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BY ELECTRONIC MAIL

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Re: Plaintiffs' Letter of June 12, 2023 Alleging Non-Compliance with MCD Provisions on Placements

Dear Mr. Mirviss, Ms. Franklin, and Forum Facilitators:

The Maryland Department of Human Services ("DHS") and the Baltimore City Department of Social Services ("BCDSS"), Defendants in *L.J., et al v. Massinga, et al*,[1] case number 84-4409 in the United States District Court for the District of Maryland, submit this reply to Plaintiffs' letter of June 12, 2023 for the purpose of engaging in good faith discussions and negotiations with the assistance of the Forum Facilitators to determine whether additional actions are necessary to address Plaintiffs' assertions. Any statements

[1] Pursuant to Federal Rule of Civil Procedure 25(d), Rafael López, the current Secretary of Human Services, has automatically been substituted as a party in the litigation.

made or offers of compromise submitted by Defendants or their counsel in this letter or during any ensuing negotiations are protected under Rule 408 of the Federal Rules of Civil Procedure, the applicable case law, and the applicable Maryland Rules and case law.

PRELIMINARY COMMENTS

DHS and BCDSS share Plaintiffs' goal that youth committed to the State's custody and care should not remain in a hospital or a clinical facility beyond medical necessity and desire to demonstrate their commitment to developing and implementing timely and effective solutions. Additional actions will be necessary to address the causes of overstays and to serve foster youth in less restrictive environments when appropriate.

During the first six months of the current Administration, DHS has shared Plaintiffs' frustration that this long-standing issue has not been more effectively addressed by prior State Administrations. However, neither a finding of noncompliance nor an enforcement action is warranted against BCDSS or DHS.

In this letter, we would like to outline the current DHS Administration's vision for moving forward and the work currently in progress to begin to address the issues. We look forward to our August 1st discussion.

DEFENDANTS' VISION AND COMMITMENT TO PROGRAMS TO ENHANCE STABILITY AND REDUCE THE NEED FOR THE MOST RESTRICTIVE PLACEMENTS

DHS is committed to the provision of family-centered, child-focused, community-based services that promote safety, family strengthening, and child well-being. There has been a 64% decrease in youth in Baltimore City out-of-home placements since FY 2010. The State of Maryland has seen a 47% decrease in the same time period. This reduction was a result of targeted efforts to support families to prevent out-of-home placements and reduce the length of stay in foster care, resulting in a 41% decrease in new entries since FY 2010.

This reduction in the number of youth in out-of-home placements had unintended consequences on Maryland's and the nation's continuum of care provider networks.[2] A

[2] The national shortage of "appropriate placements for foster children and youth with the most severe behavioral health needs" stems from intersecting pressures, including "a push by advocates and governments to reduce the number of children in institutional

number of placement provider organizations closed or altered their capacity because fewer children required their services. At the same time, the State began to see an increased need for higher levels of service—both community-based and residential—for children and youth with more complex behavioral health needs who also required longer and specialized treatment protocols. The loss of placements was exacerbated by the COVID-19 pandemic (2020-22), which impacted provider staffing and the national behavioral health and childcare provider capacity,[3] as well as families' willingness to foster youth.

Additionally, Maryland has experienced over a decade of failed attempts to reform its child placement provider rate setting to align with the actual cost of care, provide flexibility for specialized services, and capitalize on federal funding. Moreover, efforts to build robust community-based intervention and prevention services to support families and children have fallen short of meeting those needs.

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care," "[r]eimbursement rates [that] have stagnated around the country," and "a series of laws and court settlements [that have] resulted in massive reductions in residential beds available to foster youths." Marie K. Cohen, The placement crisis for high-needs kids: it is residential facilities, not foster homes, that are lacking, Child Welfare Monitor (Oct. 26, 2022), https://childwelfaremonitor.org/2022/10/26/the-placement-crisis-for-high- needs-kids-it-is-residential-facilities-not-foster-homes-that-are-lacking/

[3] Across the country, "nearly 40,000 to 66,000 children are boarding in hospitals [while] awaiting residential, group home or psychiatric placement on a yearly basis." Aysha Jawed, Rachel Boro-Hernandez, & Diane Pickett, Homeless in the hospital: A call to strengthen multidisciplinary care for children awaiting out-of-home and psychiatric placements, Frontiers in Pediatrics, Jan. 4, 2023, at 20 https://www.frontiersin.org/articles/10.3389/fped.2022.1057956. "Many of these children have complex and severe socioemotional, psychiatric, and behavioral diagnoses that require a higher level of care . . . . extend[ing] beyond care that can safely be provided at home either with a biological caregiver, kinship care or foster family." *Id.*; *see also* Marlene Lenthang, The boarding crisis: Why some kids are waiting days in the ER for psychiatric ward beds, ABC News (July 1, 2021), https://abcnews.go.com/Health/boarding-crisis-kids-waiting-days-erpsychiatricward/story?id=78432739. (While "[t]here is no nationwide data on mental health boarding numbers or wait times [for youth stuck in emergency rooms awaiting inpatient beds or residential placements,] doctors in New York, Massachusetts and Colorado have painted similar pictures of inundated [Emergency Departments].")

This Administration has developed a five-pronged approach to address the challenges it has preliminary identified. Many of the issues have been long-standing and require focused, collaborative efforts that will take time and intentionality to resolve. However, DHS under this Administration is committed to moving swiftly and deliberately as illustrated by the recent promulgation, effective July 1, 2023, of proposed emergency regulations that will revise COMAR 07.05.01.14 to expand hiring capacity for Child Placement Agencies.

DHS' additional efforts will be focused on:

1. Fully implementing the Family First Prevention Services Act to build prevention services for all children, with an emphasis on ages 0-5;
2. Expanding intervention efforts such as family findings and kinship care supports;
3. Enhancing reunification services to families;
4. Supporting youth transition from foster care to end aging out; and
5. Building Maryland's licensed provider network.

DHS also is partnering with the Maryland Department of Health ("MDH") to build a robust behavioral health continuum of care for all children and youth, improve Medicaid provider integration, and explore other opportunities to collaborate.

DHS will propose and develop detailed action plans for these objectives, subject to further discussion as part of the Executive Branch and the state budget process deliberative process. Additionally, DHS has contracted with the Mosaic Group to provide confidential research and advisory services to examine ways to reduce hospital overstay among children and youth.[4] The Mosaic Group will conduct a national review of best practices in child welfare on the continuum of placement for youth to prevent hospital overstays and review Maryland's current system of care. It will provide a confidential report of its findings and recommendations for an improved system of care to impact the hospital overstay issues. DHS has provided to Plaintiffs' counsel a copy of the contract with Mosaic Group, all procurement documents and materials, the emergency declaration, and any related materials.

In the meantime, Defendants have begun, or have continued, the following actions that exemplify their commitment to this important set of issues.

[4] Secretary's Action Agenda Item A4, May 17, 2023, Board of Public Works, https://bpw.maryland.gov/MeetingDocs/2023-May-17-Agenda.pdf

- Maryland has implemented various evidence-based and promising practices. Over the next twelve months, DHS plans to scale current programs *and develop capacity for additional programs in Baltimore City* and Statewide through the revisions and enhancement of Maryland's Family First Prevention Services Plan. These practices and programs include:

    - **Functional Family Therapy (FFT)**, available in 9 jurisdictions with 95 slots;
    - **Multisystemic Therapy (MST)**, available in 3 jurisdictions with 20 slots;
    - **Parent Child Interaction Therapy (PCIT)**, available in 3 jurisdictions with 79 slots;
    - **Healthy Families of America (HFA)**, available in 7 jurisdictions with 117 slots;
    - **Nurse Family Partnership (NFP)**, utilized in Baltimore City but not monitored by SSA; and
    - **Sobriety Treatment and Recovery Teams (START)**, available in 8 jurisdictions (259 families referred with 132 families consenting to services).

- Crisis services:

    - 211 Behavioral Health Care Coordination: DHS partnered with 2-1-1 Maryland and MDH to ensure that both community and hospital youth discharge planning efforts are coordinated. For more information, please see 2-1-1 Maryland's page (and associated fact sheet);
    - MDH launched a Behavioral Health Hospital Coordination Dashboard in 2022; and
    - In July 2022, Maryland, in coordination with the federal-level rollout of 9-8-8, launched its 9-8-8 suicide and crisis lifeline.

- DHS is developing a Request for Proposals ("RFP") to obtain providers that will provide short-term placement beds to youth who become stuck in undesirable living arrangements while BCDSS and DHS secure a more permanent living arrangement for the youth. Our current targeted release period for the RFP is fall 2023. Additional information will be available at that time.

- DHS and BCDSS are committed to ending aging out. DHS has partnered with the Annie E. Casey Foundation to develop strategies that prevent teens from entering

foster care and ensure that youth who exit foster care do so in the context of family connections with the resources needed to thrive. Planned actions include:

- Conducting a comprehensive landscape analysis focused on preventing unnecessary foster care entries for teenagers and ending aging out by supporting youth and young adult wellbeing. - Targeted Completion 2024
- Creating transformative leadership and strategy development by working to tailor a longer-term strategy for preventing child welfare system entries and ending aging out using Results Count tools and an equitable results framework. - Targeted Completion 2025
- Collaboratively working with sister agencies and the provider community to drive the Quality Service Reform Initiative ("QSRI") with the desired outcomes and targeted completion of FY25 and FY26:

  - Develop classes of residential interventions with defined medical necessity criteria;
  - Establish clear and consistent referral pathways to timely placement of children in the most appropriate settings;
  - Shorten lengths of stay and ensuring that children are in the least restrictive setting;
  - Leverage Medicaid and Title IV-E funds to maximize utilization of federal dollars; and
  - Develop clear expectations and accountability for services provided, rates paid, and outcomes achieved.

- DHS has taken actions to address and understand providers' challenges and needed supports to accept youth:

  - A new, standardized Placement Request form was developed and is being added to CJAMS. This will provide more information to support the appropriate level of care.
  - SSA has requested data from providers regarding denial of placement and reasons for denials. Denials are now being reported to SSA Placement via the central placement unit email *placementand.permanency@maryland.gov*
  - SSA restarted the Provider Advisory Council (PAC) and meets monthly. This has improved communication between providers and DHS/SSA and local departments. The last meeting was June 28, 2023, and the next meeting is

scheduled for July 26. PAC is co-led by SSA and a provider. The provider community is also solicited for agenda items prior to each month's meeting.
  - Two workgroups have been established to discuss how to improve the relationship/communication between local departments and providers and the licensure of child placement providers. Defendants anticipate that these two workgroups will meet monthly for the next several months. Suggestions from the former workgroup have already been implemented and conveyed to pertinent parties.
  - Listening Sessions regarding placement were held in 2023 regionally with local DSS staff, and separate sessions for providers of different levels of care. Information was shared regarding national and state trends, and interactive activities included discussion of what is going well, challenges, and ideas for strategies for improvement

- DHS is working collaboratively with other State agencies to address in-state resources:

  - DHS has worked with the Governor's Office of Crime Prevention, Youth, and Victim Services ("GOCPYVS") as well as other State agencies (DJS, MDH, MSDE) to obtain additional in-state resources to address the lack of beds across the State, to include residential child care (RCC) and residential treatment center ("RTC") beds.
  - DHS is collaborating with other State Agencies to reimage RTC resources, specifically State-run in-state RTCs. DHS has been included, along with other state agencies (DJS, MSDE, MDH) to increase capacity for Facility For Children and hi-intensity RTC beds by constructing a new facility on the grounds of a current state facility. This is in early stages of design currently.

The following are examples of specific BCDSS initiatives already in practice:

- The BCDSS KinCare Center serves as a one-stop resource that provides information and support services to kinship families across Baltimore City.

  - The center supports those relatives caring for children/youth outside of the public child welfare system as well as those involved within the child welfare system. Families accessing the center are connected to Kinship Navigators, experts in navigating and accessing agency and community

resources/services. The Navigators provide information and referrals, and, most importantly, the Kinship Navigator acts as an advocate for the relative provider by helping them navigate various systems. The center's goal is to address the many challenges kinship families face, including financial strain, legal custody issues, educational, emotional, and lack of support, information, and training.

- The KinCare Center provides kinship families with direct access to information, referrals, transportation assistance related to the children in their care, and concrete resources. Onsite specialized supports are available to assist kinship families with educational support and applying for benefits (such as temporary cash assistance ("TCA"), supplemental nutrition assistance program ("SNAP"), and Medicaid ("MA")) and address barriers with accessing and receiving benefits. Other supports available include linkage to therapy, housing, mentoring, daycare, support groups, training/information related to becoming a licensed restricted foster parent, and ways to pursue adoption or custody/guardianship.
- The Center for Adoption Support and Education ("C.A.S.E.") is co-located at the KinCare Center. C.A.S.E. is a non-profit provider dedicated to helping adoptive, foster, and kinship families overcome behavioral health challenges through no-cost specialized individual and family therapy, case management, education, and training. C.A.S.E. offers services to children and parents preparing for permanency and support for families post-adoption and post-guardianship. BCDSS staff can also utilize the center to learn about kinship care and resources available to families.
- Since opening, approximately 300 families have been served.

- The Youth Wellness Program is a comprehensive and coordinated mental health services system designed by BCDSS to meet the complex and unique needs of children, youth, and their families involved with BCDSS Child Welfare Services.[5]

  - The program offers the following services:
    - Individual and Family Therapy
    - Trauma screening & assessments
    - Evidenced-based treatments
    - Psychiatric evaluations & prescriber care services for medication

[5] For a complete description of this critical program, see Appendix A at the end of this letter.

- The goals of the Wellness Program are as follows:
  - Promote placement stability & reunification
  - Intervene with children and youth in crisis to minimize the impact
  - Reduce the frequency of hospitalizations and decrease the utilization of congregate care settings
  - Foster supportive relationships between youth and their caregivers
  - Address historical issues related to disrupted and fragmented services due to transitions in placement, changes in service provider, and a lack of comprehensive screening, assessments and specialized services.

- Approximately 100 Youth are currently enrolled in the Wellness Program and BCDSS expects to continue to increase enrollment as the program continues to grow.

- BCDSS has been designated as one of the pilot jurisdictions for the implementation of the federal and State statutes and guidelines surrounding the process of assessment and court intervention necessary for congregate care placements in Maryland in a State-approved Qualified Residential Treatment Program ("QRTP").

  - BCDSS has created a cadre of seven Qualified Individuals responsible for providing the assessment process required by law and guideline. For a more complete description of the QSRI initiative, see the Attachment 1, *Quality Service Reform Initiative (QSRI) Rate Setting Overview*.

Finally, and significantly, this Administration is committed to doing everything within its authority and ability to support the State of Maryland's efforts to implement rate setting reform as more fully described in the Attachment 1.[6] As explained in the presentation that was shared with the provider community on June 27 and 28, 2023, and subject to the state budgetary process, we intend to implement the rates for residential

[6] The Interagency Rates Committee ("IRC") comprises representatives from the Department of Budget and Management, Department of Health, Department of Human Services, Department of Juvenile Services, Maryland State Department of Education, Governor's Office of Crime Prevention, Youth and Victim Services, and others. See COMAR 14.31.04.02. The IRC is charged with developing and operating a rate process for residential childcare and child placement agency programs that is fair, equitable and predictable.

childcare providers beginning in July 2024 and for child placement agency providers in July 2025.

DISCUSSION

The Challenges of Maintaining the Array of Placements

In June 2023, there were fewer than 1,500 youth in foster care, including individuals over the age of 18, committed to BCDSS. The vast majority – about 80% - were in some form of family home, including, but not limited to regular foster homes, relative foster care homes, kinship care settings, treatment foster care homes, and pre-adoptive homes. The congregate care population for BCDSS youth was approximately 10%. Fourteen youth were in a Residential Treatment Center ("RTC") placement. Independent Living Programs make up approximately 8% of youth placements.

Also as of July 14, 2023, only seven youth committed to BCDSS were in a hospital or psychiatric facility overstay status.[7] Some overstays were for a short duration. Others were for longer periods of time. Although the daily numbers vary, on any given day the numbers are relatively small. In other words, over 99 percent of BCDSS foster youth are not in overstay status. This is not to minimize the seriousness of any overstay, but considering the numbers of overstays in relation to the overall foster care population is necessary for context. Those in overstay are a relatively small subset of the population committed to the care and custody of BCDSS and represent youth with some of the most challenging placement needs.

While Plaintiffs cite specific cases of youth who may not be a danger to themselves or others, the fact remains that the population under discussion includes youth with serious behavioral health issues, medical, or developmental disabilities as well as some with dual diagnoses. Some do present significant public risk factors, including but not limited to

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[7] Alleging noncompliance on the basis of less than one percent of the total plaintiff population is akin to pursuing individual enforcement actions, *see In re Zetia (Ezetimibe) Antitrust Litig.*, 7 F.4th 227, 234 (4th Cir. 2021) (numerosity for class purposes requires more than 20 individuals), which the MCD precludes, *see* MCD I.F at 2 ("[The] Decree does not permit enforcement proceedings on behalf of individual children."). Even with overstays at 3% during the 68th reporting period, June 12, 2023 Letter at 9, that represented a .8% decrease in compliance during challenging times. Only 3% of the *total* plaintiff population faced an incident; pursuing noncompliance on this basis would also be akin to bringing an individual enforcement action.

impulsive behaviors that place themselves and/or others at risk. Some are highly aggressive and have a history of having assaulted parents, siblings, foster parents, other members of foster families, other residents of residential facilities, and staff of both private providers and BCDSS. Some have engaged in fire-setting or sexual assault, and others, as the Independent Verification Agent ("IVA") has acknowledged, have repeatedly run away from their placements. *L.J. v. Massinga* Independent Verification Agent's Certification Report for Defendants' 68th Compliance Report (April 17, 2023) at p. 25. In short, among the foster youth population, these youth have the highest level of need for the most intensive level of services, and many Maryland providers are neither equipped to provide the needed care nor interested in accepting the elevated level of risk required.[8]

The reasons for the challenges in placing youth with highly specialized needs

Defendants collaborate in order to locate and maintain appropriate placements for all children in the custody of BCDSS, including those in hospital overstay status. DHS holds weekly meetings with BCDSS to discuss youth in need of placement or whose placements are in jeopardy. BCDSS has a designated Placement Specialist at the Social Services Administration (SSA) division of DHS. BCDSS also uses family team meetings to address placement challenges and barriers to stability and permanence.[9]

Defendants ask providers what they need to serve youth and offer additional supports including 1:1 and even 2:1 staffing/behavioral supports to maintain a placement

[8] At page 11 of their June 12, 2023 letter, Plaintiffs inappropriately accuse Defendants of putting "much of the onus on the children themselves." That statement is both false and inflammatory. Describing youth as having trauma-based behaviors that present a risk to self or others is not placing the blame on the children. It reflects their having the highest level of need because of their prior trauma(s).

[9] Plaintiffs' claim that those under 13 have serious problems with placement, June 12, 2023 Letter at 11, is incorrect. The placement stability rate for under 13 is 6.52. (Placement stability data, April 2022 - March 2023). While this group has not achieved the national standard rate of 4.48, the placement stability rate does not consider children who come into care and are then stepped down to be placed with a relative, or those who are able to be moved for placement with a sibling during that first year. A child might also need a higher level of care based on behaviors that emerge following removal from the biological family that were not evident at the time of removal, or might need to be stepped down once initial, presenting behaviors stabilize; both moves would be in the child's best interest.

or obtain a placement. DHS also has offered to fund a single room for youth who pose a potential threat to a roommate; typically, placements have two or more youth to a room. When Defendants receive additional information regarding clinical or behavioral improvements, the referral seeking providers is updated and resent for consideration or reconsideration. But often, despite these offers, placements are unwilling to serve youth with highly specialized needs. When there are no Maryland placements available or accessible for the youth, Defendants explore out-of-state placements and continue to offer extensive supports for the youth such as a 1:1 behavioral support.

In recent years, Defendants have encountered difficulty in maintaining sufficient placements for these youth due to factors beyond their control. The MCD was entered in 2009, and as Plaintiffs' own letter illustrates, circumstances have changed. Despite good faith efforts by DHS and MDH to increase needed capacity that Plaintiffs themselves describe, providers have been reluctant to respond to the need, and beds have been lost due to the pandemic and workforce shortages. *See* Plaintiffs' June 12, 2023 Letter at pp. 5, 16. That reality weighs against strict enforcement. The MCD should be interpreted and applied with some degree of flexibility to reflect changed circumstances.[10]

Furthermore, the MCD does not impose a performance standard analogous to strict liability. It requires that Defendants "establish and maintain a continuum of out-home-placements and caregiver supports that is *reasonably calculated* to ensure that each child is placed in a stable, less restrictive and appropriate placement." MCD at p. 17 (emphasis added). Defendants have acted reasonably in establishing a continuum that, as determined by the University of Maryland's Baltimore City Placement Review, has resulted in "[m]ost placements [being] appropriately aligned with BCDSS and DHS policy and [that] matched the level of intensity, restrictiveness, and service need of the children in the stratified sample." Placement Review at p. 16. The vast majority of youth are in appropriate placements.

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[10] *See*, *e.g.*, *New York State Ass'n for Retarded Child. Inc. v. Carey*, 706 F.2d 956, 959, 967-69 (2d Cir. 1983) (addressing, among other things, a modification to a consent decree due to the limited availability of community placements). Although Defendants here have not sought a modification of the MCD, assertions of noncompliance and assertions of grounds for potential enforcement should not be considered in a vacuum devoid of current circumstances. *See Rufo v. Inmates of Suffolk Cnty. Jail*, 502 U.S. 367, 381-82 (1992) ("Because such decrees often remain in place for extended periods of time, the likelihood of significant changes occurring during the life of the decree is increased . . . [Thus], a flexible approach is often essential to achieving the goals of reform litigation.").

Additionally, to the extent that the array of placements is insufficient to result in every child being placed in the least restrictive environment appropriate for the child's needs, the shortages have been influenced by factors outside of the Defendants' control, as previously discussed.[11] In that regard, Defendants also agree with Plaintiffs that MDH must be involved in efforts to create more capacity for the types of placements it licenses.[12] And rate reform, which Defendants have acknowledged is critical to potentially increasing capacity, is now progressing as rapidly as feasible.

Regarding hospital overstays for youth under 13, what has been said elsewhere in this letter regarding older youth applies equally.[13] Defendants are not using hospitals as "placements." Youth are admitted to a hospital when they meet the medical criteria for admission. If Defendants cannot immediately locate an appropriate placement for them when they are ready for discharge, they remain in the hospital while Defendants take all reasonable steps available to find such a placement.

Finally, Defendants acknowledge the potential need for stricter enforcement of contracts with providers who reject or eject youth in circumstances that may be inconsistent with their contractual obligations. Defendants also are assessing potential changes in future contract language. But whether such changes will result in providers actually accepting more youth whom they deem to present an unacceptable risk remains to be seen.

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[11] Additionally, due to Juvenile Justice Reform, youth who may have previously been served by Department of Juvenile Services ("DJS") are no longer eligible for DJS involvement. This reduces access to in-state treatment for sexualized behavior because an RTC provider of treatment to minors with sexualized and offending behavior (Chesapeake Treatment Center) is restricted to youth committed to the custody of DJS.

[12] Programs licensed by MDH include those for the developmentally disabled and for the medically fragile. MDH also licenses therapeutic group homes and Residential Treatment Centers.

[13] Defendants dispute Plaintiffs claim that nearly 60 of all hospital overstays are youth under age 13. According to Defendants' count, there were 47 youth under age 13 during the January 2021 to June 30, 2023 time period with an average length of overstay of 18.6 days, and six of those youth were there for medical not mental health reasons.

Efforts To Address the Placements Challenge

Plaintiffs' letter acknowledges some of Defendants' recent efforts to increase capacity that have met with limited or no success. What Plaintiffs describe is part of an ongoing effort to increase the range of services and programs available to serve foster children through procurements. In 2017, for example, DHS issued an RFP seeking proposals to provide up to 71 beds for youth needing diagnostic, evaluation, and treatment services, but it was able to award contracts for only 24 beds.

In November 2019, DHS issued another RFP for a range of services throughout the State. Only one proposal was received for High Intensity Group Home services for the emotionally and cognitively developmentally disabled; the procurement was cancelled when the IRC refused to increase the rates for the services. In December 2021, DHS issued an RFP for diagnostic, evaluation, and treatment programs and psychiatric respite programs. That procurement was also cancelled because DHS received only one proposal.

DHS is committed to completing the provider rate reform process, which may help substantially in reducing these procurement challenges and in developing a more stable provider continuum of care.

Emergency Shelter Care Homes

Plaintiffs are correct that Defendants have described emergency foster homes as an outdated concept based on the challenges of placing children with high intensity needs in such family settings. Defendants' perspective was supported by analysis and reasoning. *See, e.g.*, Defendants' 68th Court Report at pp. 59-60. Clearly, Plaintiffs' counsel and the IVA do not share Defendants' perspective and are unwilling to accept the views of the BCDSS clinical staff who interact with the youth entering care. Plaintiffs do acknowledge that Defendants have the option under the MCD to seek a modification to address this disagreement. Therefore, Defendants suggest that this issue be included among those on the agenda for the discussions and negotiations.

Relevant to any such discussion is that in lieu of the creation of emergency foster homes, BCDSS has increased its efforts to recruit appropriate foster homes equipped to provide for children and youth who exhibit behaviors that cause them to be difficult to place. Additionally, to help create more appropriate homes to care for harder to place children and youth, BCDSS is offering a series of Caregiver Connection Workshops to its foster care providers on such subjects as: Infants and Toddlers; LGBTQIA+ Youth; Caregiver Grief and Loss; Teens; Attachment Styles; and Caring for Kin.

Other efforts to strengthen existing foster homes have included offering a series of training sessions for foster parents on Trust-Based Relational Intervention ("TBRI"), which occurred from January 24 through March 7, 2023, in a series of weekly sessions. These training sessions were very successful and follow-up sessions have occurred with more scheduled in the fall. Also, multiple efforts are in progress to increase the use of kin and kinship caregivers with skills in place that will enable them to provide appropriate care for kin generally as well as those who have behaviors that make them harder to place.

Finally, as noted previously, Defendants are developing an RFP for short-term beds to serve youth who become stuck in undesirable living arrangements with a targeted posting date of the fall of 2023.

The Alleged Overuse of Maryland RTC Beds

Data collected by BCDSS for the 70th L.J. Reporting period covering the period from January 1through June 30, 2023, will indicate that BCDSS youth occupying RTC placements numbered 24. This accounted for approximately one percent of BCDSS placements. BCDSS does not seek to place a child or youth in an RTC without appropriate supporting documentation regarding the need for the type of treatment provided by the facility. BCDSS has been using the services of its new Wellness Program therapists to assist in seeking the appropriate level of care a youth needs when leaving a hospital setting. These therapists will continue to provide therapeutic services wherever the child or youth is ultimately placed. If the placement is an RTC, the Wellness therapist will assist in developing a plan whenever step down is appropriate. The number of available Maryland RTC beds has also diminished by 272 licensed beds since 2016 (from a total of 607 licensed beds), and four clinical facilities (from a total of 10 clinical facilities in 2016).[14] (See Attachment 2.) BCDSS is seeking to develop more family-based placements including increasing kinship care with the support of its Wellness Program and new Kinship Support Center.

Limited Use of Calvert Street Office

BCDSS makes every effort to limit the use of its Calvert Street office even for brief periods of time while it seeks a placement for youth. BCDSS reports on each child or

[14]Provided by the MDH Office of Health Care Quality, July 17, 2023, Licensed Residential Treatment Center beds. Please note that licensed beds may not correspond to staffed beds, which may fluctuate daily.

youth who is housed at Calvert Street for any period over 4 hours during non-regular business hours as required by the MCD and provides an explanation of the efforts to obtain placement. During the time that these stays occur, all appropriate amenities are provided.

As a result of the COVID-19 crisis, the number of available BCDSS foster homes decreased by 19%. Additionally, the availability of treatment foster homes through providers licensed by the State decreased drastically due to the lack of appropriate staff to supervise the homes engaged with the programs. In Maryland and nationwide, the availability of congregate care placements decreased due to staff shortages.

BCDSS maintains a staff that is engaged in placement efforts 24 hours a day/ 7 days a week. However, placement efforts that are caused by emergent circumstances often arise just prior to or during non-regular business hours. Placement efforts during these periods of time often result in the inability to engage with many possible placement resources that do not maintain after hours contact availability.

BCDSS maintains a number of foster care homes that will take children and youth on an emergent basis, but these homes do not meet the definition of an emergency home under the current MCD due to the lack of a monthly stipend. The existence of these homes often enables placement to occur, but the child or youth may still need to spend some time at Calvert Street while arrangements for placement are in process.

Some children and youth do spend periods of time housed at Calvert Street on multiple consecutive days. This occurs in instances where placement becomes an issue due to the continuation of extreme behaviors exhibited by the child or youth. Having a history of multiple placements results in difficulty in finding a new placement at any level. This results in limited use of the Calvert Street office; the number of children and youth staying at Calvert Street on a recurring basis is small.

Preliminary data for the 70th L.J. Reporting period covering January 1, 2023 until June 30, 2023 indicates that only 1.4% of the children and youth in the care of BCDSS during this period had one or more instances of being housed at the Calvert Street office for 4 hours or longer during non-business hours, with an average time of stay of 10.59 hours during any one incident.

Limited Use of Hotels

Defendants agree that hotels and offices are not placements. As of July 18, 2023, BCDSS has four youth in hotels. That current number represents less than three tenths of one percent—indicating that it is currently the "rare circumstance" Plaintiffs recognized

will occur even with the "proper continuum" of placements. Plaintiffs' June 12, 2023 Letter at 16.

When a youth is in a hotel, BCDSS makes every effort to locate a placement and engage the youth in the Wellness Program. For youth temporarily residing in a hotel while awaiting placement, every effort is made to have that youth continue to attend school where they are enrolled. For youth who attend a non-public separate day school, transportation may be included in their Individualized Education Program and provided for them to continue to attend at their same school.

The current circumstances of the four youth currently in hotels demonstrate the barriers BCDSS faces in attempting to place the youth. Three of the youth in hotels are refusing other placements and sabotage placement interviews. One of the three refuses to interview. The fourth youth is willing to be placed, but it has been difficult to locate a provider given her placement history. Three of the four youth participate in the Wellness Program, and BCDSS is making efforts to engage the youth to cooperate with interviews and accepting appropriate placements. The youth who refuses to interview also refuses to participate in the Wellness Program.

The Creation of High-Fidelity Wraparound Services

Plaintiffs cite to Recommendation 14 in the UMSSW Placement Review urging BCDSS to work with MDH and other agencies to develop, implement, and sustain intensive care coordination using High Fidelity Wraparound and moderate care coordination to serve youth with the moderate to intensive behavioral health needs. While asserting that such services are not widely available,[15] Plaintiffs acknowledge BCDSS's

[15] At various points in their letter, Plaintiffs refer to the lawsuit filed by Disability Rights Maryland and others on behalf of youth outside of Baltimore City who are the subject of hospital overstays. *T.G., et al v. Maryland Dep't of Human Servs., et al* in the United States District Court for the District of Maryland. However, the availability of wraparound services elsewhere in Maryland or the lack of a Wellness program elsewhere should have no bearing here. Baltimore City is unique under the MCD and must be evaluated in its own right. As Plaintiffs acknowledge, there are material differences between Baltimore City and other Maryland jurisdictions. For example, Plaintiffs note "we have not seen Baltimore City foster children shuttled from E.D. to E.D., as has occurred in other jurisdictions." Plaintiffs' Letter at 5. Conflating the two matters shortchanges these differences and inappropriately places BCDSS in a position of having to respond to assertions about actions allegedly occurring in other counties.

new Wellness Program and note Defendants' projection that it will provide much of the service described in the recommendation. Plaintiffs' conclusory speculation that it will not meet the scope of true wraparound crisis intervention should not be given any weight for purposes of determining compliance.

BCDSS also is in the process of recruiting foster care placements that are being offered critical training to assist in providing better and more appropriate care for children and youth with a higher level of need. As further discussed in Appendix A, BCDSS ultimately will be able to offer exemplary mental health services to up to 500 children and youth in the care of BCDSS. As of this time, there have been over 120 referrals to the four agency providers of these services.

BCDSS Methods for Securing Placements for Youth in Overstay Status

In addition to working with DHS/SSA as set forth above, BCDSS works closely with hospitals where BCDSS children and youth are on overstay status. Continual meetings with BCDSS and hospital staff are held to discuss the efforts to obtain placement. Updated information indicating positive changes in behavior while in the hospital is provided to BCDSS staff in order to update the placement information provided to potential providers to encourage changes in position about accepting the child or youth for placement. Placement staff continues regular contact with all potential placement resources to encourage the acceptance of the child or youth for placement.

Currently, the majority of hospital overstays of BCDSS youth are at Johns Hopkins Hospital, and a weekly meeting is held that includes BCDSS, DHS, MDH, and Johns Hopkins-involved social workers and other staff to discuss placement options and efforts and to brainstorm ways to assist in obtaining a placement for the youth.

Similarly, BCDSS children and youth who are not hospitalized but are awaiting a more appropriate placement will also have their placement documentation periodically updated with current information that may aid in the placement effort. This information is provided to any new or previously rejecting providers in order to locate an appropriate placement.

BCDSS staff meet on a weekly basis to discuss all the children and youth on hospital overstay or awaiting a more appropriate level of placement. This meeting includes administration, case management, and placement staff to identify placements for youth who are on overstay or who require a more appropriate placement. This meeting often generates agency staffings or placement FTDMs to further discuss placement alternatives.

The Placement Assessment

As Plaintiffs have noted, Defendants' view is that the recent UMSSW Placement Review was compliant with the specific requirements of the applicable additional commitment. Plaintiffs' and the IVA's views regarding the alleged deficiencies in the assessment reflect their own subjective perspectives about how such a review should be performed. These include reading into the requirements elements of numerosity and specificity that go beyond the plain text. Whatever validity there may be to Plaintiffs' arguments about how to do a "better" assessment, their arguments do not render the assessment noncompliant.

Additionally, BCDSS provided both Plaintiffs' counsel and the IVA with a complete response to the assessment describing its value to BCDSS and DHS. And Plaintiffs also rely significantly on the recommendations in the assessment. *See* June 12, 2023 Letter at pp. 17-20. They criticize Defendants for not adopting four of the assessment's recommendations while simultaneously dismissing BCDSS's assertions that ten other recommendations already have been incorporated into current practice. While not disputing Defendants' assertions about having incorporated the ten recommendations, Plaintiffs complain that it means that Defendants' response is merely "redundant of current practice." The criticism is difficult to fathom.

In any event, notwithstanding the parties' differences of opinion over the recent UMSSW assessment, Defendants suggest that the design of any further assessment be another topic for inclusion on the August 1, 2023 agenda.

Psychotropic Medications

BCDSS has started a process[16] to review all of the children and youth in care as to the receipt of psychotropic medications, the presence of a correct list of these prescribed medications, and of appropriate consents in the CJAMS record of each child or youth. Additionally, any child or youth referred to the BCDSS Wellness program will have a review of their records completed to determine all prescribed psychotropic medications with a special emphasis on any antipsychotic medications prescribed. All youth who are prescribed antipsychotic medications are referred to Shannon Barnett, M.D., who is both a practicing child psychiatrist and a BCDSS consulting psychiatrist, for further review and recommendations as to the appropriateness of the medication.

[16] *See* Attachment 3, released on March 24, 2023; effective April 1, 2023.

Comments About Plaintiffs' Case Narratives

Plaintiffs' counsel incorporated into their June 12, 2023 letter several case specific narratives involving youth in the care of BCDSS. They additionally incorporate by reference similar narratives from the IVA's Response to Defendants' 68th Report to the Court. None of the histories described contain any information that reflects on the diligence and efforts of BCDSS and its DHS partners in ultimately solving placement issues for children and youth who suffered with extremely difficult physical or emotional issues that made the immediate location of an appropriate placement difficult.

The incomplete nature of these narratives is illustrated by the case of C.C. She was involved in a catastrophic automobile accident and was at the Mt. Washington Children's Hospital for a period of many months. During her time there, she received the most appropriate medical care possible. When the hospital indicated she could be discharged, a medical provider was available, but the hospital was uncertain the provider was able to meet her needs. This resulted in continuation of her hospitalization. During this time, C.C.'s father was located and indicated his desire to provide care. He began training at the hospital in order to care for his daughter, and her stay was continued while BCDSS staff worked with her father to obtain appropriate housing where he could reside with C.C. Although these circumstances prolonged C.C.'s hospital stay, C.C. continued to receive exemplary care while waiting to reunite with her father. While C.C. waited for placement with her father, BCDSS located an out-of-state institutional medical placement; but placement there would mean was that C.C could not remain in Baltimore where she had family contacts and support. At no time was C.C.'s physical condition in jeopardy; in fact, she always received the most appropriate care while waiting for the placement with her father. Unfortunately, C.C.'s father passed away in December 2022 after she had begun residing with him, and she was immediately placed in a facility in Maryland that is appropriately meeting her health needs.

Several of the other narratives incorporated into or contained in the allegations of noncompliance also fail to acknowledge the full circumstances and efforts made by BCDSS and DHS in working to provide the most appropriate placement resources for the children and youth in their care. Some fail to appropriately capture the full history that caused delay in obtaining an appropriate placement. None of the narratives consider either the reduction of available placements caused by the onset of the COVID-19 pandemic during the time periods described in the narrative or the fact that initiatives to create more appropriate placements for medically fragile and severely emotionally disturbed children and youth have been met with little interest by the provider community.

School Attendance and Supportive Services

BCDSS maintains an Office of Education with assigned case managers who provide support services to all the assigned out-of-home case managers when school issues are involved. The unit is made up of a supervisor and five case managers who assist with initial school placement consistent with the requirements of the current MCD as well as necessary school transfers when required after a change in placement. BCDSS's goal is to expand the services provided by this unit to assist with any and all issues that may arise regarding the educational needs of the children and youth in care, including those who are residing in hospitals.

The current initiatives include working to develop contacts in all the jurisdictions in which a child or youth in the care of BCDSS may reside and attend school. BCDSS works with the hospital to refer the youth for Home and Hospital educational services. *See* COMAR 13A.03.05.01-.04. While awaiting approval and implementation of this service, youth are provided with homework packets or access to a tablet to complete assignments. Once a youth is accepted for "home and hospital services," as recognized by Plaintiffs' in their letter at page 22, those services are provided by the school system, not by Defendants; Defendants cannot control the provision, quality, or quantity of services. *See* COMAR 13A.03.05.03 (detailing that each local school system determines the manner it will offer instructional services and requiring only a minimum of 6 hours of instruction per week for a full-time student).

Additionally, BCDSS may not and has not always been able to promptly and satisfactorily address educational needs while a youth is in a hospital. During the height of the COVID-19 pandemic, Home and Hospital services were unavailable. There is one hospital that still does not permit in-person or remote instruction. BCDSS and local school systems are also challenged when youth refuse to complete assignments while in the hospital.

Defendants suggest this issue also be a subject of our August 1 discussions.

CONCLUSION

Meeting the needs of youth with complex emotional, behavioral, and medical needs in the custody of BCDSS is an ongoing, highly multifaceted challenge, but it is a challenge that the Defendants are committed to meeting and to exploring ways to address. And neither a finding of noncompliance nor an enforcement action is warranted against BCDSS or DHS.

There is no one-size-fits-all method to address the challenges. Defendants look forward to August 1 discussions to further workable solutions to address the needs of the youth.

Very truly yours,

/s/

David E. Beller

/s/

Janet F. Hartge

APPENDIX A
BCDSS YOUTH WELLNESS PROGRAM

The Youth Wellness Program or "Wellness" for short, is a comprehensive and coordinated mental health services system designed by BCDSS and its partners to meet the complex and unique needs of children and youth, and their families involved with BCDSS Child Welfare Services.

- What services are offered through "Wellness?"
  - Individual and Family Therapy
  - Trauma screening & assessments
  - Evidenced-based treatments
  - Psychiatric evaluations & prescriber care services for medication
  - Crisis services

  Neuropsychological Evaluations - it is important to note that these are highly specialized forms of evaluation designed to assess brain/CNS functions, structures, pathways, and cognition. Neuropsychological Evaluations are **not** available through Wellness; however, MATCH or a BCDSS Mental Health Navigator can assist with identifying resources for these exams.

  Certificate of Need "CON" - the required examinations needed to complete a CON are available through Wellness Program clinics; however, there is never a guarantee that the physicians, psychologists or psychiatric nurse practitioners who are permitted to complete CONs will agree with our, or another professional's assessment, that an RTC setting is required to meet the needs of the child or youth. If you are seeking RTC admission and need support to identify the resources who may complete a CON, please contact a BCDSS Mental Health Navigator and BCDSS consulting psychiatrist, Dr. Shannon Barnett shannon.barnett@maryland.gov for assistance.

- What are the goals of the Wellness Program?
  - Promote placement stability & reunification
  - Intervene with children and youth in crisis to minimize the impact
  - Reduce the frequency of hospitalizations and decrease the utilization of congregate care settings
  - Foster supportive relationships between youth and their caregivers
  - Address historical issues related to disrupted and fragmented services due to transitions in placement, changes in service provider, and a lack of comprehensive screening, assessments and specialized services.

- How is the Wellness Program funded?
  The Wellness Program is fully funded for therapy services and supports the utilization of a broad array of therapeutic interventions. The program's therapy services do **not**:

  - Have the limitations of Medicaid (Medical Assistance) reimbursement - this means we can seek as much service for a child/youth as they need
  - Subscribe to payer-based utilization reviews or service capitation - this means there is no limit to how often or for how long therapy services can be provided
  - Adversely impact the delivery of pre-existing services billed through public or private insurance - this means a child/youth in Wellness may also have an existing therapist, or be involved with a TBS, PRP, or PHP without a billing/insurance conflict. It also means that a child/youth placed in a Treatment Foster Home, Group Home or RTC, can receive services from a Wellness therapist in addition to the therapy services offered by these placement settings.

  Caveat: Psychiatric evaluations and any prescriber services (medication management) provided through Wellness Program clinics must be billed to Medicaid. In this case, the clinics will handle all of the approval, processing and billing.

- What are the advantages of accessing therapy services through the Wellness Program?
  - The frequency and intensity of services is adaptable and needs-driven. Therapy is flexible and may be increased (or decreased) based on expressed need, assessed need, or treatment goals.
  - Wellness Therapists are intended to serve as the "Home Therapist " for our children/youth and can follow youth along their Child Welfare Services pathway.
  - Youth exiting care may choose to continue therapy or prescriber services with the same clinic that provided the Wellness services as a non-Wellness client through Medicaid or are free to choose another provider.
  - BCDSS Wellness Program staff meet with the therapists delivering services to our children and youth every other week for updates so there is a high level of agency participation and engagement in the support and monitoring process.

- Is there an age limit or how old do the children have to be to participate in Wellness?
  The Wellness Program is intended to serve children and youth ages 3-21 and their families.

  For children who are 5 and younger, it is important to "team" with a Mental Health Navigator prior to making the referral to Wellness. Therapy services to young children are specialized interventions designed to give young children an outlet for emotional expression through play.

- How many therapists are there and how many clinics are involved with the Wellness Program?
  The Wellness Program is designed for 20 therapists providing services exclusively to BCDSS children and youth - this means that the therapists are dedicated to serving the agency and are not seeing other clients.

  The plan is for each of the 4 clinics to hire 5 therapists. The Wellness Outpatient Mental Health Clinics (OMHCs) include:
  - A Better Tomorrow Starts Today (BTST)
  - Advanced Behavioral Health (ABH)
  - Hope Health Systems
  - Institute for HEALing (iHEAL)

  At capacity, the Wellness Program will be positioned to serve up to 500 children/youth.

- Are the Wellness therapists licensed clinicians?
  Yes, the Wellness Program expects the therapists to be either LCSW-C/LCPC practitioners or LMSW/LGPC therapists who receive clinical supervision from a LCSW-C or LCPC.

- Have the therapists received any training on working with our children/youth and families?
  Yes, Wellness and BCDSS Learning Office staff offer an orientation to working with children and families served by the agency - *Child Welfare 101*.

  All of the Wellness therapists are also expected to participate in a specialized training BCDSS developed in partnership with the University of Maryland - School of Social Work, Black Mental Health Alliance and the Healing Youth Alliance. This training is known as the *Baltimore City Foster Care Clinician Curriculum.* The curriculum was grounded in:
  - Youth & family voice
  - Implementation science
  - A culturally relevant and responsive approach to delivering services

  This training involves 9 sessions for the therapists totaling 53 learning hours as well as a full-day session for Supervisors.

  The clinics also offer their own in-service training and skill development for their therapists.

- Are there any male therapists and is there diversity among the therapists?
  Unfortunately, there are no male therapists in the cohort at this time.

  The therapists offer a broad range of skills, professional, and lived experience and all of them selected into working with BCDSS' children, youth and families through the Wellness Program. There is racial diversity in the therapist cohort to support the needs or preferences of our children/youth.

- Is there a waitlist to access services or how long does the process take?
  There is no waitlist to access the Wellness Program's therapy services. Prescriber services (medication management) are scheduled by the clinic and are subject to the schedule of the prescriber - most appointments with a prescriber can be scheduled within 30 days of the child/youth's Intake.

  As with any mental health service provider, Wellness clinics do **not** write emergency prescriptions for children/youth who are not already seen by the clinic or under the care of the prescriber. If a child or youth is discharging from an RTC or hospital with a limited supply of medications and that child or youth is part of the Wellness program, please contact the Wellness therapist prior to discharge to arrange for the child/youth to be seen by the clinic's prescriber if ongoing medication management will be needed through a Wellness clinic.

  Wellness Intake Process:
  - From the decision to refer a child/youth to the Wellness Program, staff can generally expect to receive the referral request and link to the Wellness referral from a Mental Health Navigator within 1-2 days.
  - We ask that the referral to Wellness be completed by the BCDSS worker or Supervisor within 1 business day.
  - After the worker completes and submits the referral, the Mental Health Navigator waits 3 business days before sending the referral to a Wellness clinic. This time is provided so that the worker can:
    1. Inform the youth of the referral to Wellness for therapy.
    2. Inform the caregiver or provider of the referral to Wellness.
    3. Begin to identify and collect the pertinent mental health history needed to complete the Intake process and initiate services.
  - Typically, within 1-2 days of receiving a referral from the Wellness Program, the assigned therapist will reach out to the worker by phone and email to schedule the Intake appointment.

12. Where and how are Wellness therapy services provided?

The Wellness Program generally expects that the child/youth's Intake occurs in-person. The Intake meeting should include the BCDSS worker, the child/youth, and the caregiver. It is generally preferred that the Intake meeting take place at the youth's placement and will require some coordination on the part of the BCDSS worker.

Following the Intake, the therapy services may be delivered in the home/placement setting, in the community at a predetermined and pre-arranged setting, at the clinic, or via Telehealth (Zoom or other virtual platform). Wellness therapists routinely report checking-in via text with youth who have a cell phone or have access to a cell phone.

The Wellness Program does **not** offer services to BCDSS youth who are placed Out-of-State (OOS). If you are responsible for a youth who is placed OOS and is soon returning to Maryland, consider teaming with a Mental Health Navigator about the youth's needs. In these instances, it is typically best to refer youth to the Wellness Program 30 days prior to their return to in-state placement.

Wellness services **are provided** when the youth lives in a Maryland jurisdiction outside Baltimore City.

13. If a youth is placed in an in-state Residential Treatment Center (RTC, i.e. Sheppard Pratt Mann, Woodbourne, St. Vincent's Villa, RICA, etc.) when is the best time to refer a youth to the Wellness Program?
    Youth who are placed in Maryland's RTCs, are routinely provided a range of therapeutic services while in these settings. Often, this includes therapy providers at school and within the RTC's milieu in addition to individual and group sessions all focused on addressing the youth's emotional and behavioral needs. Youth may also have a mentor, CASA, and an attending psychiatric nurse practitioner or psychiatrist, etc., who interface with them regularly.

    When a youth who is placed in an RTC is approaching discharge to a less-restrictive setting, that is the best time to consider a referral to the Wellness Program. Typically, referring to Wellness **60 days prior to discharge** allows enough time for the Wellness therapist to connect with you and the youth to complete an Intake, connect with the RTC's clinical team about the discharge plan, and to understand the youth's Treatment Plan and any post-discharge recommendations.

14. How are Consents or Releases of Information (ROI) handled?
    For youth under 18 years old, Consent to Treatment may be completed by the BCDSS worker, child's parent/guardian, or by the Assistant Director of Behavioral Health.

For older youth 18+, they must sign a Consent to Treatment in order to receive Wellness therapy services. They may also choose (or choose not) to sign a ROI to allow information about their care to be shared with other parties.

Generally speaking, even if BCDSS holds limited guardianship and may exercise its authority to consent for therapy, it is best practice to seek consent from a child's parent/guardian if they are available and engaged in the child's care, i.e., whereabouts are known, visiting, attending meetings about their child's care, moving toward reunification, etc.

15. What happens when a child/youth referred to Wellness refuses to participate or does not want therapy?
If the youth is 18 or older, s/he may decline Wellness services and, if so, the referral is closed. An older youth who declines may be referred again should his or her position on therapy change.

Therapy is hard-work and there are often strong feelings about it from our children and families - both negative and positive. Generally, for youth under 18 our goal in the Wellness Program is to work with the child's team (worker & Supervisor, caregiver/provider, child's attorney/CASA, and other positive and supportive persons in their lives, etc.) to overcome obstacles to participation whenever possible. It is our hope that the child's team will support participation and engagement in the therapeutic process. Wellness therapists will continue outreach efforts to a child or caregiver on a regular basis to offer services or support until the Wellness Program closes the referral or places services on-hold.

There is no automatic discharge from Wellness therapy services for X amount of no-calls/no-shows as may be the case in most other outpatient mental health settings.

16. How do I make a referral to the Wellness Program?
Contact a BCDSS Mental Health Navigator to discuss the child/youth's needs and to determine whether the Wellness Program offers the best option for the child/youth to access therapy or supportive mental health services.

Patricia Keene, LCSW-C Patricia.Keene1@maryland.gov Agency cell: 443-890-6028

If the decision is to move forward, the Mental Health Navigator will send you a link to the Wellness Program's referral form which is very easy to complete and submit.