and families.

1. Proposed Demonstration

As described above and in additional detail below, Maryland has focused on incremental reforms and changes that have enabled more children to be served through shorter lengths of stay in out-of-home care and in more family-based settings. This Demonstration will serve as the necessary catalyst to move Maryland into its next phase of growth—one that serves more children and families in their homes and communities, without ever entering out-of-home placement, and does so through cost-effective interventions that are evidence-informed and strengths-based, individualized, and improve the well-being of the entire family.

Creating a Responsive, Evidence- and Trauma-Informed System to Promote Well-Being

The next steps for Place Matters are to reduce foster care entries and support youth transitioning to adulthood. Both of these goals require an increase in evidence-informed home- and community-based family preservation services and implementation of a broader trauma-informed lens for all service delivery initiatives in order to ensure the success of Alternative Response and Ready by 21.

Maryland wants to serve as many at-risk children and families as possible to avoid out-of-home placement; to do so requires enhancing the current community-based service array. DHR has shared ownership of the development of a trauma-informed and responsive service array with its sister agencies in the Children's Cabinet and recognizes that it cannot and should not develop its own home- and community-based service system parallel to those developed, managed, and utilized by DHMH, DJS, or MSDE. Instead, this Demonstration highlights DHR's interest in leveraging existing initiatives and promoting those services and supports that are evidence- and trauma-informed as well as relevant and responsive to the children and families that will be served.

As discussed above, the implementation of Alternative Response, which will be available statewide by July 2014, marks a continued practice shift toward increased family engagement and collaboration. Place Matters and Ready by 21 both frame DHR's approach to service delivery, supporting families and youth to utilize community-based services to address underlying needs—including trauma—to limit the amount of time that children spend in out-of-home care and support all youth with child welfare histories to transition successfully to adulthood. The continued success of Place Matters is contingent on the provision of the services and interventions with children and families at the engagement points when they can be most effective.

Maryland proposes to create a trauma-informed system that uses standardized assessments to identify services and supports for children and families to prevent out-of-home care and re-entries into out-of-home care as well as to improve well-being.

The National Child Traumatic Stress Network (NCTSN)[1] defines a trauma-informed child- and family-service system as "one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system….Programs and agencies…infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies."[ii]

[1]The NCTSN was established by Congress in 2000 and is funded through the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services and is jointly coordinated by UCLA and Duke University.

NCTSN goes on to define a trauma-informed service system as

> *one in which programs, agencies, and service providers: (1) Routinely screen for trauma exposure and related symptoms; (2) use culturally approved evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (3) make resources available…on trauma exposure, its impact, and treatment; (4) engage in efforts to strengthen the resilience and protective factors of children and families…(5) address parent and caregiver trauma and its impact on the family system; (6) emphasize continuity of care and collaboration across child-service system; and (7) maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience.* [ii]

This project will be innovative by leveraging existing initiatives (Place Matters, Ready by 21); improving DHR's use of the safety, risk, and functional assessment tools; extending State and local partnerships to increase community-based services; utilizing the best evidence and science available to shape workforce development and services; and infusing a new, flexible financing mechanism that will help Maryland address the unique needs and strengths of each family who comes in contact with the child welfare system.

The flexibility afforded by the Title IV-E Demonstration Waiver will enable DHR to strengthen families and serve children in their homes, reducing risks and the need to enter out-of-home care. Place Matters has enabled children to experience shorter lengths of stay in out-of-home care and exit to permanency; the IV-E Demonstration will enhance the implementation of Alternative Response to enable more children and families to be served in home with individualized, evidence-based/informed, community-based services and supports. The Title IV-E Demonstration Waiver will give DHR the flexibility to redirect funds traditionally used to support children and youth in out-of-home care into services that support children, youth and families in the community, allowing them to remain in their homes. DHR will expand intensive **family preservation and post-permanency services** to improve family functioning, safety, well-being and permanency outcomes.

Maryland's hypotheses are that:

1) Many young children at-risk for child maltreatment and their families can be safely and effectively served in their homes and communities through trauma-informed, individualized, strengths-based, culturally responsive, and collaborative services, including evidence-based/informed practices and interventions, preventing these children from entering into out-of-home placement while promoting their well-being;

2) Many families require extended services and supports during the post-permanency period to ensure that they successfully transition out of child welfare involvement without compromising safety or well-being, thereby preventing the re-entry of children into out-of-home placement; and,

3) Transition-Aged Youth need comprehensive and focused support to achieve educational and employment outcomes; financial stability; health and well-being; permanent, supportive connections; and, safe, affordable, stable housing as they move into adulthood, regardless of whether they exit care through reunification, guardianship, adoption, or emancipation.

Through this Demonstration, Maryland will *reduce entries* into out-of-home care, *reduce re-entries* into out-of-home care, and *reduce length of stay* in out-of-home care—while improving the well-being of the children, youth and families it serves.

Changing Demographics

Maryland's recent successes under Place Matters have resulted in a distribution of children in out-of-home care that is bi-modal, **with the majority of children served in out-of-home care either 0-8 years old or 14-21 years old.**

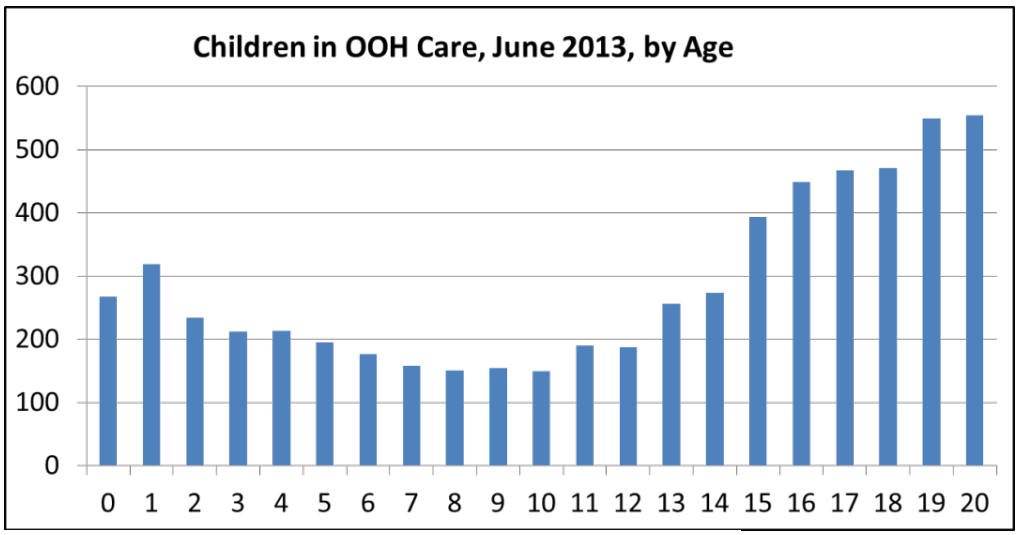
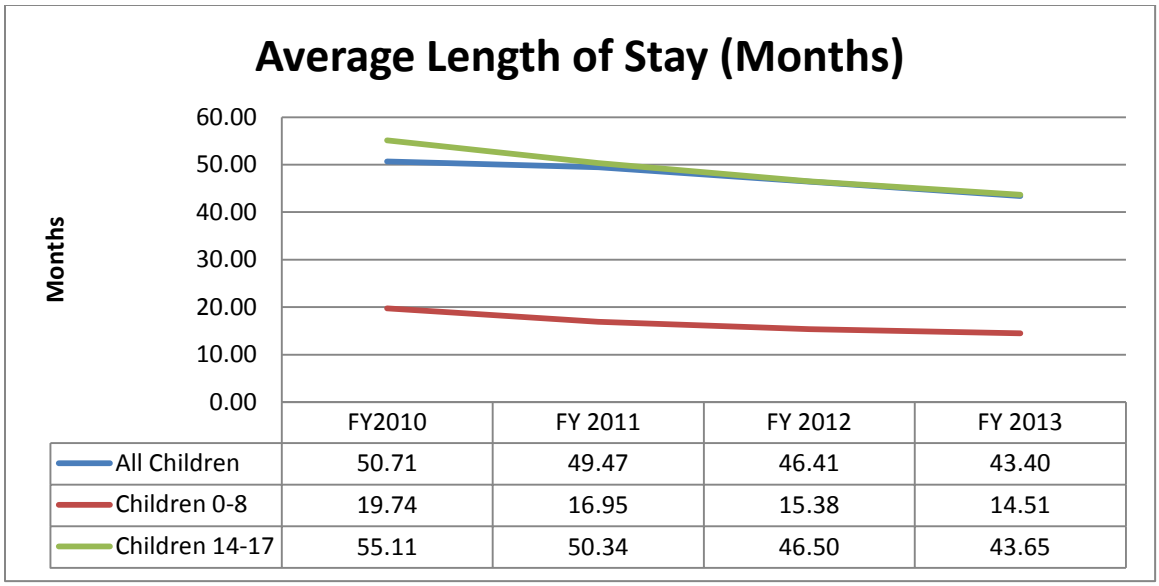


Figure 3: Children in Out-of-Home Care, June 2013, By Age

Young children, ranging in age from birth through age eight, represent an increasing proportion of the population served by the child welfare system, both in- and out-of-home. Approximately 32% of the children in out-of-home care in June 2013 were ages 0-8 (1,925). An additional 3,339 children 0-8 were served through in-home services, representing 54% of all children served in in-home services in June 2013.

More than half of the youth in foster care in Maryland are **over age 14** and nearly 30% of Maryland's foster care population is 18 and over. In 2012, 21% of all entries into foster care were youth ages 14 to 17. In 2013, 20% of all youth served through in-home services were ages 14-18. The percent of youth in foster care over 14 increased even while Maryland reduced its total foster care population by more than 40% since 2007. At the start of Place Matters, 46% of youth in out-of-home care were 14 years or older; six years later, 52% of the caseload was 14 years or older. The average length of stay in out-of-home placement has been declining for all age groups, including children ages 14-17. However, the average length of stay in out-of-home placement is much greater for older children than for younger children.

The figure that follows illustrates the average length of stay (in months) for children ages 0-8 and 14-17, as well as for all age groups. The average length of stay for all children now matches the length of stay for youth ages 14-17.



	FY2010	FY 2011	FY 2012	FY 2013
All Children	50.71	49.47	46.41	43.40
Children 0-8	19.74	16.95	15.38	14.51
Children 14-17	55.11	50.34	46.50	43.65

Figure 4: Average Length of Stay (Months)

Despite increases in reunification, adoption, and guardianship, **the majority of youth over the age of 14 in foster care are likely to remain in care until they emancipate.** The national average length of stay (ALOS) for youth aging out of foster care is 5 years[iii], while the ALOS for youth aging out (18-21) in Maryland in 2012 is 8.5 years. In fact, 699 youth were emancipated from Maryland's foster care system in 2011, the 12th highest total in the U.S.; 22% of youth exiting foster care in Maryland in 2011 were youth who aged-out of the system, the 3rd highest rate in the country.[iv]

One of the goals when a child exits from out-of-home care is to ensure that their exit is permanent and successful. However, as the length of stay in out-of-home placement decreases, the number of children re-entering out-of-home care has been increasing. (See below for additional discussion on youth re-entering out-of-home placement.)

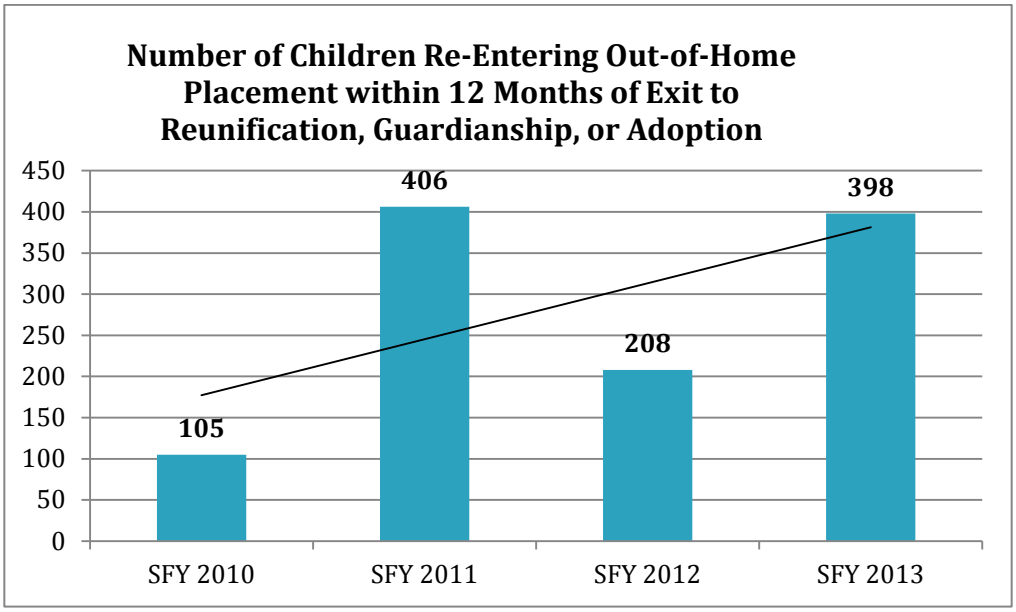


Figure 5: Number of Children Re-Entering Out-of-Home Placement

Trauma-Informed Screening & Assessment Tools

Many youth involved with the child welfare system have a history of trauma and may be further traumatized as a result of their out-of-home placement.[v] These youth are particularly likely to experience behavioral health problems: nearly half of the adolescents in the National Survey on Child and Adolescent Well-being were diagnosed with at least one mental health disorder and almost 20% reported three or more mental health problems. Additionally, youth with prior out-of-home placement had twice the rates of behavioral health problems.[vi] Youth may experience additional trauma when transitioning from foster care without permanent supports.[vii]

In 2012, the Administration for Children and Families introduced an Information Memorandum (IM) that set the course for a new child welfare strategy centered on promoting social and emotional well-being for young people who have experienced maltreatment. The IM referenced growing evidence of the social and emotional impacts of trauma and maltreatment on children and stated that screening measures and functional assessments are essential components in addressing well-being.

Maryland has been using the Safety Assessment for Every Child (SAFE-C) and the Maryland Family Risk Assessment (MFRA) tools for many years. Over the past year, Maryland has developed revisions to the SAFE-C to improve its use as a systematic analysis of the child's vulnerabilities, danger influences, and protective capacities of the family associated with the children. Additionally, the Maryland Family Risk Assessment is targeted to be replaced by an actuarial model that has been evaluated and shown to provide a more accurate assessment of risk for future maltreatment in other states. The MFRA and the SAFE-C are in the process of being implemented in the State Administered Child Welfare Information System (SACWIS).

The IM cited the Child and Adolescent Needs and Strengths (CANS) Assessment Tool as an example of a trauma screening tool that can be used to assess how experiences of trauma may impair a child's social and emotional functioning (ACF, 2012). Since 2011, DHR has used the trauma version of the Child and Adolescent Needs and Strengths Assessment (MD CANS) to assess youth in out-of-home placement settings; the CANS has been used by private agency staff since 2009. The CANS assesses youth functioning in major life domains, strengths, emotional and behavioral needs, and risk behaviors, in addition to caregiver strengths and needs. The CANS has been integrated within child and family teams to develop more individualized and ultimately more effective treatment plans and service plans. Additionally, a decision support algorithm has been piloted in three counties that provides teams with a framework to decide on the most appropriate placement type using child need and service intensity information.

The CANS assessment is used by other child- and family-serving agencies within the Children's Cabinet, including in systems of care initiatives through the Care Management Entities (CME) providing intensive care coordination, private group homes and treatment foster care agencies contracted with DHR and DJS as well as across programming within the child welfare system.

The CANS Family (CANS-F) assessment is a comprehensive family system assessment that includes domains for assessing the strengths and needs of individual caregivers and youth. It centers on the family unit as a whole for planning and measuring of service needs; therefore, all members of the household, regardless of age, are included in the assessment. Piloting of the family version of the CANS-F began in fall 2012 but is not utilized statewide. It is primarily used throughout the life of an in-home service case to assist service workers in the identification of strengths as well as underlying issues and needs for families that have been brought to the LDSS's attention. The CANS-F can help verify that the interventions or recommended services are successful in affecting change

for the family. In addition, the assessment provides a measure that is consistent across in-home and out-of-home service units through the implementation of a common assessment scheme and a common language for understanding a family and youth's needs and strengths.

Maryland has begun testing strategies for measuring change in youth functioning over time using the CANS data collected for youth in out-of-home care. Using three different approaches to understanding change in CANS scores (raw sum change, dichotomizing response options and assessing change between states, and the reliable change index [RCI]), findings were compared across each method to demonstrate how the selected change measure is related to the number of youth who show improvement over time. Maryland has found that any of the change measures were strong predictors of real-world outcomes like movement to a less restrictive setting. These findings underscore the potential that the CANS tool can have in targeting identified service needs whose improvement can mediate need for restrictive placement.

Past and current use of the CANS positions Maryland to be able to move to a more trauma-informed and individualized service delivery system for children and their families prior to, during, and after out-of-home placements. Its use as a care planning and communication tool will assist workers and families to identify and access those resources in the community that are best matched to the strengths and needs of each child and family.

The NCTSN includes the use of trauma-informed and evidence-based assessments as a component of creating a trauma-informed system. Maryland believes that the thoughtful and appropriate utilization of screening and assessment tools—in conjunction with family involvement meetings, individualized care planning, and expanded home- and community-based service array—will reduce the trauma on children who come into out-of-home care and enable shortened lengths of stay. Maryland also anticipates that, by having the necessary supports, services, and policies in place, the decreased length of stay will, for those youth who come into care, not result in increased rates of re-entry into care.

2. Statutory Goals

The Demonstration will strive to achieve all three of the statutory goals:

- Increase permanency for all infants, children, and youth by reducing the time in foster placements when possible and promoting a successful transition to adulthood for older youth;
- Increase positive outcomes for infants, children, youth and families in their homes and communities, including tribal communities, and improve the safety and well-being of infants, children and youth; and,
- Prevent child abuse and neglect and the re-entry of infants, children and youth into foster care.

3. Proposed Target Population

In addition to the children that Maryland traditionally serves under Title IV-E services (approximately 1,700 children each month), the Demonstration Project will serve youth transitioning from foster care, families who receive CPS and in-home services, and families with children in foster care with a goal of reunification or guardianship.

However, Maryland has identified two *priority* populations of children and youth to focus on for the Demonstration in order to reduce entries into out-of-home care, length of stay in out-of-home care, and re-entries into out-of-home care.

Based on a comprehensive data analysis, including information presented above, Maryland will track outcome data on children served ages

1) 0-8 years old; and,
2) 14-17 years old.

Children 0-8 and 14-17 years old represent 80.5% of all entries into out-of-home placement in SFY2013; only 493 (19.5%) of the children entering out-of-home care in State Fiscal Year (SFY) 2013 were ages 9-13.

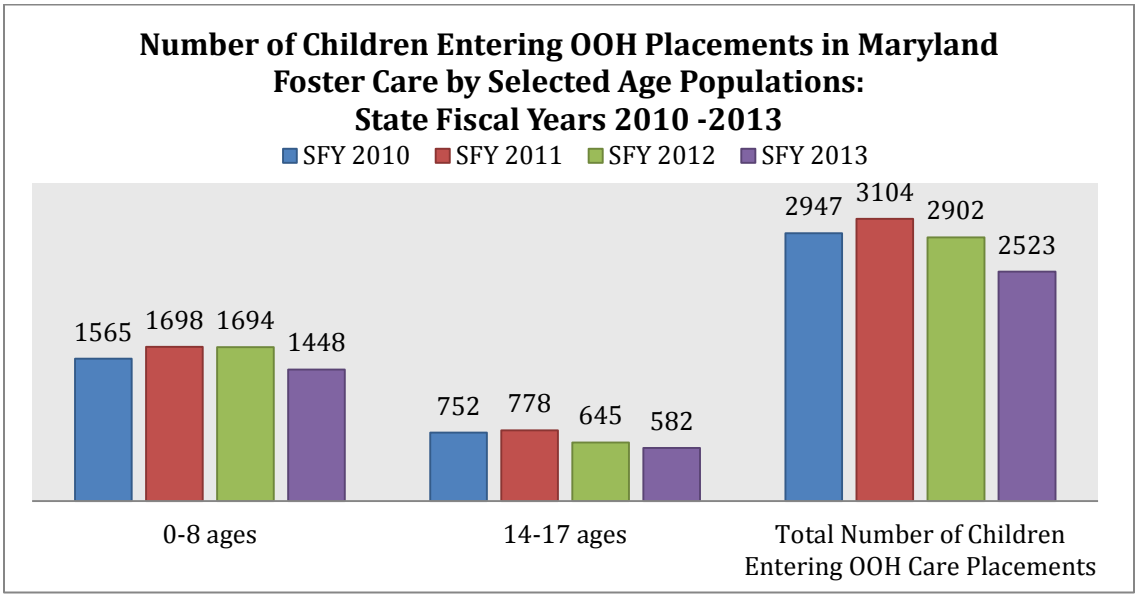


Figure 6: Children Entering Out-of-Home Placements by Age

Children Ages 0-8 Years Old

One of the populations of focus is children ages 0-8 who are in out-of-home care or at-risk of entering out-of-home care. Infants (under one year of age) were the largest single cohort of children entering out-of-home care during Federal Fiscal Year 2013, representing 19% (n=458) of all entries into out-of-home care.[viii] Children who are 1 year-old are the second largest cohort of entries, representing 7% of all entries into out-of-home care. Sixty percent (60%) of all entries into out-of-home care are for children under 10 years old. Twenty-three percent (23%) of all entries in State Fiscal Year 2013 were 1-4 year olds; 15.6% of entries were children ages 5-8.[ix]

The majority of these children are from single, female-headed households; almost two-thirds of children entering out-of-home care under the age of five are from single, female-headed households. Some of these children come from single, female-headed households that are not headed by the children's mothers; in those instances, they are frequently headed by a grandmother. A smaller percentage of babies entering out-of-home care were born to mothers who were teenagers when they gave birth (15.3%) as compared with children ages 1-4 (27.5%).

Racial disparities are present among the youth entering out-of-home care, with the disparity more pronounced as the age of entry increases. While 55% of all entries into out-of-home care were Black/African-American, only 44% of infants entering out-of-home care were Black/African American as compared with 54% of children ages 1-4. The proportion of infants who are identified as Hispanic/Latino is lower (3%) than the overall rate (5%). There are slightly more male children than female children within the population under age 8.

The majority of all children in out-of-home care have one or more siblings in out-of-home care. Infants have the lowest percentage of children with siblings in care (58%), while children ages 1-4 and 5-9 have higher percentages (78% and 86% respectively). The caregivers of infants were more frequently identified as having substance abuse problems at the time of removal (45%) compared with the average across all children in out-of-home care (22%). Among younger children, neglect is the most common type of maltreatment, particularly for infants (84%) and children ages 1-4 (82%). Physical abuse is cited for 10% of infants, 14% of children ages 1-4, and 19% of children ages 5-9.

Infants have an average length of stay of 2.7 months, while children who are 4-years old at the time of their exit from care have an average length of stay of 21.1 months. Children exiting from care at age eight have an average length of stay of 23.3 months. Among youth who aged out-of-care in FY12, 23% first entered as young children (0-3 years old).[x] Despite improvements in the lengths of stay, approximately 50% of all children ages 0-8 years old are in out-of-home care for twelve months or more. However, a greater percentage of those children in out-of-home care are experiencing lengths of stay of less than 12 months in FY13 than in FY10.

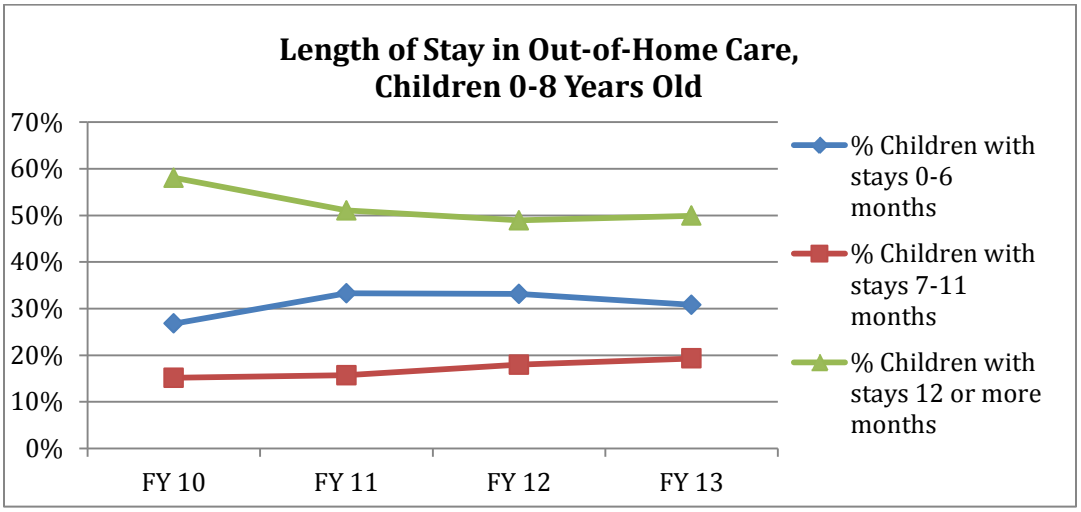


Figure 7: Length of Stay, Children 0-8 Years

Almost all of the children in out-of-home care under age eight (97%) are placed in family homes. This percentage includes placement in adoptive/pre-finalized adoptive homes, formal kinship care, regular foster care, restricted (relative) foster care, and private treatment foster care homes. Although almost 1 in 4 children entering foster care in Maryland has experienced a prior foster care episode, younger children are less likely to have experienced a prior episode. Two percent (2%) of infants have a prior experience in out-of-home care, as compared with 18% of children ages 1-4 and 26% of children ages 5-9.

Youth Ages 14-17 Years Old

The second population of focus is youth ages 14-17 in out-of-home care or at-risk of entry into out-of-home care. As discussed above, this age group represents a growing proportion of the population of youth in out-of-home care, at 24% of all entries into care in FFY13.[viii] The racial disparities become more pronounced with these older youth: 63% of all entries into out-of-home care are Black/African American, and 6% of entries are identified as Hispanic/Latino (compared with 3% among infants). Additionally, these youth are more likely to be female (63%) and to have

been born to a teen mother (35.1%). Almost one-third of 14-17 year olds entering care were born to mothers who were young adults (20 to 24 years old) at the time of their birth.

Youth ages 14-17 entering out-of-home care are slightly less likely (at 52%) to come from a single, female-headed household than other children in out-of-home care (average of 59%). Although more than half of these youth have siblings in out-of-home care, they are less likely to have siblings in care than any other cohort of children entering out-of-home care, and they are more likely to have a behavior issue identified as a characteristic at the time of removal. Fifty-four percent (54%) of youth ages 14-17 have an identified behavior issue at the time of removal, 18% have an identified disability, 2% have identified alcohol abuse issues, and 6% have identified substance abuse issues. Their caregivers are also more likely to have removal reasons of relinquishment and abandonment (25% and 15%) than any other age group. As with all youth entering out-of-home care in Maryland, youth ages 14-17 are most likely to have experienced neglect (41%), with 10% experiencing physical abuse and 7% experiencing sexual abuse.

In SFY 13, the majority (63%) of youth ages 14-17 in out-of-home care were placed in a family home, while 20% were placed in group homes and 8% were placed in residential treatment centers (i.e. psychiatric residential treatment facilities). Group homes include alternative living units, emergency group shelter care, residential group homes, teen mother programs, and therapeutic group homes. Less than 1% of youth ages 14-17 were in independent living programs, and 9% were categorized as living in "other" placements. [ix]

Even though there have been modest improvements in the length of stay of youth 14-17 years old in out-of-home care, the average length of stay for children exiting foster care increases as children grow older. Youth who are exiting out-of-home care at age 14 have experienced an average of 27.3 months in out-of-home care. Youth exiting care at age 17 have an average length of stay of 31.8 months in care; youth exiting care at age 20 have an average of 111.7 months in care. [ix]

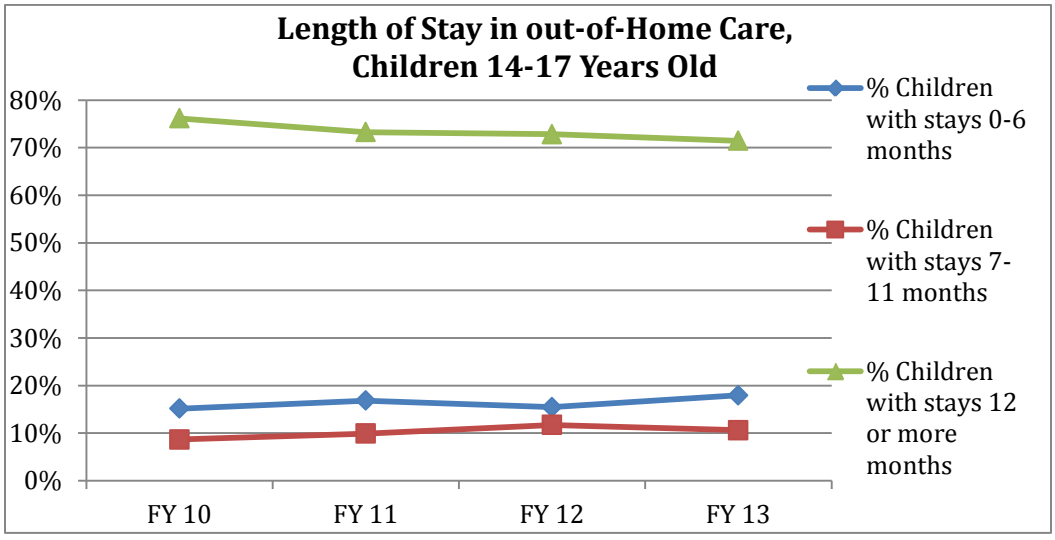


Figure 8: Length of Stay in Out-of-Home Care, 14-17 Year Olds

Reunification remains the most common type of discharge from out-of-home care for 14-17 year olds, although emancipation is the most common type of discharge for youth age 18 and older. [x] Among youth who aged out of care in FY12, 42% first entered as adolescents (13-17 years old). [x] One-third of all youth ages 14-17 entering out-of-home care have experienced a prior out-of-home placement episode.

Re-Entry into Out-of-Home Placement

As noted above, as lengths of stay in out-of-home placement have been decreasing, the number of children re-entering out-of-home placement have been increasing. Figure 9 below illustrates that the age distribution for re-entries into out-of-home care is similar to the distribution of ages for children in out-of-home placement. However, a greater proportion of children re-entering out-of-home care are infants and toddlers; the majority of children re-entering care are ages 0-8 years old.

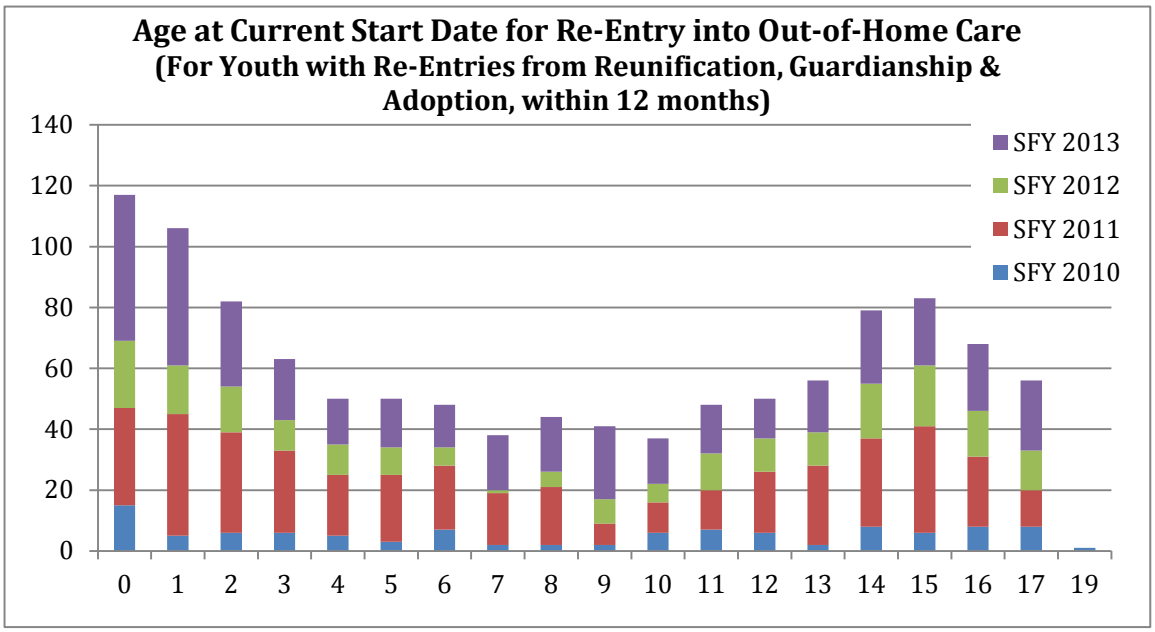


Figure 9: Age at Re-Entry into Out-of-Home Care

The children re-entering out-of-home placement within 12 months of reunification are slightly more likely to be female (52% versus 48%) and more likely to be Black/African American than White/Caucasian (65% versus 32%). This racial disparity is more pronounced than in the general out-of-home placement population, where 55% of children 0-8 and 63% of children 14-17 entering out-of-home placement are Black/African American.

Length of Stay (LOS), for Children Who Exited the Reentry Removal Episode					
LOS, in months	**SFY 2010**	**SFY 2011**	**SFY 2012**	**SFY 2013**	**Grand Total**
0-6	60	171	98	178	**507**
6-12	9	46	20	26	**101**
12-18	10	43	11	4	**68**
18-24	4	39	7		**50**
24-30	3	24	3		**30**
30-36	2	11			**13**
36-42	4	2			**6**
42-48	1				**1**
Grand Total	**93**	**336**	**139**	**208**	**776**

Table 1: Length of Stay for Re-Entry Episode (Children Who Have Exited To-Date)

As depicted in the table above, the majority (54%) of those children and youth who re-entered out-of-home placement within 12 months exited the re-entry out-of-home placement episode within one year. Another 11% of children exit from care within two years of their re-entry. Additionally,

approximately 7% of the children re-entering out-of-home placement do so through a Voluntary Placement Agreement for reasons of disability or through a time-limited Voluntary Placement Agreement. These data suggest that a flexible, individualized, comprehensive service array while in out-of-home placement and after exit from placement would benefit the child and family and assist in preventing re-entry into out-of-home care.

Estimated Number of Children to be Served

As noted above, Maryland has identified two primary populations of children to be served through this Demonstration Project: children ages 0-8 and children ages 14-17. Within those two populations, there are four primary groups of children who will be the primary beneficiaries of the Title IV-E Demonstration Project:

1. Children ages 0-8 and 14-17 receiving Alternative Response CPS services, who are at-risk for out-of-home placement;
2. Children ages 0-8 and 14-17 who at-risk for out-of-home placement due to an Investigative Response to a report of maltreatment;
3. Children ages 0-8 and 14-17 receiving in-home services, who are at-risk for out-of-home placement; and
4. Children ages 0-8 and 14-17 who are exiting out-of-home placement to reunification and are at-risk for re-entry to out-of-home placement.

The figures below are estimates of the number of children to be served under the Title IV-E Demonstration Project during the *first full year*. These children represent the universe of children that DHR is planning to serve in the hope of diverting them from out-of-home placement or reducing the likelihood of re-entry into out-of-home care. Therefore, the estimates were calculated using prior years' data and with projections, where appropriate.

Children receiving Alternative Response CPS services, at-risk for out-of-home placement = 103 children. Only two quarters of fiscal year data are available since Maryland began implementing Alternative Response at the beginning of State Fiscal Year 2014 and is utilizing a rolling implementation process. The estimated number of children who would enter out-of-home placement from all local departments in a given year was calculated by using the number of children who entered out-of-home placement while receiving Alternative Response services during those two quarters. Estimate used here is based on children ages 0-8 and 14-17.

Children receiving Investigative Response, at-risk for out-of-home placement = 1,148 children. Data on the number of children going from CPS (IR) to OOH for SFYs 2011 – 2013 were used to project an estimate for SFY 14. The estimated number of children going from AR to OOH was subtracted from this estimate, as the prior years' CPS data included children/youth who would likely now be served through AR. Estimate used here is based on children ages 0-8 and 14-17.

Children receiving In-Home services, at risk for OOH placement = 441 children. Data is available for SFYs 2010 – 2012 on the number of children who enter OOH care while receiving In-Home services. Using this data, and a projected increase (based on the 2010 – 2012) percent change, the number of children to enter care in SFY 2013 was estimated. Estimate used here is based on children ages 0-8 and 14-17.

Children exiting out-of-home care to reunification, and at-risk for re-entry to OOH placement – 179 children. Data on the numbers of children exiting OOH care to reunifications are available from SFY 2009 – 2013. Data on the re-entry rate from reunification is also available for that time period. This re-entry rate was used to determine an estimated re-entry projection for SFY 2014 (based on

the 2009-2013 percent change in total permanent exits in the reunification reentry rate), and used here. Estimate used here is based on children ages 0-8 and 14-17.

Population 1 - Children and youth receiving AR CPS services	+	Population 2 - Children and youth receiving IR CPS services	+	Population 3 - Children and youth receiving In-Home services	+	Population 4 - Children exiting OOH care to reunification	=	Total Population to Be Served Under the IV-E Waiver
103		1,148		441	+	179	=	1,871

Table 2: Estimated Number of Youth to be Served

4. Proposed Geographic Region

The demonstration will be implemented statewide. DHR will follow a variation of the model of implementation it used for Alternative Response, phasing in service interventions regionally, allowing for jurisdictional planning and service development.

Description of Service Interventions & Intended Outcomes

5. Service Interventions

Since 2007 with the implementation of its Place Matters Initiative, DHR has taken great strides in transforming Maryland's child welfare system to a family-centered, child-specific system that serves children in the least restrictive environment possible. Through this Demonstration, DHR will further its efforts by expanding in-home family supports that provide both prevention and post-permanency services. DHR will collaborate with its sister child- and family-serving agencies and community-based provider organizations in the expansion of services. The Demonstration will also focus on utilization of screening and assessment tools (discussed above), integration of assessment tools and referrals, and ongoing evaluation. DHR and its partners explored the needs of both of the populations of focus in identifying appropriate service interventions.

Creating a Trauma-Informed System

As discussed above, there is a critical need to create a trauma-informed child welfare system. In addition to expanding the use of trauma-informed screening and assessment tools, Maryland is seeking to infuse this paradigm through a number of workforce development and training initiatives.

DHR's Provider Advisory Council (PAC) created a trauma workgroup to support the development of a trauma-informed system in Maryland. At the request of the trauma workgroup, in January 2014, the Children's Cabinet's Evidence-Based Practice Advisory Committee convened a meeting focused on building a trauma-informed system of care in Maryland. Reports were provided on many of the individual initiatives already in place in Maryland, including four SAMHSA-funded trauma centers, surveys of providers regarding their capacity to provide specific trauma-informed services, and workforce development activities. The meeting ended with a commitment to moving the work forward through a smaller workgroup that will initially outline Maryland's vision for a trauma-informed system. DHR's participation in the larger Advisory Committee as well as in the trauma workgroup will ensure that the Demonstration serves to propel the work forward.

Additionally, the Demonstration will enable the Department to provide tailored training to child welfare workers, resource parents, and community providers on trauma-informed care. In June 2013, the NCTSN released a report from its Breakthrough Series Collaborative on *Using Trauma-Informed Child Welfare Practice to Improve Placement Stability.*[xi] This report outlined a series of strategies and promising approaches for this work, ranging from knowledge-building and developing practice for direct care staff, parents, and caregivers, to increasing the capacity of mental health providers to deliver evidence-based practices. Resources such as the Breakthrough Series Collaborative and *The Child Welfare Trauma Training Toolkit 2nd Edition*[xii] are resources that DHR can utilize to implement a trauma-informed system.

Maryland's Child Welfare Training Academy at the University of Maryland School of Social Work currently provides a day-long in-service training to child welfare workers on how trauma affects individuals at various stages of development and appropriate trauma-informed screening, assessment, and intervention strategies that can be employed by workers, families, and foster care providers. Unfortunately, this training is necessarily limited in its duration and availability due to fiscal constraints; training for various stakeholders will be expanded under the Demonstration, both in terms of frequency and the depth of the content, with the potential to provide training via webinar and through an online training center hosted by the University of Maryland School of Social Work.

Training is critical, not only for the child welfare workforce and other direct care staff, but also for resource parents. A component of a trauma-informed system is supporting the foster parents to learn more about the particular needs of the children that they are serving and how to support them to transition back to their homes and communities. Intergenerational trauma is frequently present in the families involved with the child welfare system, and resource parents need to be supported to work with the birth family as well as the children. The trauma of the birth parents may impact their ability to effectively work toward reunification, and increasing the knowledge of the resource parents in how to better partner with the birth parents may help to reduce lengths of stay in out-of-home placement as well as re-entries into out-of-home placement.[xiii] This Demonstration Project will provide necessary resources for DHR to provide enhanced training and support to resource parents.

When children need to enter out-of-home placement, the child welfare system must minimize the amount of trauma it inflicts on the children through the removal process. Placing children in family foster homes located within their communities of origin, and placing them with siblings, are critical strategies to mitigate further trauma and improve outcomes for permanency and well-being. This Demonstration Project will expand the resources available to recruit and train resource parents and to promote the retention of high-quality foster homes within the communities from which the children originate.

Alternative Response

The primary and overarching intervention within Maryland's trauma-informed, responsive system is the use of Alternative Response. Alternative Response expands DHR's family engagement practice to the very first contact with families, moving from a forensic investigation to full family engagement and comprehensive assessment of the family's needs during the initial response to an allegation of abuse or neglect in low risk cases. This service approach to families has been shown to decrease the recurrence of maltreatment.[xiv] Further, families diverted to an Alternative Response were found to receive a greater number of services than families in an investigative response, and tended to initiate service activities earlier.[xv] This Demonstration will serve as a vehicle for improving service delivery and early intervention, enabling DHR to expand and increase the

capacity of services available to meet the individualized needs of families served via the Alternative Response model. Services will not be limited to those that are therapeutic in nature, but will address the entire family across life domains to promote safety, permanency, and well-being. Job training, employment assistance, and housing supports will be accessed as needed to reduce the likelihood of children entering out-of-home placement. DHR has extensive partnerships across the child- and family-serving system, and will collaborate with agencies and community providers to access those services and supports.

Expanded Post-Permanency Support

Currently, DHR provides post-permanency subsidies for eligible children who exit to adoption and guardianship. Adoption subsidy eligibility and amounts are based upon a child's special needs and are intended to provide funding for specialized services required by the child due to their identified special need. Limited funding is provided for post-adoption services specifically intended to prevent a child's re-entry into foster care. Guardianship subsidy mainly covers the room and board expenses of the child that otherwise would have borne by the State, had the child remained in foster care. Post-reunification services are currently limited to the In-Home Family Services available to families at-risk of abuse of neglect.

The Demonstration will provide enhanced flexibility for DHR to provide post-permanency support to families, both through the expanded availability of evidence-based and –informed services (described below) as well as through the ability for an extended period of time for service delivery. DHR has long recognized that it is better to pay for extended post-reunification services than to pay for a child to re-enter out-of-home placement, and this Demonstration will enable Maryland to implement this policy.

Youth Ages 18-21

Youth ages 18-21 are not a population of focus for this Demonstration Project because DHR is seeking to intervene at an earlier interval, when youth first engage with the child welfare system. However, it is anticipated that the number of youth ages 18-21 in out-of-home placement will decrease as fewer come into care during their adolescent years and as more youth exit foster care to permanent living arrangements as the result of the individualized, trauma-informed services and supports they received. DHR has designed this Demonstration Project to better position all youth who spend time in the child welfare system, including those youth who do remain in care until they age-out, to be successful in adulthood and to have permanent, supportive connections and the necessary skills and resources that will support their social and emotional well-being. Lessons learned from complementary initiatives, such as Thrive@25 (discussed below) and a partnership with AIRS to provide supportive housing for youth at-risk of homelessness and the evaluation activities that accompany both initiatives, will inform the Demonstration Project and efforts on behalf of this population of youth going forward.

Evidence-Based and Evidence-Informed Practices

DHR plans to expand the network of evidence-based/informed and community-based services available across the state for families with trauma histories and child welfare system involvement. There remain critical gaps in the availability of evidence-based and evidence-informed practices that are shown to effectively improve social and emotional well-being across Maryland.

Services provided to children and their families should be home- and community-based and provided by larger provider networks beyond the LDSS. Linkages and connections need to be made to services across the community so that families can access appropriate services and supports. As

discussed below, there are multiple initiatives underway to expand the array of home- and community-based services, particularly through the Medicaid system.

Among the services and supports that were identified as having particular benefit for the families and children to be served in this Demonstration are respite care; crisis response and stabilization services; individualized, intensive in-home services (clinical); peer support; and, Wraparound care coordination. All of these services have been identified by the Children's Cabinet in Maryland, local mental health and child- and family-serving agencies, and, at the federal level, by the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) as interventions that make a difference in the lives of children and families with intensive needs.

This Demonstration will not seek to recreate these services nor will it create a separate, parallel system. Instead, DHR will work with its partners inside the Children's Cabinet to support the implementation and expansion of these services to ensure access to them for the children and families who are the focus of this Demonstration. One of the key sustainability activities (discussed below) is to work with DHMH to embed as many of these evidence-based and promising practices and approaches as appropriate—including those listed below—in the Medicaid State Plan. The Title IV-E Demonstration Waiver would support the start-up costs associated with either beginning or expanding particular EBPs or promising approaches in Maryland, as well as serve as a potential payment mechanism for these services if other sources of payment are not available.

Maryland has identified a select number of evidence-based and research-informed practices for the Demonstration. However, **during the implementation period, DHR will work with local jurisdictions to identify the specific evidence-based and research-informed practices that should be implemented and/or expanded within communities to fill specific gaps in the service array or complement existing initiatives**. Just as children and families require individualized plans of care, local communities need to craft the service array that will be most effective for their families and children. DHR will guide each county in their selection of services, focusing their choice of intervention based on targeted population data, how the intervention(s) fits with their local values and culture, how they differ from their traditional approaches, and the proposed impact on the population of focus. DHR expects that there will be regional approaches to development and implementation of interventions.

All of the EBPs listed below are included in either or both of the following sources:
(1) the California Evidence-Based Clearinghouse for Child Welfare (CEBC) [xvi] with an evidence rating of 1-3 and child welfare relevance of medium or high; and,
(2) The Washington State Institute for Public Policy's (WSIPP) *Inventory of Intervention Services for Children and Juveniles in Child Welfare, Juvenile Justice, and Mental Health Systems*, [xvii] with a classification of evidence-based, research-based, or promising practice.

A common component within these interventions is their frequent utilization of Motivational Interviewing (MI), which is itself an evidence-based practice according to CEBC. The evidence-based and research-informed practices identified below were developed using the criteria mentioned above and then matching it to the current strengths and needs of Maryland's service delivery system.

As discussed above, Maryland uses the CANS as an assessment and care planning tool. The CANS will be a critical factor in determining the appropriate services for children served through the

Demonstration to ensure that risk and protective factors are appropriately matched to the interventions available within communities.

Interventions for Children 0-8 Years Old

One of the primary goals in serving this population is to avoid out-of-home placement and divert children from the foster care system when safe and appropriate to do so. For those children who need to come into out-of-home care, the focus is to return the children to their families as soon as safely possible in order to preserve family connections, reduce the traumatic experience associated with coming into care, and provide extended family services post-reunification. Services provided to these children and their families should be community-based and not solely provided through the LDSS. Linkages and connections need to be made to services across the community and families should be able to access services and supports. Services should be individualized, focused, and intensive, and care management should be front-loaded so that reunification can occur more rapidly.

The evidence-based and research-informed practices that have been identified for consideration as appropriate interventions for children ages 0-8 and their families are:

- Family Connections/Trauma-Adapted Family Connections
- Homebuilders
- Parent Child Interaction Therapy (PCIT)
- Parent Management Training, Oregon Model (PMTO)
- SafeCare

Family Connections/Trauma-Adapted Family Connections. Family Connections is a multi-faceted, community-based program that works with families experiencing difficulty in meeting the basic needs of their children and at-risk for child emotional and/or physical neglect. Family Connections is appropriate for families with children 0-17 and includes the provision of emergency assistance and concrete services, home-based family intervention, service coordination with referrals targeted toward risk and protective factors, and multi-family supportive recreational activities. The CEBC has determined that Family Connections has promising research evidence (rating it a 3) [2] with high relevance to child welfare. [3] Family Connections has been augmented over the years to meet the needs of specific populations such as Grandparent Family Connections and Trauma Adapted Family Connections (TA-FC). TA-FC has demonstrated results indicating positive outcomes from working with families who have experienced trauma, especially complex developmental trauma. The National Child Traumatic Stress Network has identified TA-FC as an empirically supported treatment and promising practice. Family Connections is currently supported to provide services in West Baltimore City in part through grants from DHR, the Title IV-E Education for Public Child Welfare Program, the Administration on Children, Youth and Families, and the Helena Foundation.

Homebuilders. Homebuilders is an intensive family preservation program intended to keep children from being placed out-of-home. Homebuilders works with the caregivers to provide in-home crisis intervention, counseling, and life skills education over a short-term period. CEBC has rated Homebuilders as having high child welfare relevance and gave it a rating of 2 for being

[2] The CEBC has a scale of 1-5 for the scientific rating of programs. A lower score indicates a greater level of research support. See http://www.cebc4cw.org/ratings/scientific-rating-scale/ for additional detail.
[3] The CEBC has 3 levels of relevance to the child welfare system: high, medium and low.

supported by scientific evidence. WSIPP has rated Homebuilders as an evidence-based program that is 99% cost beneficial. In the past, Homebuilders has been provided in Baltimore and Prince George's Counties, but it is not known to be available currently.

Parent-Child Interaction Therapy (PCIT). PCIT is intended for children ages 2-6 years old and their caregivers. It is focused on improving child behavior and parent-child relationship problems. PCIT is characterized as a dyadic behavioral intervention designed to reduce externalizing child behavior programs while increasing social skills and cooperation. Caregivers are taught traditional play-therapy skills and coached by therapists as they practice them with their children. As a time-unlimited program, families are able to receive treatment until they demonstrate mastery of the skills. Treatment lengths vary, averaging 14 weeks with hour-long weekly session. PCIT is currently available in seven Maryland jurisdictions: Baltimore, Caroline, Carroll, Dorchester, Kent, Queen Anne's, and Talbot Counties. WSIPP has identified PCIT as an evidence-based intervention and states that it is 100% cost beneficial. CEBC has assigned a scientific rating of 1 to PCIT and identifies it as having medium relevance for the child welfare population.

Parent Management Training, Oregon Model (PMTO). PMTO is intended to reduce child behavior problems and promote healthy development, and has been rated as highly supported by scientific evidence (rating of 1) by the CEBC in the area of child and family well-being and is identified as having medium relevance to child welfare. PMTO consists of a set of parent training interventions intended to improve parenting practices and to decrease and prevent family coercion, youth conduct problems, substance abuse, internalizing and externalizing behaviors, and other issues among children. PMTO is delivered through both group and individual training sessions. PMTO is best utilized for families with children ages 4-12. PMTO is not known to be available in Maryland.

SafeCare. SafeCare is an in-home parenting model for parents with children ages 0-5 who are at-risk for or have a history of child abuse or neglect. SafeCare provides direct skill training with parents using four modules: health, home safety, parent-child/parent-infant interactions, and problem solving and communication. Each module has an assessment and five training sessions. The California Evidence-Based Clearinghouse for Child Welfare (CEBC) has rated SafeCare as having high relevance to the child welfare system and a scientific rating of 2, indicating that it is supported by research evidence. The Washington State Institute for Public Policy (WSIPP) has given SafeCare a rating of evidence-based under its suggested definitions[4] and has found it to be 100% cost beneficial. SafeCare Augmented, a modification of SafeCare that includes motivational interviewing and additional training of home visitors on the identification and response to imminent child maltreatment and risk factors, has been identified as meeting the Department of Health and Human Services' criteria for an evidence-based early childhood home visiting service delivery model under Home Visiting Evidence of Effectiveness (HomVEE), which makes it eligible for Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant funding.[xviii] SafeCare Home Visiting has been assigned a rating of 3 under the CEBC.

Interventions for Youth Ages 14-17

As with the younger children, one of the primary goals in serving this population is to intervene at the point of first contact with the child welfare system in order to avoid out-of-home placement and divert children from the foster care system when safe and appropriate to do so. For those children who need to come into out-of-home care, the preference is for a shorter length of stay in order to

[4] WSIPP has current definitions and suggested definitions. The suggested definitions are more comprehensive than the current definitions.

preserve family connections, reduce the traumatic experience associated with coming into care, and provide extended family services post-reunification. As with the services for the younger children, these interventions should be community-based and not solely provided through the LDSS. Linkages and connections need to be made to services across the community and families should be able to access services and supports. Services should be individualized, focused, and intensive, and care management should be front-loaded so that reunification can occur more rapidly.

The evidence-based and research-informed practices that have been identified for consideration for children ages 14-17 and their families are:

- Family Connections/Trauma-Adapted Family Connections
- Functional Family Therapy
- Homebuilders
- Multi-Systemic Therapy
- Parent Management Training, Oregon Model (PMTO)
- Trauma-Focused Cognitive Behavioral Therapy

Family Connections/Trauma-Adapted Family Connections; Homebuilders; and Parent Management Training, Oregon Model were described above and are not repeated here.

Functional Family Therapy (FFT). FFT is designed for 11-18 year olds with behavioral health problems including conduct problems and substance abuse problems. It is geared towards improving family relationships by teaching families how to promote the safety of their children, improve communication skills, and skills for solving family problems. FFT is provided in a variety of community-based settings and is a strengths-based model that focuses on risk and protective factors impacting the youth and his or her environment. FFT is delivered over a 3-4 month period. FFT has been rated by the CEBC as supported by scientific research (rating of 2) and having medium relevance to child welfare. FFT has been rated as a promising practice by WSIPP when provided to youth in the child welfare system. FFT is currently available in Maryland in multiple jurisdictions and is one of the services included under the proposed 1915(i) Home- and Community-Based Services State Plan Amendment for Children with Serious Behavioral Health Needs. Maryland also has an intermediate purveyor of FFT to support implementation and ongoing fidelity monitoring of FFT.

Multi-Systemic Therapy (MST). MST is an intensive program that uses an environmental systems approach to work closely with youth with involvement in the juvenile justice system. MST works with 12-17 year olds and with the parents and caregivers. MST for Child Abuse and Neglect (MST-CAN) is an adaptation of MST that was developed to treat families who have been referred to child protective services for physical abuse or neglect to support the family to keep the children in the home with increased safety. The focus is on the whole family with particular attention paid to the parents and the likelihood that the parents may have experienced trauma. Treatment is typically 6-9 months for MST-CAN. WSIPP has rated MST-CAN as being a research-based intervention; MST for juvenile justice is rated by WSIPP as an evidence-based practice that is 98% cost beneficial. CEBC rated MST-CAN as being highly relevant to child welfare and being supported by research evidence (rating of 2). MST is currently available in Maryland in multiple jurisdictions, and Maryland is home to an MST Network Partner that assists with dissemination and implementation of MST. MST-CAN is not yet available in Maryland.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is a clinical intervention that includes psychoeducation about child trauma and trauma reminders; parenting components; relaxation, affective modulation, and cognitive coping skills tailored to the youth, family and

culture; in vivo mastery of trauma reminders; and conjoint youth-parent sessions. TF-CBT works to enhance safety and the future developmental trajectory of the youth. The National Child Traumatic Stress Network includes TF-CBT in its list of empirically supported treatments and promising practices, and WSIPP has identified it as an evidence-based practice. CEBC rates TF-CBT as being well-supported by research evidence (rating of 1) and as having high relevance to child welfare. Several cohorts of clinicians in Maryland have been trained in TF-CBT, although the number of certified clinicians and the number of practicing clinicians is unknown.

Connections to Expanded Service Array

EBPs and promising practices do not comprise the total universe of services and supports that are necessary to effectively support these families and children. Among the services that are currently available to some degree in Maryland but are not at-scale nor universally available to all Maryland residents are:

- Common Elements/Managing and Adapting Practice (MAP)
- Intensive care coordination using a Wraparound service delivery model
- Mobile Crisis and Stabilization Services
- Peer Support
- Respite Care (in-home and out-of-home)

Additionally, there are early childhood interventions and practice models that are increasingly available throughout the state but may not be accessible by all children depending on whether they are enrolled in formal child care and the nature of the program. These interventions and practice models include Early Childhood Mental Health Consultation and the Social and Emotional Foundations of Early Learning.

6. Time period

The time period for the proposed Title IV-E Waiver Demonstration will be no later than October 1, 2015 through September 30, 2019, although the actual implementation date will be determined. The Demonstration will run for the full five years permitted under the Statute.

7. Specific Outcomes

Maryland will implement a responsive, evidence- and trauma-informed system that uses standardized screening assessments to identify strengths and areas of need. This will ensure that families, children and youth involved in the child welfare system have greater access to an individualized array of evidence-based interventions and voluntary supports tailored to their strengths and needs so that they are more likely to experience greater safety, permanence, and well-being, thereby decreasing the number of children in congregate care, maintaining more children in their communities, reducing the number of out-of-home placements, reducing lengths of stay in out-of-home care, and increasing reunification throughout the State.

Specifically, the Demonstration will enable Maryland to better ensure that children ages 0-8 and their families receive comprehensive screening and assessment for strengths and areas of need, are afforded access to voluntary supports and have greater availability of auxiliary evidence-based practices focused on parenting and well-being (when needed). This will improve the likelihood that families will improve parenting skills and practices, reduce internalizing and externalizing behaviors, increase social skills, promote healthy development, and decrease family coercion. These factors, in turn, are expected to improve the chance that the family will remain intact and

have greater capacity to care for their children in their homes. The risk for child maltreatment will be mitigated and children will achieve safety, permanency, and well-being in their homes, thereby preventing out-of-home placement. If out-of-home placement is necessary, these services and supports will help to ensure that their length of stay is for 90 days or less.

Maryland will also use this Demonstration to better ensure youth of transition-age (14-17 years old) receive comprehensive screening and assessment, greater access to services and supports related to education, employment, housing, health and behavioral health, and supportive permanent connections, as well as access to evidence-based programs to address the symptoms and behaviors of youth with behavioral health needs so that the youth will be more likely to reduce conduct problems, reduce substance abuse problems, improve family communication and relationships, increase problem-solving skills, increase developmentally appropriate, pro-social behavior, and neutralize the impact of trauma. As a result, these youth will be more likely to experience reunification, adoption or guardianship as a placement discharge reason and more likely to be in school or working, connected to a permanent support, and stably housed. Ultimately, these outcomes will lead to decreases in out-of-home placement, re-entries, and reductions in lengths of stay in out-of-home placement settings.

Specific outcomes expected to be impacted by the Demonstration include:

- Increased youth/family functioning
- Decreased entries into foster care (new and re-entries)
- Reduced lengths of stay
- Improved social and emotional functioning
- Improved educational achievement
- Increased exits to permanence
- Decreased reports of maltreatment

By ensuring the consistent and universal application of the CANS tool to assess safety and well-being, case managers will be able to readily detect intervention areas across key domains, including life domain functioning, child strengths, caregiver strengths and needs, child behavioral/emotional needs, child risk behaviors, and trauma history, thereby equipping case managers with the information necessary to make the appropriate referrals to evidence-based and research-informed interventions.

The increased availability of evidence-based and evidence-informed interventions afforded by the Demonstration will better ensure that case managers will have the capacity to meet elevated risk and needs areas identified in the assessment process among children and youth in the target population. With the appropriate interventions in place, acuity in those areas will be more likely to diminish, resulting in improvements in the aforementioned domains and decreases in instances of future child maltreatment.

Case managers will be able to take full advantage of Alternative Response as a mechanism for providing in-home services and will be able to augment their family case planning efforts with these evidence-based and evidence-informed practices. The more robust service array would strengthen the Alternative Response model, providing more options for caseworkers seeking to divert less serious cases of child maltreatment and improving the child welfare system's effectiveness in reducing risk and preventing further involvement with the child welfare system that may likely have occurred if such interventions were not available.

Intervention: Maryland will implement a responsive, evidence- and trauma-informed system that uses standardized screening and assessment tools to identify strengths and areas of need:

So That

Families with child welfare involvement are provided an opportunity to access voluntary, collaborative, and individualized services

So That

1) Children and youth can remain in their homes and avoid out-of-home placements

and

2) Children and youth in out-of-home care have shorter lengths of stay and do not re-enter out-of-home placement

So That

1) Children and youth have fewer trauma symptoms, improved social and emotional well-being, success in school, healthy development, and overall improved safety and permanency;

and

2) Families have improved parenting skills and practices, decreased family coercion, and improved well-being across the family unit

So That

1) Children are safe from future abuse and neglect

and

2) Children avoid out-of-home placement

and

3) Families are successful.

8. Evaluation Design

Independent Evaluator

Maryland will design and implement a strong evaluation to assist DHR, ACF, and other states to learn the extent to which the new interventions are successful in improving outcomes and addressing identified targets for change. DHR will enter into an intergovernmental agreement with the University of Maryland School of Social Work (UM SSW) to serve as an independent contractor to assess the effectiveness of the project. UM SSW has a long history of collaboration with DHR and conducting comprehensive and high quality program evaluations and research projects. The Dean of UM SSW, Richard Barth, PhD, MSW, is a national and international leader in child welfare, and the expertise found within UM SSW will ensure an evaluation of the highest caliber.

Research Design

Maryland's evaluation will assess the completion and impact of the specific aims of the Demonstration:

(1) Utilize trauma-informed screening and assessment tools for individualized, strengths-based, comprehensive service planning;

(2) Improve services to children and families to prevent placement and promote stability and permanency:
   a. Fully implement Alternative Response services, expanding and enhancing the availability of in-home services;
   b. Expand scope and duration of aftercare services following reunification, adoption, and guardianship;
   c. Increase availability of evidence-based and research-informed practices to improve family capacity, youth and family functioning, and youth permanency and well-being;

(3) Improve services to transition-age youth to promote well-being and independence:
   a. Fully implement Ready by 21 through expansion of services and supports available to older youth to support education, employment, supportive connections, and housing;
   b. Expand access to evidence-based and research-informed practices for transition age youth with behavioral health needs;

The target populations for the Demonstration include youth age 0 to 8 years old and youth who are 14-17 years old. Within these age groups, the planned activities target youth who are at-risk for placement, including re-entry into foster care, or experiencing reunification, guardianship or adoption following placement. [See earlier section of proposal that describes these samples].

The evaluation will access statewide administrative data as well as primary data collection, including data from providers, youth and families. For efforts planned for statewide implementation (e.g., Alternative Response, Ready By 21), the evaluation will follow a **longitudinal design**, where cohorts that were served prior to the treatment roll-out will be compared to cohorts who received these efforts.

For more targeted efforts that will vary by jurisdiction (e.g., selection and implementation of specific evidence-based or research-informed practices), the evaluation team will identify **appropriate comparison samples and use propensity score matching** to help account for any pre-treatment differences.

As all youth are assessed with the CANS, these assessment measures will be available in addition to individualized measures that correspond to each intervention effort. The evaluation team will also track administrative data indicators, including length of stay, decreased placement and re-entry, increased placement stability, and increased family-style placements.

Maryland's evaluation will include three components: a process evaluation, an outcome evaluation, and a cost evaluation.

Process Evaluation

The process evaluation will follow a **mixed method design**, relying primarily on archival records and secondary data, supplemented with stakeholder (i.e., administrators, workers, family members, and youth) surveys and interviews to triangulate findings and increase depth of understanding. The process evaluation will describe the planning and implementation readiness across the state in order to understand the baseline service array and needs in jurisdictions as the Demonstration is implemented.

The process evaluation will also assess the extent to which the service delivery goals of expanding the availability of interventions to prevent placement and promote stability are being accomplished. In addition, all activities related to implementation fidelity and monitoring will be included in the process evaluation.

Specific questions to be answered by the process evaluation include:

(1) Who is being served by the Demonstration activities (e.g., Alternative Response, Aftercare services, evidence-based practices, transition-age youth services)?
(2) What services are delivered and what is their frequency/duration/dose?
(3) Are services being delivered with fidelity (as relevant)?
(4) Are children, youth and families receiving the services needed to promote safety, permanency and well-being?

Measures:

- Description of youth served: Demographics, CANS and other assessment scores, placement history, special needs;
- Description of EBP/research-informed practice: what was provided, dosage, fidelity, duration, and costs; and,
- Qualitative stakeholder feedback related to service provision and needs.

Outcome Evaluation

The outcome evaluation will monitor and measure the impact of the Demonstration activities on child, youth and family outcomes related to safety, permanency and well-being. For efforts that will be implemented statewide, including Alternative Response, expanded post-permanency services and Ready by 21, a longitudinal time-series research design will be used to assess differences since baseline. By monitoring key indicators such as rates of re-entry, placement stability, and lengths of stay at specific intervals throughout the project, the progress on outcomes can be tracked.

For individualized efforts implemented in specific jurisdictions, such as the selected evidence-based and research-informed treatments, **quasi-experimental designs** (comparing the intervention group or jurisdiction with a similar comparison group) will utilize propensity score matching (PSM) to account for baseline differences and allow causal estimation. *If it is logistically possible and ethically sound to randomly assign participants to evidence-based treatments in some jurisdictions where more than one treatment intervention is available, we will pursue this option for a stronger research design.*

In addition to outcome measures of service delivery (i.e., entry, placement, maltreatment investigations), Maryland child welfare workers routinely collect data using several standardized instruments, including the Child and Adolescent Needs and Strengths (CANS), SAFE-C safety assessment, and independent living skills assessments. These outcome measures will be included in the analysis to assess changes over time. Each specific evidence-based intervention that is implemented through the Demonstration will also have standardized assessment tools that correspond to the goals of the intervention. These assessments will be completed minimally at baseline and completion. When appropriate, comparison youth will also complete the assessments.

The outcome evaluation will answer the following specific questions:

(1) How have maltreatment, placement and re-entry rates changed over time?
(2) How have CANS, SAFE-C and other risk assessments changed over time?
(3) How have specific evidence-based practices improved family functioning, youth safety, permanency and well-being (compared to youth in counties where these interventions are

not yet available and/or comparing groups of youth who received different evidence-based practices)?

Measures to be included in the outcome evaluation—to be stratified by age group in reporting:

- Rates of reunification, adoption or guardianship for youth;
- Rates of re-entry into foster care;
- Rates of alternative response compared to investigative response;
- Rates of residential treatment/group care placement among youth in care;
- Rates of high school graduation by age 19 for transition age youth;
- Rates of post-high school education involvement for transition age youth;
- Rates of full-time employment for transition age youth not enrolled in school;
- Rates of negative police contact/legal involvement for transition-aged youth;
- Presence of supportive permanent connection;
- Rates of housing stability within first year after leaving care (youth over 18);
- Increased youth functioning on specified outcome target (e.g., depression, delinquency, independent living skills) at program completion and 6 months later;
- Family/Youth satisfaction with EBP program; and,
- Rates of placement stability within subsequent 6 and 12 months;

Cost Evaluation

The cost evaluation will be conducted in conjunction with the process and outcomes evaluations outlined above as well as with the cost neutrality monitoring described below. The youth included in the samples described above will be utilized as the sample for the cost evaluation. The cost evaluation will seek to assess the total cost of care for the youth in both the treatment and comparison groups.

The funding sources that the evaluation team will seek to analyze include, but are not limited to:

- Title IV-B funds (Source: DHR)
- Title IV-E funds (Source: DHR)
- Discretionary & Formula Grant Funds (Source: DHR)
    - Chafee Funds
    - CAPTA Funds
    - Other
- Title XIX funds (Source: Department of Health and Mental Hygiene[5])
    - Capitated Rate for Managed Care (Somatic, Dental, Pharmacy & Primary Behavioral Health)
    - Non-Capitated Somatic, Dental, Pharmacy, and Behavioral Health Costs
    - Specialty Behavioral Health Service Costs, including psychopharmacology costs
- State General Funds
    - DHR: Child Welfare Services (non-federal funds)
    - DJS: Services for youth who are co-committed or have DJS involvement
    - Children's Cabinet Interagency Fund: Services through Care Management Entities (non-federal funds)
- SAMHSA System of Care Grant Funds (Source: DHMH)

[5] DHR/UM SSW will need to, with the permission of the Department of Health and Mental Hygiene, contract with The Hilltop Institute at the University of Maryland Baltimore County in order to access the Medicaid and MCHP data on these youth.

As other funding streams are available, including block grants from SAMHSA, these funds may be included as well. The cost evaluation will also assess statewide efforts such as Alternative Response where there are not treatment or comparison groups. Any historic comparisons would consider the factors of inflation and changing costs over time.

Cost Analysis & Cost Neutrality

9. Estimate of Costs or Savings of the Project & Description of Basis of Cost Neutrality

As detailed in Section 10, receipt of a capped allocation will, by definition, be cost neutral to the federal government. Maryland assures that any funds currently being utilized for child welfare purposes within the budget of Maryland DHR will continue to be utilized for such purposes (i.e. any savings resulting from the demonstration will be used to further the provision of child welfare services). While the specific amount of savings is yet to be determined, savings are expected to be minimal during the initial demonstration period and to gradually increase during implementation of the project.

10. Method of Measuring & Ensuring Federal Cost-Neutrality

Maryland proposes that capped allocation for Title IV-E foster care funds over the course of the demonstration be based on the funds that Maryland would have received in the absence of the waiver. Receipt of a capped allocation will, by definition, be cost neutral to the federal government.

Maryland proposes that the capped allocation include foster care maintenance payments and foster care administration, excluding funding for the State Automated Child Welfare Information System (SACWIS) and Title IV-E foster care training. Maryland further proposes that the capped allocation include only foster care funds and exclude funding for Title IV-E Adoption Assistance and Guardianship Assistance Payments.

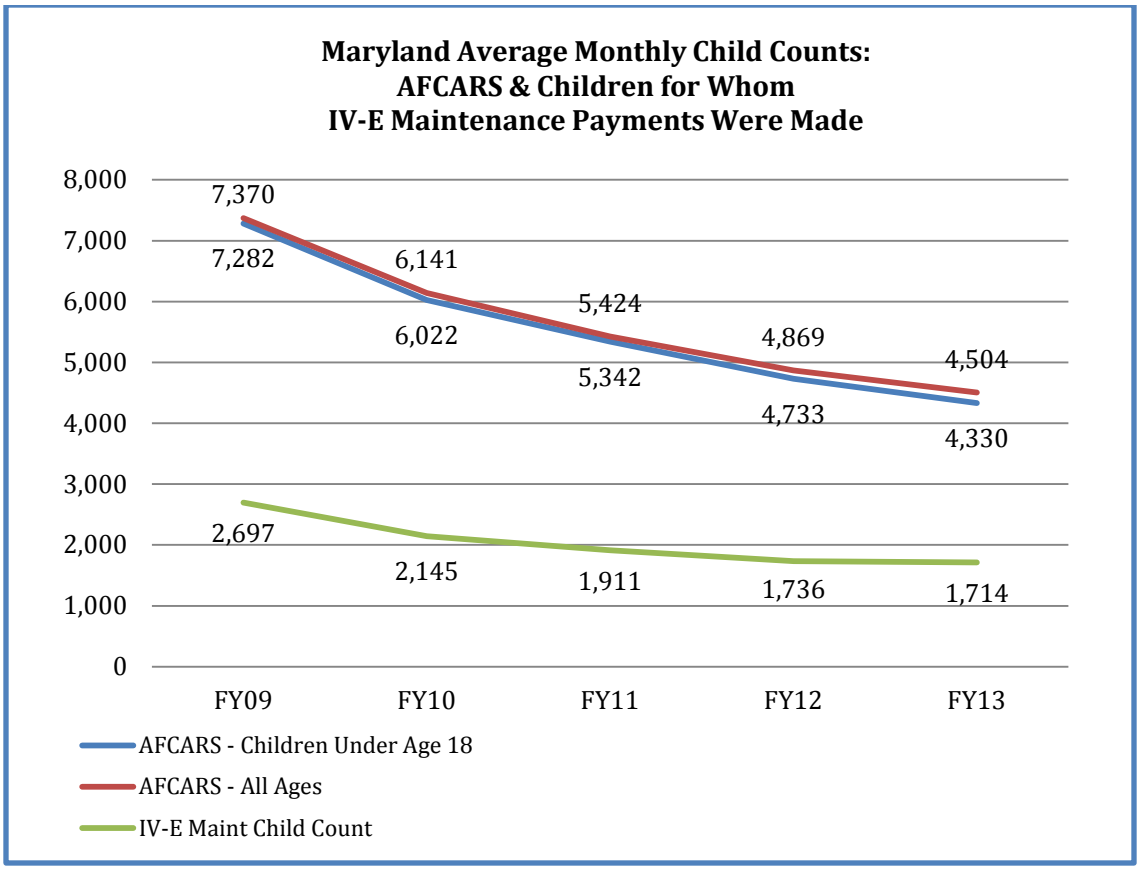


Figure 10: Average Monthly Child Counts

Maryland has experienced a significant reduction in the number of children in foster care in recent years, but this trend is stabilizing. It is expected that foster care maintenance expenses will reflect this trend in the coming years and show relatively flat growth. The figure above shows the trends for the past five years. While the number of children in out-of-home care is reducing, the trend for children for whom IV-E payments were made has stabilized.

Maryland currently has a relatively high maintenance cost per eligible IV-E child in foster care due to the previous success in diverting children who could remain in-home. As the number of children in out-of-home care has decreased, the maintenance payment per child has increased. In the absence of a waiver, this high cost of care per child would be expected to continue.

The following figures show the Title IV-E maintenance per child. Figure 11 shows the maintenance payments as reported on the Quarterly Financial Reports (Form CB-496). This trend is affected by variations in prior quarter adjustments.

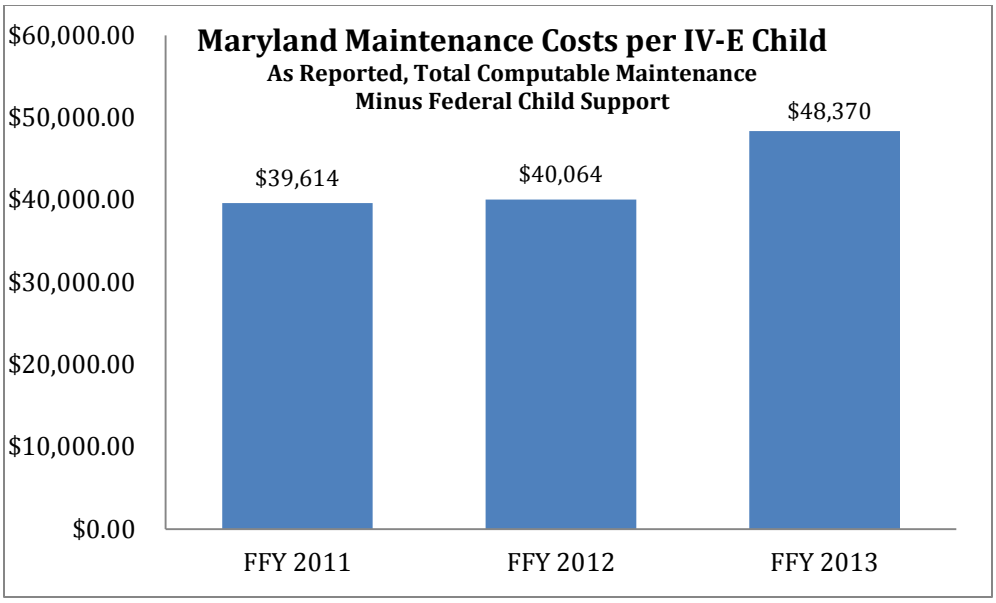


Figure 11: Maryland Maintenance per IV-E Child

Figure 12 shows the maintenance payments per child using only the current quarter payment amounts.

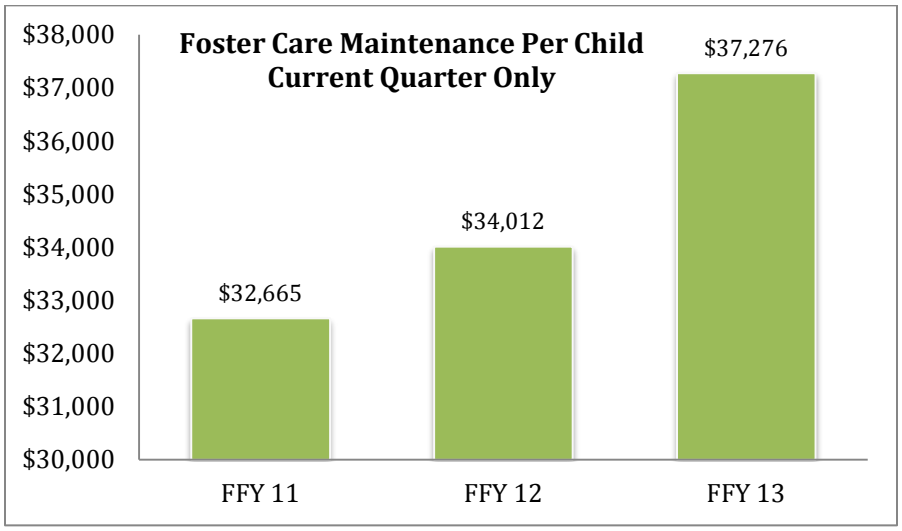


Figure 12: Foster Care Maintenance per Child, Current Quarter

Due to the increasing trend in maintenance payments per child, Maryland proposes to establish a base maintenance amount for the capped allocation that recognizes the most recently completed federal fiscal year as a starting point and provides an annual growth factor that recognizes the trend in recent years.

For IV-E Foster Care Administration, Maryland proposes establishing a base for the capped allocation using the average of five federal fiscal years to balance out fluctuations in prior quarter adjustments. Because of factors such as expected salary increases and staffing needs, IV-E foster care administration is expected to increase over the coming years. Maryland proposes to establish an annual growth factor that recognizes currently known factors that will increase IV-E

administration. In addition, Maryland proposes to establish contingencies and triggers for future adjustments to the capped allocation for factors where the future amount is not currently known. The following graph shows the trend in the past five federal fiscal years of Title IV-E maintenance and administration. This is followed by a table showing the amounts reported on the Quarterly IV-E Financial Reports.

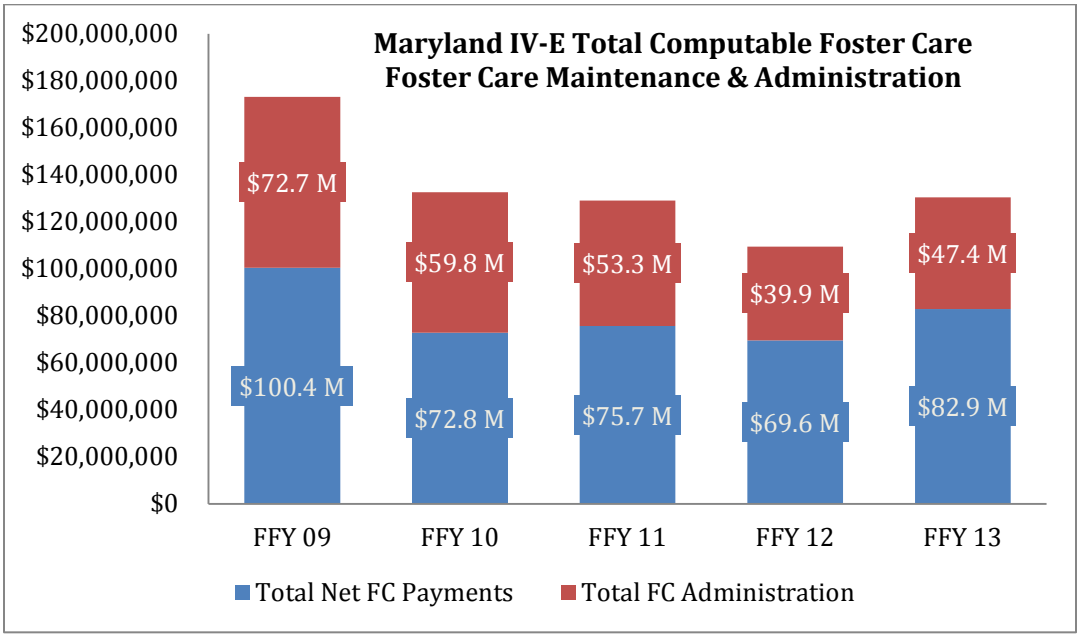


Figure 13: Maryland IV-E Total Computable Foster Care Maintenance & Administration

Total Computable (State and Federal) Foster Care Claims Maintenance and Administration					
FFY	Total Maintenance Payments	Federal Child Support	Total Net FC Payments	Total FC Administration	Net Maintenance and Administration
FFY 09	$101,157,631	$739,800	$100,417,831	$72,719,986	$173,137,817
FFY 10	$73,525,514	$723,504	$72,802,010	$59,798,924	$132,600,934
FFY 11	$76,099,579	$397,782	$75,701,797	$53,288,198	$128,989,995
FFY 12	$69,897,443	$347,155	$69,550,288	$39,932,108	$109,482,396
FFY 13	$83,335,152	$417,054	$82,918,098	$47,436,819	$130,354,917

Table 3: Total Computable Foster Care Claims

Based on the current and expected trends and growth factors, Maryland proposes to consult with the Children's Bureau and establish base amounts for Title IV-E Maintenance Payments and IV-E Administration that incorporate the factors referenced above and which represent what the State would have received in the absence of the demonstration waiver.

11. Description of Related Projects

As mentioned previously, the activities proposed in Maryland's Title IV-E Demonstration will build on and sustain the progress made under **Place Matters**, **Ready by 21, Youth Matter,** and **Alternative Response, and leverage the work of the Children's Cabinet in expanding the availability of home- and community-based services and evidence-based practices in Maryland**. The Demonstration will also harmonize with Maryland's ongoing system enhancement initiatives and will closely coordinate with Maryland's System of Care expansion efforts by interfacing with many existing, similar projects serving the child welfare population. Through synergetic collaboration, the Demonstration will inform and improve the service array available to youth in child welfare targeted by these initiatives, ultimately improving outcomes. The following are major, related initiatives that will be complementary to the Demonstration; none of the initiatives described below will require approval of waivers in another program in order to ensure coordinated activities.

Title XIX-Related Initiatives

1915(i) Home and Community-based Services State Plan Amendments: The Department of Health and Mental Hygiene (DHMH) currently is in the process of submitting a Title XIX (Medicaid) §1915(i) Home-and Community-Based Services (HCBS) State Plan Amendment (SPA) for children and youth with serious behavioral health problems. This SPA builds upon the successes and lessons learned of Maryland's Centers for Medicare & Medicaid Services-funded 1915(c) Psychiatric Residential Treatment Facilities (PRTF) Demonstration Program (2007-2012). Participants will have access to the full range of Medicaid somatic and behavioral health services. In addition, youth and families enrolled in the SPA will receive intensive care coordination using a Wraparound practice model.

The 1915(i) HCBS benefit will be available to those youth who are under age 18 at the time of application and who meet the medical necessity criteria, as well as being Medicaid-eligible. Those youth who are in the care and custody of the local department of social services will be able to apply to be served under the 1915(i) HCBS benefit. The Title IV-E Waiver Demonstration provides a vehicle for strengthening cross-system partnerships between LDSS and Maryland's local mental health authorities as they build that capacity, particularly as it relates to intensive in-home services, and the potential expanded availability of Functional Family Therapy as Maryland's first child- and adolescent EBP eligible for Medicaid reimbursement. The 1915(i) HCBS Benefit is expected to be open for enrollment by the start of Federal Fiscal Year 2015.

DHMH is also in the initial planning stages for a 1915(i) SPA for children ages 0-6. Although still in the early stages of development, this SPA would have the potential to expand resources for young children and their families, reducing the burden on the child welfare system and preventing out-of-home placements.

Behavioral Health Integration. The State of Maryland is going through a behavioral health integration process, bringing the Mental Hygiene Administration and Alcohol and Drug Abuse Administration into a single administration. As part of the integration activities, Maryland will continue to maintain a behavioral health carve-out under its 1115 Waiver but will be moving its Administrative Service Organization (ASO) to a risk-based model over the next several years. The new ASO contract is expected to be implemented in January 2015, with a gradual phase-in of pay for performance technologies. The ASO will be able to utilize the resources under the Demonstration, and, with the use of various risk and assessment tools under the Demonstration and as part of the 1915(i) HCBS program, the ASO and the local departments of social services will be better positioned to triage children and families to appropriate services and supports and to

improve communication among the family, the local department, and the providers and partners involved with the child and family.

Other Federally-Supported Initiatives

Thrive@25*: Thrive@25* is Maryland's recently-awarded two-year planning grant from the Administration for Children and Families to prevent and end homelessness among youth involved with the child welfare system and with child welfare histories. *Thrive@25* will support the activities of the Title IV-E Waiver Demonstration by focusing on the risk and protective factors that need to be addressed to promote well-being and ensure that youth with foster care histories do not become homeless. The evaluation and needs assessment activities of *Thrive@25* will be shared with the evaluation team for the Demonstration, ensuring that the lessons learned from both *Thrive@25* and the Demonstration will be communicated to leverage experiences and better position Maryland to be awarded a Phase II implementation grant from ACF for ending youth homelessness.

Promise Heights. Promise Heights is an area in West Baltimore characterized by high poverty and crime, low levels of academic achievement, and a population with poor health. To leverage the local collaborations and partnerships that were implemented in Promise Heights, the University of Maryland was awarded both a 2012 U.S. Department of Education Promise Neighborhoods Planning Grant and a 2012 grant from the Children's Bureau to establish the Promise Heights Child Welfare Early Education System Transformation (C-WEST) initiative. C-WEST builds upon cross-agency and cross-community collaboration between early education and child welfare systems to better serve young children, ages 0-5, who are at-risk for involvement in child welfare. The findings from C-WEST will inform the implementation of the Demonstration, and the Demonstration will enable the community to access a greater array of evidence-based promising practices that are trauma-informed and tailored to the specific needs of younger children.

Project LAUNCH. In FY2012, Maryland's Department of Health and Mental Hygiene received the Project LAUNCH (Linking Actions for Unmet Needs in Children Health) grant from SAMHSA to improve the health and well-being among young children, ages 0 to 8 in Prince George's County, Maryland. The activities in Prince George's County, including implementation of Strengthening Families (an evidence-informed intervention) and expansion of Early Childhood Mental Health Consultation (ECMH-C), will position the jurisdiction to take full advantage of the opportunities presented from the Demonstration. Likewise, the Demonstration can leverage the initial implementation and expansion activities that have already occurred to enhance access to evidence-based and evidence-informed interventions.

Race to the Top Early Learning Challenge Grant. In FY2012, the Maryland State Department of Education (MSDE) received a Race to the Top Early Learning Challenge Grant from the U.S. Department of Education. This grant is supporting an interagency agenda with ten priority projects to create a seamless birth to grade 12 reform agenda to ensure that all young children and their families are supported in the state's efforts to overcome school readiness gaps and create an even better early childhood education system. DHR is a partner with MSDE on the implementation of this grant, which includes support for Maryland's Early Childhood Mental Health Consultation Program (noted above) and its implementation of the Social and Emotional Foundations for Early Learning (SEFEL).

System of Care Grants & Wraparound Implementation: MD CARES, Rural CARES, Co-Occurring Planning Grant, and LIFT: Maryland has three current SAMHSA-funded system of care grants: MD CARES (Maryland Crisis and At-Risk for Escalation diversion Services for children), Rural CARES

(Coordination, Advocacy, Resources, Education and Support), and a System of Care expansion grant, known as LIFT (Launching Individual Futures Together). Both MD CARES and Rural CARES seek to improve behavioral health outcomes for children, youth, and families served by, or at risk of entering, the foster care system at the congregate level of care. Additionally, these System of Care grants have served youth with intensive behavioral health problems in family homes, kinship homes, family foster homes and treatment foster homes instead of in congregate care settings. Youth enrolled in MD CARES and Rural CARES have been served by the Care Management Entity (CME) that is contracted by the Governor's Office for Children on behalf of the Maryland Children's Cabinet. The CME has served additional populations of youth over the past several years, including those enrolled in the PRTF Demonstration Waiver and multiple state-funded populations. The Children's Cabinet designated a number of slots in the CME for youth with DHR involvement, and those slots have been transitioned into a Stability Initiative for youth with both child welfare and/or juvenile justice involvement in or at-risk of congregate care.

One of the activities under LIFT is to redesign the Title XIX Targeted Case Management (TCM) for youth up to age 18. In the redesign, the first two levels of TCM will be similar to the current general and intense levels of TCM and the third level will align with the medical necessity criteria for 1915(i) SPA. Upon rollout of the 1915(i) SPA for children with serious behavioral health needs and the redesign of TCM, Medicaid-eligible youth who historically have been served through slots available in the Children's Cabinet CME contract will be able to access service delivery using the Wraparound practice model through the State's Medicaid system, which will free up the limited number of state-funded slots for youth and families who are not eligible for public behavioral health system services. Redesign of TCM will provide a continuum of care that will allow for Medicaid-eligible youth who no longer meet the medical necessity criteria for the 1915(i) to continue to be served using the Wraparound practice model at a lower intensity level through TCM.

Technical Assistance Resources

DHR is fortunate to be located in close proximity to and have strong relationships with a number of nationally-recognized and federally-funded resources. Among them are:

- The **Technical Assistance Network for Children's Behavioral Health (TA Network)**, SAMHSA's newly-funded national technical assistance center for Children's Mental Health Initiative (CMHI) Program grantees (aka System of Care grantees), housed at The Institute for Innovation and Implementation at the University of Maryland School of Social Work, which is a partnership among The Institute and 10 partner universities and organizations;
- The first **National Center on Evidence-Based Practice in Child Welfare**, funded by the Administration for Children and Families and based at the University of Maryland School of Social Work's Ruth H. Young Center for Families and Children;
- The **National Child Welfare Workforce Institute**, based at the University of Maryland School of Social Work;
- The Institute for Innovation & Implementation, University of Maryland School of Social Work, which serves as the **Children's Cabinet's Center of Excellence on Systems of Car**e, including its evidence-based practice center; and,
- The **Family-Informed Trauma Treatment Center (FITT Center)**, a grantee of the National Child Traumatic Stress Network (NCTSN).

Financial Accountability

12. Accounting of any Federal, State, tribal, local and private investments made during the past two fiscal years to provide the service interventions

The Accounting of Investments Template for federal fiscal years 2012 and 2013 (please see Appendix 1) provides a detail of all investments made by Maryland DHR for the provision of child welfare services included in the scope of this application.

As noted in section 11, Maryland has undertaken several initiatives that are complementary to the demonstration project. These are:

- Thrive@25 – Grant period 9/30/13-9/29/15; Total estimated award: $715,845
- 1915(i) Home and Community-based Services State Plan Amendment –Estimated number of children served in FFY 15: 100; Total estimated cost of care (federal and state): $5 million
- Promise Neighborhood (Current no-cost extension through 12/31/14)
- C-WEST-Final Grant Period 10/1/13-9/30/14: $243,402
- Project LAUNCH – FFY14 Award: $838,778 (FFY17 is the final year)
- System of Care Grants and Wraparound Implementation –
    - MD CARES –FFY14 Award: $979,017 (in final year)
    - Rural CARES – FFY14 Award: $1,499,664 (FFY15 will be the final year)
    - LIFT—FFY14 Award: $997,547 (FFY16 will be the final year)
    - Stability Initiative (Care Management Entity, Funded through Children's Cabinet Interagency Fund): $5,008,335 (State General Funds for SFY 14)

Note that while the above initiatives serve children who are also served by Maryland DHR, the related funding is not included in the Accounting of Investments Template as the funding is not within the jurisdiction of Maryland DHR.

13. Assurance of Continued Accounting of the Same Spending for Each Year of the Approved Demonstration

Maryland assures that it will continue to spend and provide an accounting of such spending on child welfare services for each year of the approved demonstration.

Impact of the Demonstration on the Agency

14. Statutory and Regulatory Requirements under Titles IV-B or IV-E Requiring Waivers

Waivers of the following provisions of the Social Security Act and Program Regulations as outlined in the terms and conditions for the proposed demonstration project include the following:

1) Section 472 (a): Expanded Eligibility: To allow the State to expend title IV-E funds for children and families who are not normally eligible under Part E of title IV of the Act as described in the Terms and Conditions.
2) Section 474(a)(1) Expanded Claiming: To allow the State to claim at the Federal medical assistance percentage any allowable expenditures of foster care maintenance payment cost savings.

3) Section 474(a) (3) (E) and 45 CFR 1356.60(c) (3): Expanded Services: To allow the State to make payments for services that will be provided that are not normally covered under Part E of title IV of the Act; and to allow the State to use title IV-E funds for these costs and services as described in the demonstration application.

The State requests that the Children's Bureau provide assistance in identifying any additional statutory or regulatory provisions that may need to be waived.

15. Description of how the Demonstration will affect SACWIS

MD CHESSIE is the state automated child welfare information system used by DHR. All case information on families and children served is recorded in MD CHESSIE. Information for cases of children and families served under the demonstration project will be recorded in MD CHESSIE. DHR will work with the selected evaluator to determine if any additional data fields are needed to capture information for the purposes of the evaluation and make those necessary enhancements.

16. Description of IV-E Agency's Capacity

As discussed throughout, since 2007, Maryland has been working steadfastly to improve its child welfare system. Numerous policies and procedures have been promulgated to ensure consistent application of reforms, and DHR will ensure that all necessary policies and procedures are developed to implement this Demonstration. DHR continues to seek the input of stakeholders (described below) and will ensure that implementation is conducted in partnership with the local jurisdictions. Maryland has recently rolled out both Youth Matter and Alternative Response and has achieved success in its use of a cohort method of implementation, working with a small number of jurisdictions at a time to ensure that the necessary resources are made available to support transitions, training, and technical assistance needs. As illustrated above, there are numerous related projects currently underway that speak to DHR's ability to partner with other agencies, local departments, providers, universities, and other stakeholders. DHR has committed external partners in this work, as seen through the letters of support (see below). Staff within the Social Services Administration and DHR's budget office are prepared to ensure that any changes that are needed within the operations of the Department are made to ensure smooth implementation.

17. Steps Taken to Assurance County, Local, Tribal, and/or Judicial Cooperation

DHR has reached out to its partners to ensure support and cooperation in the implementation of the Demonstration. Letters of support are included in the appendix from:

- The Governor of Maryland
- The Lieutenant Governor of Maryland
- The Governor's Office for Children on behalf of the Children's Cabinet
- The Department of Budget and Management
- The Department of Health and Mental Hygiene
- The Department of Juvenile Services
- Casey Family Programs
- The Foster Care Court Improvement Project
- The Provider Advisory Council
- The Maryland Association of Social Services Directors
- The Maryland Association of Local Management Boards

18. Child and Family Service Review and implementation of the Program Improvement Plan

Maryland has completed its PIP and successfully met the benchmark for 10 of the 10 items for improvement. The Demonstration will further support the improvement in the following CFSR areas:

- **Item 3** – Services to families to prevent foster care entry/re-entry
- **Item 17** – Needs and services of child, parents, and foster parents (In-Home/ OOH)

In the second round of the CFSR, the case review information identified that the needs of the child, parents, and foster parents were not always assessed, services were not always provided, and that the services that were provided to prevent children from foster care entry/re-entry did not always address the key safety concerns or underlying issues. There were also instances where services were not provided post-reunification or not to the entire family unit. The focus on Alternative Response and the use of the CANS and other risk and assessment tools will enable DHR to collaborate with families and get to the underlying issues, including intergenerational trauma, and identify and provide appropriate services and supports to meet those needs. The focus on the family unit as a whole through this collaboration will also ensure that families receive more comprehensive services and supports necessary to prevent entry/re-entry into foster care.

19. Court Order

The Baltimore City Department of Social Services, one of DHR's 24 local departments of Social services, operates under a Modified Consent Decree as a result of the case known as L.J. v Massinga, now known as L.J. v Dallas. The original consent decree was ordered in 1988 and modified in 2009. The modified decree provides for specific benchmarks for agency performance on well-being measures for children in foster care including placement, education, health care and workforce standards. The expanded services made available through the Title IV-E waiver will aide in the City's efforts to meet the specified benchmarks in the decree.

20. Partnerships & Public Input

As demonstrated from the description of the many initiatives already underway in Maryland, DHR and its partners have been positioning itself for the development and implementation of this Demonstration. For several years, DHR has convened a Provider Advisory Council (PAC), which includes representatives from DHR and from multiple providers that serve children and families in child welfare. Additionally, SSA regularly convenes a Children and Family Services Review Advisory Board, which includes state and local child- and family-serving agencies, providers, universities, and advocates. During fall 2012, the Advisory Board explored the challenges and opportunities that exist to better serve the population of youth ages 0-5 and their families, as well as continuing to discuss implementation of Ready by 21.

In August 2013, SSA convened a Title IV-E Waiver Demonstration workgroup that included representatives from different divisions of DHR and several of the local departments of social services to begin the work to develop a Demonstration proposal. Subsequently, DHR convened a joint meeting of the PAC, Advisory Board, and workgroup in October 2013. This meeting presented an opportunity to review the Title IV-E Waiver application and implementation requirements and to solicit feedback from stakeholders. After an overview presentation, the invitees were asked to discuss and respond to three items:

1. Keys for successfully implementing a child welfare system that focuses on child well-being
2. Interventions the State should consider for out-of-home placement prevention

3. Interventions the State should consider for post-permanency services.

Results of the discussion indicated strong support for applying for the IV-E Waiver as a vehicle for increasing permanency, increasing positive outcomes, and preventing re-entry among infants, children, and youth involved in Maryland's child welfare system. Participants identified that collaboration and the sharing of information and data, robust local systems of care that are resourced adequately, individualized services and supports, shared responsibility among child-serving agencies, non-traditional services for families, and a shared definition of well-being are key elements for implementing a child welfare system focused on child well-being. In addition, they indicated that prevention efforts should involve EBPs that are family-focused and targeted to their needs, a community empowerment model that leverages professionals and their services, trauma-informed approaches espoused by all child-serving systems, and strong local partnerships with pathways for information sharing. Notes from the meeting, including a roster of those in attendance, are included in the appendix.

Subsequent to that meeting, SSA leadership met with the directors of the local departments of social services to provide them with a similar overview and opportunity to provide input, and then reconvened the workgroup to analyze data and make recommendations. DHR committed to sharing the design of the Demonstration with the participants of the joint meeting.

Additional Requirements

21. Health Insurance for all Special Needs Children

The State assures that DHR provides health insurance coverage for all special needs children for whom DHR has entered into an adoption assistance agreement, including those not supported by Title IV-E funds.

22. Child Welfare Program Improvement Policies

As highlighted in the introduction, Maryland has undertaken numerous system reforms since 2007 to improve the safety, permanency and well-being outcomes for children. These include the follow reforms that correspond to specific Child Welfare Program Improvement Policies as articulated in P.L. 112-34:

- *Child Welfare Program Improvement Policy #3: Title IV-E Guardianship Assistance Program:* Maryland has operated a Guardianship Assistance program since 1997. In 2008, Maryland received approval to access Title IV-E funding for eligible youth. Eligibility can be extended up to age 21 (same criteria as extension of adoption subsidy and foster care to age 21). (SSA #11-21).

- *Child Welfare Program Improvement Policy #5: Limiting Use of Congregate Care:* As detailed above, Maryland has reduced the percentage of youth in congregate care from 19% to 11% as a result of specific policy changes (SSA #10-11).

- *Child Welfare Program Improvement Policy #8: Preparing Youth in Transition.* Through Ready by 21, Maryland has instituted an array of policies to ensure that youth receive services to prepare them for independence, including:
  - Ready by 21 manual – Benchmarks, Transition Planning, Enhanced After Care;
  - Maryland Tuition Waiver (SSA #14-6);
  - Family and Friend Contact (SSA #12-20); and,
  - Family Unification Vouchers (SSA # 11-11).

- *Child Welfare Program Improvement Policy #10: Establishment of Specific Programs to Prevent Foster Care Entry or Provide Permanency:* The Family Centered Practice model (implemented in 2008) introduced a number of practices which include:
  - Family Involvement Meetings– involve family members and youth in key decision making points such as removal, placement changes and transition planning (SSA #10-08);
  - Family Finding – targeted efforts to identify meaningful connections for youth by reviewing prior records and identifying relatives; and,
  - Kinship Navigator Program – Kinship navigators are available in seven of Maryland's jurisdictions to provide information, referral and linkage services to kinship placements that are not supported by child welfare (children are not in the care and custody of LDSS). The central office provides assistance to jurisdictions that do not have an identified navigator.

As part of the Demonstration, Maryland intends to implement *Child Welfare Program Improvement Policy #2: Addressing Health and Mental Health Needs of Children in Foster Care.* Maryland plans to implement policies to support the development and implementation of a plan for meeting the health and mental health needs of infants, children and youth in foster care. The provision of appropriate health and mental health services are critical to our goal of building a service array to serve families and children before, during and after a foster care placement. Possible improvements include:

(1) Improved sharing of medical information among and between biological families, foster families, health care providers, DSS, and schools;
(2) Training of behavioral health care providers regarding the special concerns and needs of foster youth;
(3) Partnering with Department of Health and Mental Hygiene (DHMH) to better ensure access to behavioral health services for infants, children and youth, including:
    - Exploring mechanisms to include evidence-based practices as part of Maryland Medicaid State Plan to prevent children and youth from entering foster care;
    - Partnering with DHMH to ensure that children and youth in foster care considered a specialty group by the Administrative Service Organization in the administration of the behavioral health carve-out (1115 waiver), particularly as foster care lengths of stay continue to decline, in order to limit the amount of churn families experience with their Medicaid enrollment and preserve continuity of care; and,
    - Ensuring that all former foster youth continue to enroll in Medicaid up to age 26;
(4) The inclusion of trauma-informed assessments and services in treatment regimen.

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[i] Source: Maryland Department of Human Resources. 2014, January. 03 File - Trends data.
[ii] National Child Traumatic Stress Network (NCTSN). (n.d.). *Creating Trauma-Informed Systems.* Available from the NCTSN website: http://www.nctsnet.org/resources/topics/creating-trauma-informed-systems
[iii] Samuels, 2013
[iv] KIDS COUNT, 2013
[v] American Academy of Pediatrics, 2012; Pecora, 2010
[vi] Heneghan et al., 2013
[vii] Frey, Greenblat, & Brown, 2005
[viii] Unless otherwise indicated, data throughout this section come from: Maryland Department of Human Resources. 2013, November. Preliminary Analysis-Descriptive Details Concerning Children Entering Foster Care. Source: MD CHESSIE.

[ix] Maryland Department of Human Resources. 2013, November. FY2013 and FY2014/Q1 Entries, by Entry Month and Age. Source: MD CHESSIE/OOH Served Report.
[x] Data Advocacy, Casey Family Programs. 2013, March. Maryland: Older Youth in Out-of-Home Care. Data source: AFCARS.
[xi] Agosti, J., Conradi, L., Halladay Goldman, J., and Langan, H. (2013). Using Trauma-Informed Child Welfare Practice to Improve Placement Stability Breakthrough Series Collaborative: Promising Practices and Lessons Learned. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.
[xii] http://www.nctsnet.org/products/child-welfare-trauma-training-toolkit-2008
[xiii] National Child Traumatic Stress Network, Child Welfare Committee. (2011). *Birth parents with trauma histories and the child welfare system: A guide for resource parents.* Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.
[xiv] Loman & Siegal, 2004; Shusterman et al., 2005
[xv] Siegal & Loman, 2000; Loman & Siegal, 2004
[xvi] http://www.cebc4cw.org/
[xvii] http://www.wsipp.wa.gov/ReportFile/1374/Wsipp_Updated-Inventory-of-Evidence-Based-Research-Based-and-Promising-Practices_Inventory.pdf
[xviii] http://homvee.acf.hhs.gov/document.aspx?rid=1&sid=18

Appendices

Appendix 1: Accounting of Investments Template

Appendix 2: Letters of Support

Appendix 3: October 2013 Stakeholder Meeting Notes & Roster of Attendees

Appendix 1: Accounting of Investments Template

CHILD WELFARE DEMONSTRATION PROJECT - ACCOUNTING OF INVESTMENTS TEMPLATE
PRE-IMPLEMENTATION REPORTING PERIOD

STATE/TRIBE: Maryland **FEDERAL FISCAL YEAR:** 2012 **REPORT DATE:**

Program And/Or Category Name	IV-E Programs		IV-B (Subparts 1 and 2)		Medicaid Funding	SAMHSA Funding	Other Federal Formula Grant Funding (e.g., TANF, SSBG)	Other Federal Discretionary Grant Funding (e.g., grants from ACF, SAMHSA)	State/Local Funding (Not including amounts shown elsewhere as match)	Private Investment (e.g., foundation funding)	TOTAL COSTS
	Federal Share	Non-Federal Share	Federal Share	Non-Federal Share							
Section A. Traditional Title IV-E Program Costs											
Foster Care Maintenance Payments	30,227,990	30,227,990	1,153,062	384,354			2,638,470		161,373,221		$ 226,005,087
Foster Care In-Placement Administration	20,357,817	20,357,817	2,214,360	738,120	2,527,466	-	99,955,557	471,124	80,618,529		$ 227,240,790
Foster Care Candidate Administration											$ -
Foster Care Training	484,624	272,012					1,545,745		917,034		$ 3,219,415
SACWIS Operational Costs (exclude SACWIS development)	371,070	371,070					242,316		3,619,868		$ 4,604,324
Adoption Assistance Assistance Payments	23,047,380	23,047,380							24,438,199		$ 70,532,959
Adoption Assistance Administration	665,732	665,732									$ 1,331,465
Adoption Assistance Training											$ -
Guardianship Assistance Assistance Payments	331,043	331,043							11,951,858		$ 12,613,943
Guardianship Assistance Administration	67,424	67,424									$ 134,847
Guardianship Assistance Training											$ -

Program And/Or Category Name	IV-E Programs		IV-B (Subparts 1 and 2)		Medicaid Funding	SAMHSA Funding	Other Federal Formula Grant Funding (e.g., TANF, SSBG)	Other Federal Discretionary Grant Funding (e.g., grants from ACF, SAMHSA)	State/Local Funding (Not including amounts shown elsewhere as match)	Private Investment (e.g., foundation funding)	TOTAL COSTS
	Federal Share	Non-Federal Share	Federal Share	Non-Federal Share							
Section B. Service Interventions Designated for Funding under the Waiver Demonstration											
Prevention Services Subtotal			1,572,963	524,321			14,618,063				$ 16,715,346
In-Home/Family Preservation Services Subtotal											$ -
Interventions for Birth Parents of Children in Foster Care Subtotal											$ -
Interventions for Children in Foster Care Subtotal											$ -
Interventions for Caregivers of Children in Foster Care Subtotal											$ -
Post-Permanency Services Subtotal											$ -
Other Category Subtotal											$ -
Totals (Section A Lines + Section B Subtotals)	$75,553,080	$ 75,340,467	$ 4,940,384	$ 1,646,795	$2,527,466	$ -	$ 119,000,152	$ 471,124	$ 282,918,709	$ -	$ 562,398,177

CHILD WELFARE DEMONSTRATION PROJECT - ACCOUNTING OF INVESTMENTS TEMPLATE
PRE-IMPLEMENTATION REPORTING PERIOD

STATE/TRIBE: Maryland **FEDERAL FISCAL YEAR:** 2013 **REPORT DATE:**

Program And/Or Category Name	IV-E Programs		IV-B (Subparts 1 and 2)		Medicaid Funding	SAMHSA Funding	Other Federal Formula Grant Funding (e.g., TANF, SSBG)	Other Federal Discretionary Grant Funding (e.g., grants from ACF, SAMHSA)	State/Local Funding (Not including amounts shown elsewhere as match)	Private Investment (e.g., foundation funding)	TOTAL COSTS
	Federal Share	Non-Federal Share	Federal Share	Non-Federal Share							
Section A. Traditional Title IV-E Program Costs											
Foster Care Maintenance Payments	31,028,180	31,028,180	1,127,351	375,784			2,618,909		141,343,384		$ 207,521,786
Foster Care In-Placement Administration	22,579,244	22,579,244	4,127,416	1,375,805	2,808,102		93,220,411	242,221	79,906,944		$ 226,839,388
Foster Care Candidate Administration											$ -
Foster Care Training	1,356,697	452,232.33					3,996,888		2,387,554		$ 8,193,371
SACWIS Operational Costs (exclude SACWIS development)	392,156	392,156					236,868		2,814,722		$ 3,835,902
Adoption Assistance Assistance Payments	23,921,154	23,921,154							20,308,769		$ 68,151,076
Adoption Assistance Administration	433,718	433,718									$ 867,435
Adoption Assistance Training											$ -
Guardianship Assistance Assistance Payments	891,488	891,488							15,525,563		$ 17,308,539
Guardianship Assistance Administration	13,389	13,389									$ 26,779
Guardianship Assistance Training											$ -

Program And/Or Category Name	IV-E Programs		IV-B (Subparts 1 and 2)		Medicaid Funding	SAMHSA Funding	Other Federal Formula Grant Funding (e.g., TANF, SSBG)	Other Federal Discretionary Grant Funding (e.g., grants from ACF, SAMHSA)	State/Local Funding (Not including amounts shown elsewhere as match)	Private Investment (e.g., foundation funding)	TOTAL COSTS
	Federal Share	Non-Federal Share	Federal Share	Non-Federal Share							
Section B. Service Interventions Designated for Funding under the Waiver Demonstration											
Prevention Services Subtotal			1,212,779	404,260			14,507,680				$ 16,124,719
In-Home/Family Preservation Services Subtotal											$ -
Interventions for Birth Parents of Children in Foster Care Subtotal											$ -
Interventions for Children in Foster Care Subtotal											$ -
Interventions for Caregivers of Children in Foster Care Subtotal											$ -
Post-Permanency Services Subtotal											$ -
Other Category Subtotal											$ -
Totals (Section A Lines + Section B Subtotals)	$80,616,025	$ 79,711,561	$ 6,467,545	$ 2,155,848	$ 2,808,102	$ -	$ 114,580,756	$ 242,221	$ 262,286,936	$ -	$ 548,868,995

Appendix 2: Letters of Support

- The Governor of Maryland
- The Lieutenant Governor of Maryland
- The Governor's Office for Children on behalf of the Maryland Children's Cabinet
- The Department of Budget and Management
- The Department of Health and Mental Hygiene
- The Department of Juvenile Services
- Casey Family Programs
- The Foster Care Court Improvement Project
- The Provider Advisory Council
- The Maryland Association of Social Services Directors
- The Maryland Association of Local Management Boards

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

MARTIN O'MALLEY
GOVERNOR

STATE HOUSE
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TTY USERS CALL VIA MD RELAY

January 21, 2014

Ms. JooYeun Chang
Associate Commissioner
Children's Bureau
Administration on Children and Families
1250 Maryland Avenue SW, 8th Floor
Washington, DC 20024

RE: Child Welfare Demonstration Projects (ACYF-CB-IM-12-05)

Dear Associate Commissioner Chang:

It is my pleasure to provide my full support for the Department of Human Resources' application for a Title IV-E Waiver Demonstration project. Since my Administration came into office in 2007, Maryland has seen tremendous improvements in reducing the number of children and youth served in out-of-home care and moving more children into permanent, supportive relationships. Under the *Place Matters* initiative, the Department of Human Resources has institutionalized what was, just seven years ago, an unprecedented shift in how Maryland cares for children in foster care- striving to maintain children safely in their families and homes, limiting the length of time children remain in foster care, and reducing the utilization of congregate care. This work continues to be implemented with the belief that all children in Maryland deserve a safe place to call their home. We are proud that out-of-home placements are the lowest they have been in 26 years.

However, although we have made considerable progress, our vision has yet to be fully realized. In particular, younger children and transition-age-youth are overrepresented in our foster care system, and re-entries of children into our-of-home placement following reunification continue to persist. We believe that, in order to maintain and expand upon the initial successes of *Place Matters*, we must bring additional flexibility and resources to Maryland to meet the individualized needs of children and youth who are involved with our child welfare system.

We applaud the Administration of Children and Families for your efforts in highlighting the importance of creating and implementing trauma-informed systems and moving beyond safety and permanency to achieve well-being. This Demonstration will provide Maryland with the tools necessary to take the next steps in transforming our child welfare system into one that is trauma-informed and utilizes evidence-based and research-informed practices to support children and families in their communities.

Maryland's history of collaboration and strong infrastructure will ensure the success of this Demonstration. I have every confidence that the leadership in the Department of Human Resources will make the Demonstration a success. As always, I am thankful for the support from our federal partners at the Department of Health and Human Services and am excited for this opportunity to work together to ensure the well-being of Maryland's most vulnerable children and youth and their families.

Sincerely,

Martin O'Malley
Governor

STATE OF MARYLAND
OFFICE OF THE LT. GOVERNOR

ANTHONY G. BROWN
LT. GOVERNOR

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TTY USERS CALL VIA MD RELAY

February 26, 2014

Ms. JooYeun Chang
Associate Commissioner
Children's Bureau
Administration on Children and Families
1250 Maryland Avenue SW, 8th Floor
Washington, DC 20024

RE: Child Welfare Demonstration Projects for Fiscal Years (FYs) 2012-2014 (ACYF-CB-IM-12-05)

Dear Associate Commissioner Chang:

I am pleased to give my heartfelt support for the Department of Human Resources' application for a Title IV-E Waiver Demonstration. Maryland has made significant progress in reducing the number of children and youth served in out-of-home care and moving more children into permanent, supportive relationships. Through our Place Matters initiative we have helped over 17,000 children find permanent places to live since 2007. We are proud of our accomplishments and yet recognize that there are still more successes to be realized.

Maryland endeavors to take the next step to continue to assist our vulnerable children, in particular, young children and teenagers. In order to take the next step to provide services, Maryland must be able to use federal funding and resources in the most flexible manner possible. The Title IV-E Waiver Demonstration would provide Maryland with that flexibility.

I thank the Administration of Children and Families for the opportunity to provide that flexibility and for continuously challenging child welfare professionals to improve outcomes for children. I am confident that the partnership between the Department of Human Resources and the Administration of Children and Families will continue to better the lives of Maryland's most vulnerable population. The Demonstration is a wonderful opportunity to allow flexibility in ensuring the safety, permanence and well-being of Maryland's children and families.

Sincerely,

Anthony Brown

AGB/bmw

CC: Secretary Ted Dallas, Maryland Department of Human Resources

MARYLAND
Governor's Office for Children
Promoting the well-being of Maryland's children

State of Maryland Executive Department

Martin O'Malley
Governor

Anthony Brown
Lieutenant Governor

Anne Sheridan
Executive Director

February 10, 2014

Ms. JooYeun Chang
Associate Commissioner
Children's Bureau
1250 Maryland Avenue SW, 8th Floor
Washington, DC 20024

RE: Child Welfare Demonstration Projects for Fiscal Years (FYs) 2012-2014 (ACYF-CB-IM-12-05)

Dear Associate Commissioner Chang:

As Executive Director of the Governor's Office for Children (GOC) and Chair of Maryland's Children's Cabinet, I would like to offer my full support for the proposal from the Maryland Department of Human Resources (DHR) for a Title IV-E Waiver Demonstration Project to prevent and reduce entries and re-entries into out-of-home placement and shorten lengths of stay in out-of-home placement, while furthering the development of an evidence-based and evidence-informed system consisting of trauma-informed, home- and community-based services and supports.

The Children's Cabinet, which includes all of the child- and family-serving agencies, including DHR, and the Department of Budget and Management, oversees a comprehensive, collaborative approach to the development of integrated systems of care that are child-and family-focused, individualized, and strengths-based. The Children's Cabinet continues to support the implementation, fidelity and outcomes monitoring, and training and coaching for several evidence-based and promising practices in Maryland, including Multi-Systemic Therapy, Functional Family Therapy, Wraparound, and Trauma-Focused Cognitive Behavioral Therapy. The Children's Cabinet Interagency Fund has supported DHR in its implementation of *Place Matters* through funding to support up to 100 DHR-involved children to be served through Care Management Entities using a Wraparound service delivery model in order to divert them from congregate care settings.

The Governor's Office for Children is responsible for the annual compilation and analysis of data on Maryland's eight results for child well-being. Through this process, we have seen the reductions in the numbers of children served in out-of-home placements and know that much progress has been made. We feel that this Demonstration Project offers an important opportunity to sustain this trend and further enhance our service array

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by bringing to scale innovative evidence-based and promising practices. The Children's Cabinet has a strong history of leveraging federal funding opportunities to sustain and expand innovation, as we have done with multiple Department of Health and Human Services' System of Care Grants and the 1915(c) Psychiatric Residential Treatment Facilities Demonstration Waiver. We believe this Demonstration will provide the support and financing that are necessary to accelerate the progress that has been achieved, without sacrificing quality, safety, or permanency outcomes for children and families.

On behalf of the Children's Cabinet, I offer our full commitment to partnering with DHR in the implementation of this Demonstration. A truly interagency approach will be critical to the success of the Demonstration, and our history of collaboration for more than 35 years will serve as a foundation for the innovation that will come with this Demonstration. I look forward to a favorable federal review and look forward to our continued partnership on behalf of Maryland's children, youth and families. Please do not hesitate to contact me if I can be of further assistance.

Sincerely,

Anne Sheridan
Executive Director, Governor's Office for Children
Chair, Children's Cabinet

MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

MARTIN O'MALLEY
Governor
ANTHONY BROWN
Lieutenant Governor

T. ELOISE FOSTER
Secretary
DAVID C. ROMANS
Deputy Secretary

January 15, 2014

Ms. JooYeun Chang
Associate Commissioner
Children's Bureau
1250 Maryland Avenue SW, 8th Floor
Washington, DC 20024

RE: Child Welfare Demonstration Projects for Fiscal Years (FYs) 2012-2014 (ACYF-CB-IM-12-05)

Dear Ms. Chang:

As Secretary of the Maryland Department of Budget and Management (DBM) and as principal fiscal adviser to the Governor, I offer this letter of support for the application by the Department of Human Resources for a Title IV-E Waiver Demonstration Project. DBM recognizes the importance of this Demonstration Project in providing the necessary flexibility to implement the programs and services that have been identified by the Department of Human Resources and the Children's Cabinet as fundamental to the success of children and families served by the child welfare system.

On behalf of the State of Maryland, I assure you that the State will continue to provide an accounting of the federal, State, and local investments made, including any private investments, for each year of the approved Demonstration Project. Further, I confirm that Maryland provides health insurance coverage for all special needs children for whom the Department of Human Resources has entered into an adoption assistance agreement.

The Department of Budget and Management is in full support of Maryland's application for a Title IV-E Waiver Demonstration Project and I strongly recommend this application for approval. We have every confidence in the leadership at DHR and within the local departments of social services and their ability to successfully implement this Demonstration Project and achieve the goals outlined in the application. Please do not hesitate to contact me if I can provide additional information.

Sincerely,

T. Eloise Foster

T. Eloise Foster
Secretary

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STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

January 24, 2014

Ms. JooYeun Chang
Associate Commissioner
Children's Bureau
1250 Maryland Avenue SW, 8th Floor
Washington, DC 20024

RE: Child Welfare Demonstration Projects for Fiscal Years (FYs) 2012-2014
(ACYF-CB-IM-12-05)

Dear Associate Commissioner Chang:

As Secretary of the Department of Health and Mental Hygiene (DHMH), it is my pleasure to provide this letter of support for the application by the Department of Human Resources (DHR) for a Title IV-E Waiver Demonstration Project. Among other responsibilities, DHMH operates Maryland's Title XIX Program, oversees the behavioral health system, and partners with local health authorities to provide public health services. We routinely partner with DHR across populations to ensure that Maryland's most vulnerable residents have access to the services and supports that they need to be successful.

DHR's application represents an opportunity for Maryland to turn the curve on entries and re-entries into out-of-home placement, and aligns with our other initiatives through the Children's Cabinet and within our individual child- and family-serving agencies to increase the array of home- and community-based services, including trauma-informed and evidence-based practices. The innovation of this proposal rests with its emphasis on building upon the work that has come before to effectively and comprehensively implement Alternative Response and provide tailored, strengths-based services.

As a pediatrician and someone who has served in the local, state and federal executive branches, I am aware of the complexity of the child welfare system and also of the importance of preventing child maltreatment as a public health issue. This application is a critical component in our collective strategy to reduce risk factors and promote resiliency and well-being for all Marylanders.

I appreciate the opportunity to provide my support for this application and urge you to provide it with a favorable review.

Sincerely,

Joshua Sharfstein, M.D.
Secretary

MARYLAND
Department of
Juvenile Services
Successful Youth • Strong Leaders • Safer Communities

One Center Plaza
120 West Fayette Street
Baltimore, MD 21201

Anthony G. Brown
Lt. Governor

Martin O'Malley
Governor

Sam Abed
Secretary

February 18, 2014

Ms. JooYeun Chang
Associate Commissioner
Children's Bureau
1250 Maryland Avenue SW, 8th Floor
Washington, DC 20024

RE: Child Welfare Demonstration Projects for Fiscal Years (FYs) 2012-2014 (ACYF-CB-IM-12-05)

Dear Associate Commissioner Chang:

As Secretary of the Maryland Department of Juvenile Services, I would like to extend my support for the application from the Department of Human Resources (DHR) for a Title IV-E Waiver Demonstration Project. As a sister agency to DHR, and with the number of youth who are co-committed to our two agencies, I know how important it is to ensure that services and support provided to children and youth are individualized, strength-based, and evidence-informed. I also recognize the critical importance of providing services to families when they first present as at-risk of child maltreatment, not after a child has been placed into out-of-home care. This Demonstration will enable Maryland to better meet the needs of children and families when they are first in contact with DHR, rather than waiting for the children to be removed from the home in order for comprehensive services to be implemented.

This Demonstration will provide Maryland with an opportunity to expand the knowledge and resources available to create a trauma-informed system. We know that many of the youth we serve—and many of the youth that DHR serves—have experienced trauma and many of the behavioral health symptoms that they exhibit stem from those experiences. Through the use of comprehensive screenings and assessment tools, we can identify the specific strengths and needs that can form the basis of an individualized, comprehensive, trauma-informed plan of care.

The Department of Juvenile Services has collaborated with DHR on the development of this application and is fully prepared to support DHR in its implementation, including as it pertains to the Title IV-E claiming for youth served through our Department. This Waiver will provide Maryland with an extraordinary opportunity to bring to bear many of the initiatives that have been seeded over the years, and positively impact the lives of children and families.

Thank you for the opportunity to provide my support and please do not hesitate to contact me if I can provide additional information.

Sincerely,

Sam Abed
Secretary

Phone: 410-230-3333 Toll Free: 1-888-639-7499 TDD: 1-800-735-2258

casey family programs
fostering families. fostering change.®

February 6, 2014

JooYeun Chang
Associate Commissioner of the Children's Bureau
Administration for Children and Families
U.S. Department of Health and Human Services
370 L'Enfant Promenade, S.W.
Washington, D.C. 20447

Re: Support for the Maryland State Child Welfare Demonstration Waiver

Dear Associate Commissioner Chang,

Casey Family Programs works with children, families and communities to ensure that all children can be raised in safe and permanent families. Building on more than 40 years of experience in the field, we provide strategic consulting services to help public child welfare agencies in all 50 states. Through our nationwide consulting services we have invested funding and staff resources in evidence-based practices focused on family-centered prevention and interventions that serve to achieve safe reduction and well-being outcomes.

Casey Family Programs has been partnering with the state of Maryland for five years. The primary projects have centered on the state's Place Matters initiative and its efforts to develop and refine its family engagement and support strategies. As an operating foundation, we have invested close to one million dollars in cash and technical assistance in Maryland. We have done this because we believe in the state's capacity to improve the safety, permanency and well-being outcomes for children and families. Their data continues to reflect progress towards safe reduction of children in care and the effectiveness of family centered practices.

It is my pleasure to provide this letter of support for Maryland's application for a Title IV-E Waiver Demonstration Project. I have had the opportunity to work with Maryland on their implementation of Place Matters and other child welfare initiatives, and I believe that this Demonstration Project is being proposed at the opportune time for Maryland. This application is comprehensive and realistic, and will enable the Department of Human Resources (DHR) to fully implement Alternative Response and move Place Matters into an initiative that goes beyond safety and permanency to achieve well-being.

We have assisted DHR on their application and we remain impressed with the Secretary and the Director of the Social Services Administration articulation of Maryland's vision for the child welfare system in the upcoming years. Their plan for achieving this vision is consistent with the goals outlined for this Demonstration and the goals of the Administration on Children and Families. The stakeholders have been supportive of this

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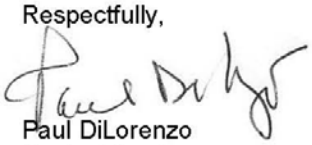
2001 8th Avenue | Suite 2700 | Seattle, WA 98121

Demonstration Project and eager to join together with DHR to take this next step forward.

I believe Maryland is well-positioned to successfully implement this Demonstration Project and recommend it for your positive consideration.

Respectfully,



Paul DiLorenzo
Senior Director
Strategic Consulting

FOSTER CARE COURT IMPROVEMENT PROJECT

Maryland Judiciary/Court of Appeals
2001-B Commerce Park Drive
Annapolis, MD 21401
Phone: (410) 260-1427 Fax: (410) 260-3585

February 4, 2014

Ms. JooYeun Chang
Associate Commissioner
Children's Bureau
1250 Maryland Avenue SW, 8th Floor
Washington, DC 20024

RE: Child Welfare Demonstration Projects for Fiscal Years (FYs) 2012-2014 (ACYF-CB-IM-12-05)

Dear Associate Commissioner Chang:

On behalf of the Maryland Judiciary's Foster Care Court Improvement Project (FCCIP), it is my pleasure to submit this letter of support for the application by the Maryland Department of Human Resources (DHR) for a Title IV-E Waiver Demonstration Project.

The FCCIP strives to improve the Court's performance in the handling of child abuse and neglect cases and to ensure the safety, permanency, and well-being of children and foster care. We focus on five specific areas through an oversight committee and six subcommittees. The partners in FCCIP are not limited to the members of the judiciary; we have members on our committees from DHR, the University of Maryland, advocacy organizations, and other state and local organizations. In addition to supporting compliance efforts, much of our work centers on improving outcomes for children and families. We see the Demonstration Project as an opportunity to expand our impact to improve the well-being of children and families who come into contact with the child welfare system.

I strongly recommend this application for a favorable review and look forward to continued work together to improve safety, permanency, and well-being for Maryland's children and families.

Sincerely,

Tracy Watkins-Tribbitt, MSW
Director

cc: Hon. Mary Ellen Barbera, Chief Judge
Hon. Patrick L. Woodward, FCCIP Chair

January 21, 2014

Ms. JooYeun Chang
Associate Commissioner
Children's Bureau
1250 Maryland Avenue SW, 8th Floor
Washington, DC 20024

RE: Child Welfare Demonstration Projects for Fiscal Years (FYs) 2012-2014 (ACYF-CB-IM-12-05)

Dear Associate Commissioner Chang:

On behalf of Maryland's Provider Advisory Council (PAC), a 16-member body representing private child- and family service providers, we would like to provide our support for the application by the Department of Human Resources for a Title IV-E Waiver Demonstration Project. PAC members provide an array of home, community-based, and residential services for children and families involved with the child welfare system. We are pleased that the application reflects the need for more evidence-based and research-informed practices in Maryland. We are also very supportive of the use of this Demonstration Project to fully implement Alternative Response within a trauma-informed system.

This Demonstration Project will improve the availability of individualized services while enhancing the workforce within DHR and in the provider community. We know that the families that come into contact with the child welfare system have complex needs, and this Demonstration Project reflects the need to tailor services to the strengths and needs of each child and each family.

Thank you for the opportunity to provide our support for this application.

Sincerely,

Joseph Leshko, Co-Chair
Arrow Child & Family Ministries

Zachary Dingle, Co-Chair
Jumoke, Inc.

MASSD Maryland Association of Social Service Directors

Co-Chairs
Gloria L. Brown – Prince George's County
Karen S. Butler – Howard County

Vice Chairs
Cathy Dougherty – Queen Anne's County
April Sharp – Talbot County

Treasurer
Patti Mannion – Somerset County
Secretary
Amy Scrivener – Calvert County

January 21, 2014

Ms. JooYeun Chang
Associate Commissioner
Children's Bureau
1250 Maryland Avenue SW, 8th Floor
Washington, DC 20024

RE: Child Welfare Demonstration Projects for Fiscal Years (FYs) 2012-2014 (ACYF-CB-IM-12-05)

Dear Associate Commissioner Chang:

It is our pleasure to submit this letter of support for Maryland's Title IV-E Waiver Demonstration Project Application on behalf of the Maryland Association of Social Services Directors (MASSD). As the local administrators of the child welfare system, we know first-hand the implications of having insufficient or ineffective services available. We also understand the challenge of being unable to serve a child or family until after the child has been placed in out-of-home care. Therefore, it is with pleasure that we offer our support for the Department of Human Resources' application. Our collective efforts to reduce the number of children in out-of-home care have met with success, but we have more to do in order to prevent entries and re-entries into out-of-home care.

This application will provide DHR and the local departments of social services with enhanced flexibility to identify those services and supports that will be most effective at preventing child maltreatment in our particular communities. It will also ensure that our implementation of Alternative Response is comprehensive and that we move our system into one that is truly trauma-informed.

We are committed to the children and families we serve, and this Demonstration Project affords us an opportunity to intervene in a timely and responsive manner before we need to place a child in out-of-home care. This Demonstration Project will take us to the next level in our implementation of Place Matters, and we strongly urge you to provide it with a favorable review.

Thank you for the opportunity to provide our support for this endeavor.

Sincerely,

Director Gloria Brown, Co-chair
Maryland Association for Social Service Directors
Prince George's County DSS

Director Karen Butler, Co-chair
Maryland Association for Social Service Directors
Howard County DSS

Maryland Association of
LOCAL MANAGEMENT BOARDS

January 21, 2014

Ms. JooYeun Chang
Associate Commissioner
Children's Bureau
1250 Maryland Avenue SW, 8th Floor
Washington, DC 20024

RE: Child Welfare Demonstration Projects for Fiscal Years (FYs) 2012-2014 (ACYF-CB-IM-12-05)

Dear Associate Commissioner Chang:

On behalf of the Maryland Association of Local Management Boards, it is my pleasure to submit this letter of support for the Maryland Department of Human Resources' application for a Title IV-E Waiver Demonstration Project. Maryland's local management boards (LMBs) are the coordinators of collaboration for local child- and family services. Bringing together agencies, providers, families, and community representatives, LMBs support the identification and setting of priorities for Maryland's 24 local jurisdictions.

Our focus is on improving the quality of life for children and families and increasing linkages and connections to support all children and youth to be successful in life. We track local indicators of child well-being and know that there have been marked improvements in the number of children in out-of-home placement over the past several years. We also know that more work remains to be done, and this Demonstration Project will be a critical tool to continue the work. It will give Maryland the flexibility to more broadly implement evidence-based and promising practices in a way that is tailored to the strengths and needs of the local jurisdictions. A statewide emphasis on trauma-informed care and a prevention mindset are in keeping with the founding principles of the LMBs in the mid-1990's, which continue to be relevant today—a focus on prevention, early identification, and early intervention to promote success at home, in school, and in the community.

Thank you for the opportunity to provide our support for Maryland's application. We look forward to our continued partnership with DHR and the local departments of social services in the implementation of the Demonstration Project.

Sincerely,

P M Brown

Pamela M. Brown, Ph.D.
President
Maryland Association of Local Management Boards

Appendix 3: October 2013 Stakeholder Meeting Notes & Roster of Attendees

Social Services Administration
Child and Family Advisory Board Meeting
311 W. Saratoga Street
Baltimore, MD 21201

October 31, 2013

The Child and Family Advisory Board and invited guests (see Appendix A for a list of participants) met on October 31, 2013 to review the Title IV-E Demonstration Waiver Application Process. The Social Services Administration (SSA) is considering an application for the IV-E Waiver program.

Paul DiLorenzo of Casey Family Programs presented background information on the Title IV-E Demonstration Waiver, key requirements of the waiver application, cost information, implementation time frames and the states that have applied. The presentation also included common strategies included in the states' Title IV-E Waiver strategies, including but not limited to:

- identifying trauma-informed assessments and care
- Family/youth engagement
- Kinship care
- Reduce reliance on congregate care or residential treatment

Carnitra White, SSA Executive Director reviewed the Place Matters data, how SSA uses data to measure success, Alternative Response. Federal Goals to be addressed by the waiver application:

- Increase permanency for all infants, children and youth
- Increase positive outcomes
- Prevent child abuse and neglect and the re-entry of infants, children and youth

The Board and guests were asked to discuss and respond to three questions and to give the top responses in their report out:

1. Discuss and record what you believe will be keys for successfully implementing a child welfare system that focuses on child well-being?
2. What interventions should the State consider for preventing children at risk? When discussing, consider and record evidence-based practices and promising practices in Maryland and nationwide.
3. What interventions should the State consider for preventing children at risk? When discussing, consider and record evidence-based practices and promising practices in Maryland and nationwide.

The results of the discussion follow. The top responses are in italics.

1. Discuss and record what you believe will be keys for successfully implementing a child welfare system that focuses on child well-being?

- *Collaboration / sharing of information and data*
- *Focus on family well-being*
- *Very strong local system of care that is resourced adequately*
- *Should be for all families and communities with the understanding that one size does not fit / fix all*
- *All child services agencies to share responsibilities and commit to creative thinking to blend funding and incentivize providers to re-tool to deliver evidence based and trauma informed services that individualize plans of care*
- *To agree on a definition of well-being and how to measure it*
- *Non-traditional services for families; getting families what they need (often economic security type services)*
- *Public relations campaign to change the image of child welfare.*

Collaboration

- Consistency between providers
- Multi-D approach to families
- Cross Training
- Continuum of services and supports
- Stakeholders eliminating barriers and connecting to meet children's needs
- Develop a community-based assessment of the problem
- Build awareness with the whole community network, including education and child care (2 comments)
- Sharing of successes and struggle across jurisdictions
- Common goals/language/training/linkage between systems – services, data, collaboration/shared responsibility among agencies (6 comments)
- Linkable with adult system
- Clarity on regulations re: sharing of information **and** a consistent system for doing so
- Backbone support organization

Communication

- Feedback loop from state to local and back (2 comments)
- Public relations campaign/Robust change image of child welfare agency/partner/support

Data/Outcomes

- Lack of bridges between data systems
- Strong evaluation of process and outcomes and data support (6 comments)
- Build in an incentive for family involvement in reporting successes
- Know the desired outcomes from the start

Funding

- Non-traditional services fill gaps/identify gaps and access money

- Policy and funding flexibility, including emergency needs (school supplies, uniforms, etc.) (3 comments)
- Blended funding, shared responsibility and creative thinking
- Identify funding for group home providers to “re-tool” to deliver in-home services

Services

- Strengths-based
- Time required to develop service
- Focus on individualized services/plans of care instead of programs (2 comments)
- System of care approach (i.e., remove all silos)
- Alternative response
- Embrace family-centered strength based model (2 comments)
- Establish minimum standard for families
- Evidence Based Programs (EBP) and Evidence Informed (EI) as well as promising practices that allow for flexibility (3 comments)
- Expand family treatment models for substance abuse treatment
- Move from transactional work to transformative
- Integration with behavioral health system
- Focus on trauma-informed care (3 comments)
- Very strong local “system of care” that is resourced appropriately (4 comments)
- Process of implementation
- Non-Judgmental
- Should be for all families in all communities
- How do you identify families and join families prior to report of child abuse or neglect?
- Parallel process must exist between Child Protective Services system and all community stakeholders to support and sustain family well-being issues (creative partnerships) (3 comments)
- Don’t ignore family financial needs
    - How do we measure?
    - What is true level of need?
- Aftercare – Define post permanency for all Permanency Plans/exit, specific program/services
- Case management/Drop centers
- Increase involvement of fathers (unmarried and married)

Training/Staff

- Train all staff, providers, etc. including all areas of Department of Social Services (DSS) (i.e., Family Investment Administration, etc.)
- Train staff and school based services
- Buy-in at all levels
- Adequate staffing
- Dedicated caseworkers/agency workforce
- Gradual, well planned implementation
- Understand roles

2. What interventions should the State consider for preventing children at risk? When discussing, consider and record evidence-based practices and promising practices in Maryland and nationwide.

- *One size does not fit all*
- *Treatment needs to be informed by assessment (data)*
- *Family work should be done through trauma-informed lens*
- *Prioritize EBPs that are family focused and target the needs – individual trauma – of our youth across the age continuum (using data) services*
- *Community empowerment model that leverages professionals and their services*
- *All systems touching families need to take a trauma informed approach to help identify triggers early*
- *Strong local partnerships with pathways for information sharing*
    - *Housing*
    - *Education*
    - *Health*
    - *Mental health*
    - *Workforce*
    - *Business*
    - *Non-profits*
    - *Early Childhood Education*
    - *Accessible / available / affordable quality early care and education for all families and children*
    - *Strengthen partnership with community*

Evidence Based Practice

- Level of risk and age of child determines Evidence-based practice most impact
- State plan should absorb EBPs – how can we play a role?
- Expansion of evidence-based parenting programs with adequate funding to sustain and by blending funds (Multidimensional Treatment Foster Care (MTFC), Multisystemic Therapy for Child Abuse and Neglect (MST-CAN), Multisystemic Therapy (MST), for example) Parent–Child Interaction Therapy (PCIT) (2 comments)
- Evidence Based (2 comments)

Education

- Focus on early-education aged children
- Parent education
- Quality early care and education for all families/children (full day/week)
- Knowledge of child development

Visitation

- Home visiting programs, early childhood intervention (2 comments)
- Home visiting nurse beyond newborns

Local / Community

- Identify triggers early (pre-DSS) – community open table

- By re-tooling group providers, in-home diagnostic programs and diversion for high intensity behavior with youth
- All systems serving families need to take and train - centered approach
- Other system involvement is essential
- Connect services to schools, Health Departments
- Strong local partnerships – information sharing, Core Service Agency's (CSA's) Housing, costs of not-for-profit, schools, early childhood coalitions, Developmental Disability Services (DDS), Behavioral health/health homes (3 comments)
- Community empowerment model leveraging professional services
- Multi-disciplinary – mental health, physical health, public health/community interventions
- Screening – in community and multiple sites
- Flexible, real, collaborative practice that is funded (2 comments)

Families

- Family work should be done through a trauma-informed lens
- Alternative Response
- Family-centered practice
- Creative parent/child placement in mentor home, community home. I.e., faith-based collaboration
- Wraparound d services provided in the home to maintain children in their birth families
- Strengthening families (2 comments)
- Build Parent/Family Resilience
- Family Connections Program (2 comments)
- Relevant to family needs-based on good, holistic assessment
- Ongoing assessment throughout interaction with family
- Concrete support in times of need
- Child Advocacy Center – Connecting our families

Services

- Social-Emotional Foundations of Early Learning (SEFEL)
- Completion of the SCCAN (State Council on Child Abuse and Neglect) plan
- Behavioral Health Services
    - Mental Health
    - Substance Abuse (2 comments)
- Social/emotional health of children
- Treatment needs to be informed by assessment/data
- Trauma informed care (2 comments)
- Increase support to families and children with disabilities
- Early identity risk
- Preventive services
- Supports for information kin placements
- Menu of options
- Wraparound

Other

- Housing – affordable, supportive
- Strong employment and higher education partnerships with colleges and Business Community
- Social Connections
- Performance based
- Change perception of agency

3. What interventions should the State consider for post-permanency services?

- *After care services*
- *One size does not fit all*
- *Treatment needs to be informed by assessment (data)*
- *View post permanency services as the same as preventive services*
- *Separate reunification from adoption and guardianship recidivism and therapy, identify EBP or Evidence Informed Practice such as CASE's – use data and outcomes*
- *Take the stigma out of asking for help by making ongoing support available*
- *Support a wraparound model that is robust, has a broad system of providers, who can respond timely (look at New Jersey)*
- *Families need post-permanency services*
- *Develop and make available a resource list websites, resources*

Post Services

- View post-permanency services as the same as prevention services
- Post adoption services affordable for families, including mental health and maximizing Medical Assistance (2 comments)
- Post reunification Family Support services including economic security
- Crisis-response post-permanency
- Adoption focused therapists
- Extend services/intervention for a greater length of time (3 comments)
- More Realistic expectations
    - May not be "cured"
    - There will be bumps in the road

Services

- Wraparound model that is robust and has a network of providers able to provide services across providers
- Wraparound services provided in the home to maintain children in their birth families, also mental health, respite (2 comments)
- Support non-traditional services and providers – mentoring, equine therapy, art therapy, youth services programs
- Compensate providers for aftercare services; integrate services across providers; make effective linkages
- Same services – supportive based on family
- In-home, trauma-based, attachment based
- Systems of care approach
- Supports/programs to engage other youth (adoptive)

- Intensive services (i.e., Psychiatric Rehabilitation Program)
- Home visiting nurse beyond newborns

Families

- Strengthen family services continuum from prevention to permanency
- Parent education – behavioral and in-home based and individualized
- Creative parent/child placement in mentor home, community home. i.e., faith-based collaboration
- Positive Parenting Programs
- Providing resources to help families not revert back to the issues that brought child into care
- Assurance that there is someone out there to support them
- Trust/Respect for the family
- Family engagement – acceptability and buy-in from families served
- True family finding – more extensive, especially for adoption
- Peer support for parents (i.e. family recovery program, Baltimore City, 0-5)
- Adoptions together
- Peer support – other families
- Take the stigma out of asking for help – make ongoing supports available

Community/Local

- Build Community infrastructure to support, establish a bridge of service delivery
- Where services are delivered – transportation is a huge issue
- If we pick a menu – how do we ensure local flexibility and access?
- Build local capacity
- Peer mentoring – local flexibility
- Community empowerment model leveraging professional services

Data/Outcomes

- Programs that measure outcomes
- Focus on measure long-term outcomes long-term connection to family
- Financial DSS subsidy (Guardianship Assistance Program (GAP)/Adopt)

Other

- De-stigmatize seeking the seeking help
- Remove adversarial interaction
- Separate re-unification from the rest and get more data; look for successful intervention
- Develop a resource guide
    - List website/Resource
    - Hard copies
    - Hotline
    - 211/Revitalize
- Prevention is where you choose to intervene
- Incentives
- Crisis response / Expand publicizing

Other Services, Should the State apply for the IV-E Waiver?

- *Intensive services for caregivers / parents while child is out of home or before to facilitate reunification and minimize re-entry*
- IV-E Waiver – Yes
- Focus on child well-being – Yes
- Change Child Protective Services law to mandate intensive in-home intervention (that includes respite) – would need to develop these services statewide and that include parenting high intensity youth component
- Adequately fund EBP
- Focus should be on family, instead of just child
- System Integration
    - Behavioral health
    - Schools
    - Housing
- Intensive services for caregivers/parents while child is out of home or before to facilitate reunification and minimize re-entry
- Family Retreat (Anne Arundel County)

Appendix A

Last Name	First Name	Organization	Board Member / Guest / DHR
Ahluwalia	Uma	Montgomery Co. HHS	Guest
Ayer	David	DHR	DHR
Barr-Stanley	Sheritta	DHR	DHR
Berry	Steve	DHR	DHR
Brown	Pamela	Local Management Boards	Guest
Brown	Carmen	Arrow Project, Inc.	Guest
Brylske	Paul	Kennedy Krieger	Guest
Cabellon	Angela	DHR	DHR
Chipungu	Stafford	Budget and Finance	DHR
Cronin	Patricia	The Family Tree of MD	Board Member
Crowder	Shanda	SSA	DHR
Dallas	Ted	DHR	DHR
Diehl	Lesa	DHMH, (Allegany Co.)	Guest
DiLorenzo	Paul	Casey Family Programs	Board Member
Dingle	Zach	Provider Advisory Council Jumoke	Board Member
Flanigan	Patricia	DJS	Board Member
Garvey	Kate	MASSD President	Board Member
Giles	Charlotte	DHR	DHR
Harburger	Deborah	UMD SSW	Guest
Hiers	Tomi	DHR	DHR
Hughes	Peggy	Budget and Finance	DHR
Keegan	Kevin	Catholic Charities	Guest
King	Rene	DHR	DHR
Kistler	Sharon	Board of Child Care	Guest
Knebel	Carrie	CONCERN	Guest
Koretzky	Margie	Baltimore Co. CSA	Guest
Lane	Dr. Wendy	University of Maryland School of Medicine	Board Member
Lardner	Mark	DHR	DHR
Lee	Bethany	UMD SSW	Guest
Leshner	Agnes	Montgomery Co. HHS	DHR
Malat	Kim	Governor's Office for Children	Board Member
Manning	Terry	Children's Guild	Guest
Marks	Jeanne	Pressley Ridge	Guest
McAllister	Sabrena	Citizens Review Board for Children	Board Member
McBride	Bernard	Behavioral Health System	Guest
McGinnis	John	MSDE Representative	Board Member
McLendon	Audrey	DHR	DHR
Mellerson	Samantha	Baltimore City DSS	Guest
Mittelman	Mark	New Pathways	Guest
Monseaux	Nancy	DHR	DHR

Norman	Richard	Martin Pollack Project	Guest
Powell	Karen	DHR	DHR
Ramelmeier	Debbie	SSA	DHR
Rock	Melissa	Advocacy of Children and Youth	Board Member
Rondeau	Jonathon	Family Leagues of Baltimore	Guest
Rozeff	Leslie	UMD School of Social Work	Board Member
Schagrin	Judith	Baltimore Co. DSS	DHR
Shannahan	Ryan	UMD SSW	Guest
Sharp	April	Talbot Co. DSS	DHR
Shaw	Terry	UMD School of Social Work	Board Member
Strawder	Tuverla	Youth Assistance Unit Maryland Department of Juvenile Services	Guest
Sullivan	John	Baltimore City DSS	Guest
Taylor	Jill	DHR	DHR
Thompson	Damon	Pressley Ridge	Guest
Tinney	Shelly	MARFY	Guest
Watkins-Tribbit	Tracy	FCCIP	Board Member
White	Carnitra	DHR	DHR
Wilkins	Anita	DHR	DHR
Williams	Margaret	MD Family Network	Board Member
Wood	Maurice	Youth Assistance Unit Maryland Department of Juvenile Services	Board Member
Zabel	Michelle	UMD School of Social Work	Board Member
Zachik	Al	DHMH, Office of Child and Adolescent Services	Board Member