

INTRODUCTION

As of June 30, 2004, 10,738 children were in Maryland's out-of-home placement system, 490 fewer than we reported last year, a 4.4% decrease.

Status of the Child Welfare System in 2004

- ◆ The federal Child and Family Services Review (CFSR) – an audit that encompasses best practices and in-depth assessment of outcomes for children – was conducted through field activities of a federal-State team in the fall of 2003. The federal government issued its report on June 8, 2004. In FY 2004, the Department of Human Resources (DHR) and the Social Services Administration (SSA) asked key stakeholders to collaborate on creating a Program Improvement Plan (PIP), which will be submitted to the federal government as the primary response to the results of the CFSR. As the development of the PIP proceeded, SSA became more and more guarded. The PIP was submitted to the federal government on September 9, 2004, but at this writing, citizens have not seen the final version.
- ◆ The State continues to project an overall structural budget deficit, although the size of the deficit seems to be getting smaller. Child welfare services to families and children have been reduced, but total DHR child welfare spending rose to \$444 million (3.2%) in 2004 because more was spent on high-cost forms of care for about 3,000 children.
- ◆ The State continued to struggle with a child welfare workforce that is very substantially below the strength needed to protect children, implement permanency plans, and promote the well-being of children for whom the State is responsible. The General Assembly required that DHR fill a number of vacant positions or undergo financial sanctions.
- ◆ The Child Welfare Accountability Task Force established by the Department of Budget and Management issued its mandated report to the General Assembly.
- ◆ Fewer children are entering care, and a smaller proportion of those are associated with parental substance abuse; length of stay seems to be moderating.

GOALS OF CRBC'S 2004 ANNUAL REPORT FOR OUT-OF-HOME PLACEMENT

- ◆ To review strengths and development needs of the out-of-home placement system and provide recommendations to promote achieving CRBC's priority goals. (See pages 2-4.)
- ◆ To provide a profile of Maryland's children in out-of-home placement during FY 2003. Data are obtained from CRBC's database and from DHR's Foster and Adoptive Child Tracking System (FACTS). (See pages 5-11.)
- ◆ To analyze the results of the federal Child and Family Services Review. (See pages 12-13.)
- ◆ To analyze the Report of the Child Welfare Accountability Task Force. (See page 14-17.)
- ◆ To report on the results of case reviews conducted by local boards during fiscal year 2004. (See pages 18-21.)

PRIORITY ISSUES AND RECOMMENDATIONS

CRBC'S ADVOCACY PRIORITIES FOR FISCAL YEAR 2005

The Children's Legislative Action Committee (CLAC) is comprised of CRBC volunteers who advocate for statewide improvement in child welfare policies and legislation. Analysis of data and members' case review experience are tools CLAC uses to in developing priorities on which to focus its annual advocacy activities. The three priority areas for 2005 are:

◆ **Improve Accountability for Child Welfare Services**

As a result of advocacy by CRBC and the Coalition to Protect Maryland's Children, and with the leadership of Delegate Samuel I. Rosenberg, the General Assembly requested that the Department of Budget and Management (DBM) create a Child Welfare Accountability Task Force to study DHR's child welfare accountability system and charged the Task Force with developing recommendations in five specific areas:

1. A method to determine reported and unreported child abuse and neglect;
2. Performance measures and qualitative assessment tools for individual cases;
3. Best practices for delivering child welfare services;
4. Measures of child and family outcomes, and;
5. An analysis of how the State might maximize federal revenues.

The Task Force completed its report in early December 2004, and made 16 recommendations. (In-depth discussion can be found on pages 14-17.)

Recommendation:

- ◆ **The State should implement the recommendations of the Task Force. In doing so, the State should assure the continuation of an independent case review component in the accountability system. (See discussion on page 17.)**

- ◆ **Continue to implement the Child Welfare Workforce Initiative of 1998 (HB 1133)**
 During the 2004 session of the General Assembly, DHR reported that it had 1,814 caseworkers and supervisors actively deployed in late 2003 and needed 204 more to meet standards adopted by the Legislature. In acting on the FY 2005 budget, the General Assembly has required that 1,891 positions be filled or that DHR forfeit up to \$3.5 million in State general funds. As of the first deadline (October 1, 2004), DHR reported that it intends to meet the goal, but needed 138 more staff, citing recruitment difficulties and a late start in gearing up to increase hiring. DHR has agreed to provide clear figures to all interested persons regarding how many child welfare staff are deployed and how many are needed to meet the caseloads standards established by the Child Welfare League of America. DHR has accepted CRBC's recommendation that caseload standards will incorporate cases of children in after care, which previously had been omitted from the caseload in calculating how many positions are needed. We are also pleased to report that the counties with the most serious workforce shortages (on a percentage basis) did get substantial relief since we issued our 2003 report, which highlighted that issue.

After the enactment of the Child Welfare Workforce Initiative of 1998, DHR developed a methodology for determining how many caseworkers and supervisors would need to be hired to meet standards established by the Child Welfare League of America. For each of the following service categories, the staff requirement is calculated by dividing the caseload by the caseload ratio standard established by the League:¹ (See Exhibit I) In addition, it is assumed that one supervisor is needed for every five caseworkers.

¹ For example, in 2001, there were 876 family preservation cases and the CWLA ratio is 1:6. Therefore, 146 caseworkers were needed.

Exhibit I
Caseload Ratios by Type of Service – DHR Formula

Type of Service	CWLA Ratio Standard
Intensive Family Preservation	1:6
Child Protective Services Investigations	1:12
Child Protective Services Continuing	1:17
Child Protective Services Screening	Special DHR formula
Foster/Kinship Care	1:15
Adoption (Child's Case)	1:16
Adoption (Prospective Adoptive Family)	1:30
Services to Families with Children	1:15

Then, the total number of staff to be added is determined by subtracting the number of incumbents from the total need. For some of the calculations, counties with excess staff were held harmless.

Foster parent support services are excluded from the formula. This practice carries negative consequences for the children and for the State. Maryland lost about 1,200 foster homes (more than 25%) between October 2000 and April 2004. If foster parents lack support, it may be more likely that a difficult child will have to be re-placed. The State is experiencing a costly shift of children into more restrictive and more expensive forms of care. (For more on the increasing cost of care, see <http://www.dhr.state.md.us/crbc/annual/2003ohp.html>, pages 14-16 of our 2003 Annual Report.) Increasing foster parent support could be a viable strategy for reducing costs and for placing children in the most family-like settings.

The formulas for family preservation, continuing child protective services, and continuing services to families with children cases do not accurately indicate the true need for those service categories because the dramatic decline in staffing levels that occurred between October 2001 and July 2004 has artificially reduced the number of cases. As local departments experienced an increasing number of vacancies, caseworkers are shifted to child protective services investigations and foster care. The other categories are left without staff and fewer such cases are opened. Since the formula that calculates the need for caseworkers is totally dependent on the number of active cases, the hiring slowdown became a self-fulfilling prophecy that now falsely signals a need for fewer workers. During this period, the number of child protection investigations fell by about 4%, but family preservation fell by 33%, services to families with children by 41%, and continuing child protection by 14%. If these categories had stayed level, the formulas would show a need for 99 additional caseworkers and 20 additional supervisors. In addition, several hundred positions occupied by non-professional support staff – clerks, secretaries, transportation aides, casework aides – have been lost since October 2001.

The current approach of tying caseload allocations to the number of active cases (to the exclusion of all other factors) gives local departments an incentive to pad the caseload. This becomes a problem in times when the budget is in surplus. Measures of a jurisdiction's need for child welfare services could be included in the formula. For example, Oregon incorporates into their allocation formula factors such as the frequency and relative severity of abuse/neglect allegations phoned into the various counties and their respective return home rates. (See <http://www.cwp.pdx.edu/html/pgAllocation.shtml>.)

Finally, CRBC recognizes that a substantial upgrade in staff training is also needed to fully respond to the Workforce Initiative, performance issues raised by the CFSR, and the recommendations of the Child Welfare Accountability Task Force.

Recommendations:

- ◆ **The State Budget should include a number of caseworkers and supervisors that will ensure meeting the caseload standards established by the Child Welfare League of America. The budget should also allow for staff to be hired on a continuous basis so that trainees can replace departing staff without the delays that currently plague the system. The Governor should propose an adequate number of casework staff in his budget. Failing that, the General Assembly should enact legislation requiring that the budget meet the established standards. In calculating the number of staff required to meet the standard, there should be a one-time adjustment to increase family preservation and foster parent support services at least to their October 2001 levels.**
- ◆ **DHR should adopt a new caseload allocation formula based on caseloads and indicators of need for each jurisdiction such as the child population, child poverty, and number and severity of maltreatment reports.**
- ◆ **Training and quality of supervision should be priorities for DHR and should focus on child protection, permanency, placement reform, substance abuse treatment, accountability, and safety in out-of-home placement. In the long term, DHR should establish a child welfare training academy as recommended by the Child Welfare Accountability Task Force (see below).**
- ◆ **Report, Investigate, and Prosecute Child Abuse and Neglect, Assist Families and Protect Victims.**
 - 1) Results of case reviews by Maryland's local child protection panels indicate a need to improve thoroughness of investigations and risk and safety assessments. Both the panels and federal auditors found that too few families get appropriate services following a finding of maltreatment. National data shows that Maryland provides services to only 15% of victims, the nation's lowest rate. The State is missing opportunities to identify families and children sooner and to intervene more effectively and more cost-effectively. In addition, all children in State custody through a local department of social services or the Department of Juvenile Services should be protected from abuse and neglect.

Additional information is available in our 2003 Child Protection Report at <http://www.dhr.state.md.us/crbc/pdf/child03.pdf>.

Recommendations:

- ◆ **DHR, in collaboration with key partners in the health, education, law enforcement, and legal communities, should define new standards for:**
 - 1) **what constitutes a thorough investigation of maltreatment allegations;**
 - 2) **protection of children who are found to be abused and neglected; and**
 - 3) **protection of children in State custody.**
- ◆ **In order to protect vulnerable children and build families' capacity to meet their children's needs, DHR – in partnership with the Department of Budget and Management and the Governor's Office for Children, Youth, and Families – must find a way to increase family support and family preservation services.**

MARYLAND'S OUT-OF-HOME PLACEMENT POPULATION

ENTRIES INTO OUT-OF-HOME PLACEMENT FOR FY 2003 AND FY 2004

CRBC defines an entry into out-of-home placement as the beginning of any episode including when the child remained in care for one day.² Exhibits II and III show the changes and trends of the out-of-home placement entries. The overall number of entries was up 1%. Exhibit II shows that the number of children with special needs seems to have risen significantly. This could be related to the implementation of new policies, including relaxed terms for voluntary placement, regarding children who enter care because of their own needs for treatment for mental health or developmental delay rather than because of maltreatment. (See, however, Exhibit III, below, for contradictory evidence.)

Exhibit II
Characteristics of Children Entering Placement, FY 2003 and 2004³

Characteristics	2003	2004	Relative Rate of Change
# of entries	3838	3876	+1%
% Male	49%	50%	+2%
% Female	51%	50%	-2%
% African-American	64%	64%	0%
% White	29%	28%	-3%
% Hispanic	2%	2%	0%
% under 5 years of age (at placement)	38%	38%	0%
% between 5-11 years of age	30%	29%	-3%
% between 12-18 years of age	32%	33%	+3%
% of children in sibling group	43%	41%	-4%
% with parental substance abuse as case factor	54%	51% ⁴	-6%
Children with special needs ⁵	47%	50%	+6%
% addiction/dependency	13%	12%	-8%
% emotional problems	19%	24%	+26%
% mental retardation	2%	3%	+50%
% developmental disabilities	3%	4%	+33%
% learning disabilities	2%	3%	+50%
% medically fragile	13%	11%	-15%

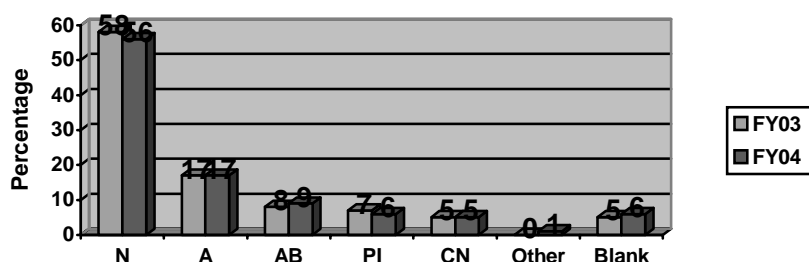
² SSA does not include one-day episodes or disrupted aftercare in its count of entries. This will result CRBC having a higher number of entries and re-entries than SSA. Our definition is based on the child's view of disruptions in living situation.

³ In this and similar Exhibits, categories may not add to 100% due to rounding error, and percentage increases are approximations.

⁴ For children entering in FY04 under the age of five, parental substance abuse factors apply to 64% of cases that factors; for children under two – substance abuse factors are 71% of cases with factors.

⁵ The "Children with special needs" category is the percentage of children entering placement who had a documented special need, considered only those where the special needs data was completed.

Exhibit III Primary Reasons Children Entered Care during FY 03 & FY 04



Abbreviations

N – neglect

A – abuse, including physical & sexual abuse

AB – abandonment

PI – parental illness

CN – child's special needs, including behavior problems

Other – includes death or Incarceration of parent or caregiver

Source: CRBC/CIS

Statewide, neglect is overwhelmingly the primary reason children enter out-of-home placement. No increase is discernible in the proportion of entries due to “child’s special needs.” It is possible that an increase in children entering due to mental health or developmental problems is masked here because of confusion over how to register the primary reason for that type of situation. DHR should report on how many children entered under the reforms.

Length Of Stay in Out-of-Home Placement for FY 03 and FY 04

CRBC uses three methods to evaluate length of stay in out-of-home placement.

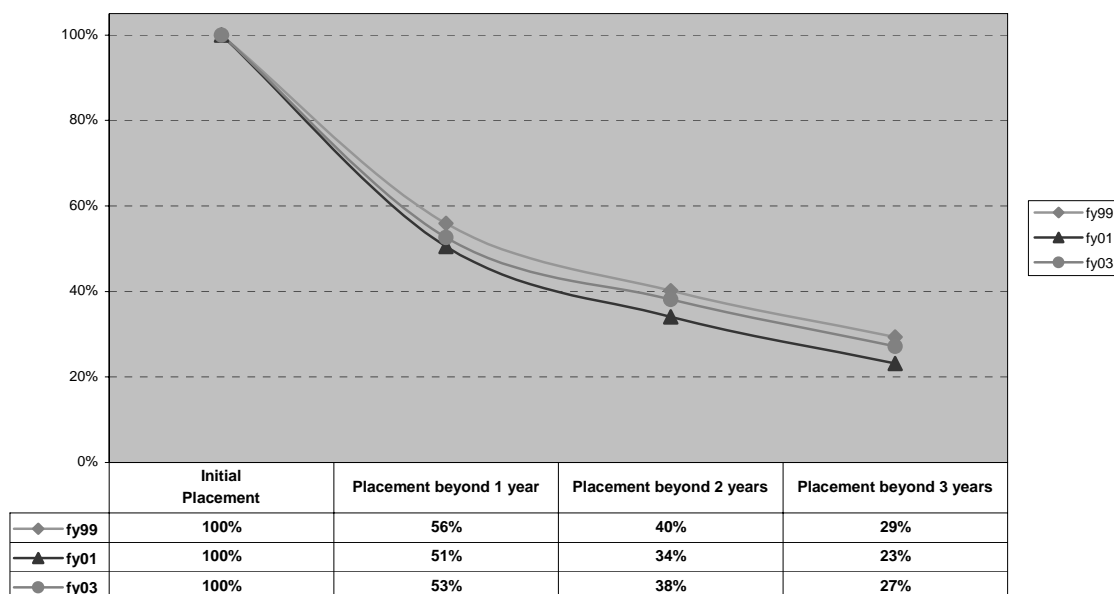
Actual Average Length of Stay (AALS) - Measures how long children who left placement during a specified period had been in out-of-home placement. This method does not consider children who are currently in care and may have been in care for a long period. It can provide an overly optimistic perspective if a large percentage of children exiting in a given year have had short-term stays in out-of-home placement. **The actual average length of stay for both FY 03 and FY 04 was 29 months.**

Projected Average Length of Stay (PALS)- Equals the average daily population during the reporting period divided by the number of exits during the reporting period. PALS is the only measurement that accounts for the experience all children who were in out-of-home placement for the reporting period and is less affected by children who remain in out-of-home placement for 6 months or less (generally 1/3 of the population will have short stays). **In FY 03 PALS was 34 months and it dropped to 32 months for FY 04.** The narrowing of the gap between AALS and PALS indicates that the system is not experiencing major changes in case flow dynamics as it was throughout the 1990s. In a totally stable system, AALS and PALS would be the same. (See pages 10-11 for further discussion of this issue.)

Cohort Analysis – A group of children who entered care during an interval are followed to see what percentage leave by specified intervals. The length of time that a child has spent in care has an impact on the child’s prospects for permanent placement. Exhibit IV shows that a child’s chances of leaving out-of-home placement drastically decline after the first year in care.

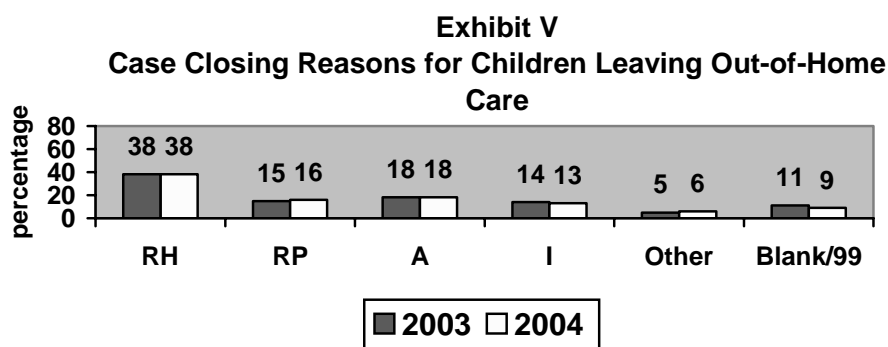
Exhibit IV measures exit and not necessarily permanent placement. It shows that for children who entered placement in 2003 a higher percentage left placement (by the specified time intervals) than those who entered in 1999 but not as high a percentage as for the 2001 cohort. (2003 data are used because 2004 data are too preliminary to show trends as of this writing.) This result suggests that length of stay will be leveling off rather than continuing to decline.

Exhibit IV Percentage of Children Remaining in OOHP After Specified Intervals⁶



EXIT FROM OUT-OF-HOME PLACEMENT

During FY 04, 4138 children exited placement; 4185 exited during FY 03. Analysis of exit reasons relies on case closing data, which are slightly different from exit data. Exit occurs when a child returns home while case closing may not occur until a period of aftercare is completed.



Abbreviations

- RH – returned home
- RP – relative placement with le
custody to the relative
- A – adoption
- I – independence/age
- Other – unrelated guardian, ca
transfer, not appropriate
care, runaway, child diea
court-ordered return hom
against DSS advice
- 99 – Other

Source: CRBC/CIS

Figure 1

For several years, there has been a declining proportion of case closings for the desirable reasons of returned home, relative placement, and adoption. The percentage of children leaving care by reason of independence/age had been rising. FY 04 reverses that trend – it dropped from 14% to 13%. Since reports of adoption lag for months, it is likely that the proportion shown as adoption will rise when more complete data are available. Case Closing reason “99” is listed on FACTS as “Other.” Since, the interpretation of that code is ambiguous, it is good to see that figure dropping. Overall then, there is a modest trend towards better

⁶Data for children entering in FY 2003 for “Placement beyond 2 years” are projected from incomplete results; for “beyond 3 years” are estimated from prior years’ experience.

length-of-stay, and permanency-planning outcomes, but the extent of the problem is enormous. Further discussion of the length-of-stay issue can be found below.

Adoption Process

Maryland is not meeting the federal standard of completing a high proportion of adoptions within two years. More importantly, children are losing their opportunities to have permanent homes. CRBC believes that the causes of this unfortunate phenomenon include 1) general problems with permanency planning that are discussed in the section on the Child and Family services Review; 2) rising caseloads; and 3) specific reductions in programs and contracts that are intended to recruit, screen, train, and approve adoptive families.

Exhibit VI
Average Number of Months to Complete Adoption Process for FY 04 Exits⁷

Process	Average Number of Months to Complete Adoption Process for FY 04 Exits ⁷					
	Baltimore City		Baltimore County Montgomery County Prince George's County		Other Counties	
	2003	2004	2003	2004	2003	2004
Establish plan of adoption	39	36	20	23	14	18
File TPR ⁸	6	5	5	3	5	5
Obtain TPR	16	14	15	11	11	14
Final Adoption	64	66	47	43	38	39

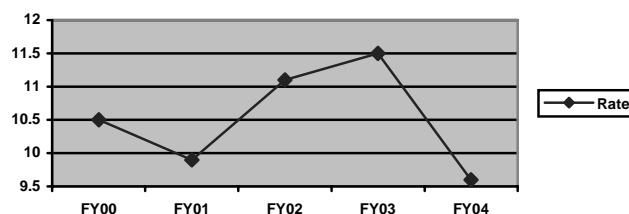
Source: CRBC

Data on children who exited out-of-home placement through adoption show the larger the jurisdiction the longer the process to final adoption. Note that in 2004, times to file and obtain TPR dropped in Baltimore City and the larger counties. Time to establish the plan fell in Baltimore City and generally rose in the counties. Still, Baltimore City took three years to establish a plan of adoption, much longer than other jurisdictions.

Delays in the adoption process lead to serious consequences. Only about 40% of the children who have a permanency plan of adoption ever get adopted. Once the plan has been adoption, return home or relative placement is extremely unlikely; therefore, adoption delays often mean children grow up in care. The number of adoptions dropped in 2003. It appears to have risen modestly in 2004 to 746, but not enough to reach the 2002 level, when 935 adoptions occurred (more than 21% of the cases closed). SSA's goal for finalizing adoptions in FY 2004 was 950.

Re-Entries Into Out-Of-Home Placement Exhibit VII

Percent of Children who Re-enter Out-of-Home Placement Within One Year of Leaving



⁷ The entries in months first three rows (establish plan, file TPR, obtain TPR) apply only to the indicated step. The bottom row (final adoption) is cumulative from entry to adoption. (This is *not* the sum of the previous steps for a variety of technical reasons.)

⁸ This data field includes only children within the CRBC review population.

Slightly more than a quarter (26%) of children entering placement had prior episodes of out-of-home care. CRBC tracks the percentage of children who re-enter placement within one year of leaving placement in order to give a perspective on the appropriateness of permanent placements and the effectiveness of after-care services. Exhibit VII shows a fluctuating rate of re-entry with the latest results showing a substantially lower re-entry rate. A rise in the re-entry rate is often associated with an increase in the percentage of children with shorter lengths of stay; however, the most recent results break this pattern. (See Exhibit III.) Considering the critical nature of re-entry in children's lives, we recommend that DHR investigate the factors that cause this fluctuation. In all the years we have been tracking indicators such as these, however, there has not been exhaustive investigation of causes and effects. This highlights the need to implement Task Force Recommendation 5, which proposes a partnership with a research institution that would generate and analyze statistics. (See page 14.)

Maryland's Total Out-of-Home Placement Population

Exhibit VIII

Profile of Maryland's Out-of-Home Population for Fiscal Years 2003 & 2004

Characteristics	2003	2004	Rel. Rate of Change
# of children	11228	10738	-4%
% Male	52%	52%	0%
% Female	48%	48%	0%
% African-American	76%	76%	0%
% White	21%	20%	-5%
% Hispanic	1%	1%	0%
% under 5 years of age (at placement)	38%	37%	-3%
% between 5-11 years of age	39%	39%	0%
% between 12-18 years of age	23%	24%	4%
% under 5 years of age (end of FY)	18%	18%	0%
% between 5-11 years of age	29%	27%	-7%
% between 12-18 years of age	41%	42%	2%
% over 18 years of age	12%	12%	0%
% of children in sibling group	65%	66%	+2%
% with par. substance abuse as case factor	65%	63%	3%
Children with special needs			
% addiction/dependency	8%	8%	0%
% emotional problems	25%	27%	8%
% mental retardation	4%	5%	25%
% developmental disabilities	4%	4%	0%
% learning disabilities	4%	4%	0%
% medically fragile	9%	9%	0%

Percentages may not add to 100 due to rounding error or incomplete information.

Data on all children in out-of-home placement on the last day of the fiscal year (June 30th) for 2003 and 2004 are shown in Exhibit VIII. It suggests:

- The overall trend towards a smaller population since 1997 continues.
- There is modest movement towards a population of teenagers.

- The trend toward a higher percentage with special needs, which showed up in Exhibit? regarding children entering care also appears here.

CASE FLOW BY JURISDICTION
Exhibit IX
CASE FLOW STATISTICS FOR JULY 1, 2003 – JUNE 30, 2004

Jurisdiction	# of Cases in Care on July 1, 2003	# of Cases Entered Placement During FY 04	# of Cases Left Placement During FY 04	# of Cases in Care on June 30, 2004	Projected Average Length of Stay (months)	Actual Average Length of Stay (months)
Allegany	97	68	66	99	18	17
Anne Arundel	227	122	97	252	30	23
Baltimore County	642	424	393	673	20	20
Calvert	51	34	22	63	31	22
Caroline	30	18	17	31	22	17
Carroll	57	21	29	49	22	19
Cecil	65	42	41	66	19	19
Charles	122	27	22	127	68	30
Dorchester	32	14	19	27	19	22
Frederick	238	133	151	220	18	17
Garrett	50	23	30	43	19	22
Harford	229	123	139	213	19	22
Howard	111	55	49	117	28	23
Kent	15	6	6	15	30	24
Montgomery	510	244	251	503	24	28
Prince George's	757	201	290	668	29	33
Queen Anne's	17	11	9	19	24	19
St. Mary's	81	26	30	77	32	26
Somerset	47	36	21	62	31	29
Talbot	37	16	19	34	22	27
Washington	218	166	134	250	21	17
Wicomico	143	72	75	140	23	22
Worcester	47	27	27	47	21	19
Baltimore City	7,173	1,971	2,201	6,943	38	34
Statewide	10,996	3,880	4,138	10,738	32	29

This year, the projected average length of stay (PALS) and the actual average length of stay (AALS) are only three months apart. When we started displaying data in this format in our 1999 report, the figures were 13 months apart (PALS equaled 37 months, AALS equaled 24 months). At that time, we wrote that if the system remained relatively stable, PALS and AALS would converge. This is now happening. Compared to 1999, for instance, a larger proportion of children who are leaving the system have been in care a relatively long time, which has driven

up the AALS figure. Since relatively few children left the system during 1999, PALS was high, and many of those children are now old enough to age out of the system in 2004.

Jurisdictions differ vastly in regards to entries, exits, lengths of stay, and total population. Smaller jurisdictions often show a greater volatility in AALS and the PALS than the four largest jurisdictions (Baltimore City, Baltimore County, Prince George's County, and Montgomery County). Smaller jurisdictions are more affected than larger jurisdictions by factors such as a few children or a large sibling group that have very short or very long lengths of stay. Charles County, which had a severe shortage of staff during the fiscal year, had very few exits, and, thus, a long stay is projected. Frederick and Wicomico, which faced a similar challenge, however, show shorter-than-average lengths of stay.

While PALS has fallen steadily over the past several years, we are, nonetheless, very concerned that children remain in care too long – 32 months for 2004, and for many years hovering around 36 months. This is entirely too long a portion of a child's life to be uncertain about family ties and to be the subject of a bureaucratic system that can be a source of shame, even while it protects.

The burden of long stays falls disproportionately on the 23% of children who enter placement and stay longer than three years (see Exhibit IV). We estimate the average length of stay for these children at approximately a decade.

We believe that implementing the recommendations offered in this report could significantly reduce the average length of stay.

ANALYSIS OF THE CHILD AND FAMILY SERVICES REVIEW

Summary of Findings

The Child and Family Services Review process is the federal government's first-ever attempt to assess the quality of child welfare services. (See <http://www.acf.hhs.gov/programs/cb/cwrp/> for access to reports.) Maryland was the 47th State to go through the process. The federal government has developed 14 factors to consider in evaluating each State's effectiveness:

<u>Type of Measure</u>	<u>Domain</u>	<u>Factor</u>
Outcome	Safety	1. Children are protected from abuse and neglect
Outcome	Safety	2. Children safely maintained in their own homes
Outcome	Permanency	3. Children have permanency and stability of living arrangements
Outcome	Permanency	4. Children experience continuity of family relationships
Outcome	Well-Being	5. Families have enhanced capacity to care for children
Outcome	Well-Being	6. Children receive services to meet educational needs
Outcome	Well-Being	7. Children receive services to meet health needs
Systemic Factor		8. Statewide Information System
Systemic Factor		9. Training
Systemic Factor		10. Service Array
Systemic Factor		11. Agency Responsiveness to the Community
Systemic Factor		12. Foster/Adoptive Parent Licensing, Recruitment, Retention
Systemic Factor		13. Agency Responsiveness to the Community
Systemic Factor		14. Foster/Adoptive Parent Licensing, Recruitment, Retention

There is an elaborate methodology of assembling statistics, case data, and opinions to perform this complex assessment. Information is gathered at the State level and in three selected jurisdictions (which must include the jurisdiction with the highest number of child welfare cases).

The full audit process consists of the following steps:

- **State self-assessment** – The State submits a set of standard statistics on the outcomes and is asked to describe its effectiveness on the systemic factors.
- **In-depth case reviews** – A team of federal and state reviewers audits 50 cases on a total of 23 items for 7 outcomes related to permanency, safety, and well-being. The audit includes interviews with parents, children, foster parents, caseworkers, and other participants. Federal team leaders perform quality control.
- **Stakeholder interviews** – The State-level team interviews State-level officials such as DHR executives and managers, members of the Foster Care Court Improvement Committee, members of the CRBC State Board, care providers, and many others. Also, at each of the three local sites, teams interview key stakeholders.
- **Determination of substantial conformity** – After the State-federal team gathers all the information and rates cases, a determination is made for each of the 7 system components and each of the 7 outcomes based on statewide statistics, information in the self-assessment, case reviews, and stakeholder interviews. (See <http://www.acf.hhs.gov/programs/cb/cwrp/>.)

Maryland's 100-page self-assessment was filed in September 2003. The outgoing Glendening Administration had hired a contractor to prepare it, and the new administration did not have time to review it thoroughly. The State Board found it to be of little use. It suppressed both strengths and weaknesses, and relied too much on long descriptions of policy and procedure. Although there was a limited process for stakeholder input, the assessment did not represent a broad-based consensus about the *effectiveness* of the child welfare system.

The federal review team arrived in November 2003 to conduct the case reviews and stakeholder interviews. CRBC and many other stakeholders were fully involved, and there was a consensus in the child welfare community that the audit process was rigorous, thorough, and fair.

For the major outcomes, a State must score 90% to be rated in **substantial conformity (SC)**; otherwise the rating is, **area needing improvement (ANI)**. Out of 14 elements – 7 outcomes and 7 systemic factors – Maryland received SC on 3 and ANI on 11. The Program Improvement Plan must address the 11 ANI areas.

Maryland's results are unsatisfactory. The federal government sets very high standards. No state was rated SC on more than two outcome areas. Maryland was among 24 states that had zero SC ratings in the outcome area and among 13 states that had 3 or fewer SC ratings among the systemic factors. Only six other states and Puerto Rico had as few as 3 SC ratings overall.

The worst outcome area for Maryland was, "children have permanency and stability of living arrangements." The score was 26.7%, compared to the standard of 90%. (For a more detailed picture, consult Appendix I, in which CRBC staff summarizes the findings and indicates areas that were particularly strong or in need of improvement.) The federal evaluators found that:

- ◆ The permanency goal was continuously in the child's best interests during the audit period in only 34% of cases.
- ◆ Court practice – especially, ordering futile plan of reunification - was identified as a key barrier. The score for implementing reunification plans was 38%.
- ◆ The waiver of reunification is underutilized – thus reinforcing a key CRBC finding.
- ◆ Plans of long-term foster care are used excessively, even for young children. This is an area where CRBC may need to be more vigilant.
- ◆ Parents are not receiving adequate reunification services.
- ◆ Effort toward adoption is insufficient, including delays in termination of parental rights; failure to use mediation, a known best practice; and inconsistent use of dual licensure.⁹ The score for implementing adoption was 42%.

Performance Improvement Plan

Maryland now must improve its performance or eventually face up to \$1.5 million per year in federal penalties. In September, Maryland completed the first step in this process, which is to file a Program Improvement Plan, addressing the 11 areas that are ANI. Earlier, Social Services Administration officials had stated that the PIP would be a vehicle for far-reaching system reform. During the process, however, it became evident that the purpose was redefined as compliance with federal standards and that the PIP would promise minimal improvement. Although many stakeholders participated in developing suggestions for the PIP at the outset, there were firm limits on participation. To cite a key example, stakeholders were not included in the process of setting numerical goals for improvement. Maryland's PIP will have to include a target for making progress toward the federal standard of 90% on each outcome element. In the area of permanence, the current score of 26.7% requires several quantum leaps in performance. Stakeholders were not involved in a discussion of whether that target should be 80% or 40%. The final product was completed in secrecy, and the draft that was submitted to the federal government has not been released as of this writing in December 2004.

Secretary McCabe has begun a process of creating a more ambitious reform agenda entitled "Putting Children First." We expect that stakeholders will play an active role in that effort and that DHR will clarify the relationships between that reform effort, the PIP, the required federal Child and Family Services Plan, and the SSA strategic plan.

⁹ Dual licensure allows foster parents to adopt without a further home study. Although this has been announced practice in Maryland for nearly a decade, implementation has been disappointing.

REPORT OF CHILD WELFARE ACCOUNTABILITY TASK FORCE

RECOMMENDATIONS OF THE TASK FORCE

Below is a list of the recommendations of the Task Force, taken verbatim from the Executive Summary of the Task Force's report.¹⁰

1. The Governor and General Assembly must make a long-term commitment to enhance and stable funding and support for abused and neglected children in order to create a culture of excellence in Maryland's child welfare system. This cannot be accomplished without a commitment to those communities within our state that contribute the highest number of children to out-of-home care.
2. The Governor and the General Assembly must make a long-term and stable commitment to achieving Child Welfare League of America (CWLA) caseload standards in order to assure that families get help and children are adequately protected.
3. The Department of Human Resources (DHR) should convene a widely representative group of stakeholders to develop a new vision and a set of principles for the child welfare system by which workers, supervisors and administrators will operate, and upon which the system will be judged.
4. DHR should re-examine and clarify key central office roles and the relationship of the central office to the county offices. Issues such as contracting for services and the allocation of staff must be addressed.
5. DHR should implement the outcome measurement system outlined in Appendix B that expands on the federal outcome measures, and is used to measure performance at the State and local levels. A university-based data repository should be established for research purposes to which all state agencies substantively involved with children who have experienced maltreatment would contribute appropriate data.
6. The Governor and General Assembly must commit stable funding to implement a fully functional statewide child welfare information system (CHESSIE) as quickly as possible.
7. DHR should develop a quality assurance system that includes an assessment of performance at the State level, and self-assessment at local levels.
8. The Governor and the General Assembly should ensure sufficient funding for the development of child welfare best practices in order to provide cutting edge services to children and families, and to more cost effectively use limited resources.
9. DHR, in collaboration with Maryland institutions of higher learning, should enhance training and develop a comprehensive Child Welfare Training Academy for child welfare workers, supervisors, managers, foster parents, and providers in order to ensure that staff and managers are equipped to provide the highest quality services to children and families. This new Training academy should build on the existing training programs in Maryland.
10. DHR and the Department of Budget and Management (DBM) should revise the accounting structure and workload measures used by the Social Services Administration and the local

¹⁰ The full report can be found online at

[http://progressivemaryland.org/files/public/documents/archive/2004/TaskForceReport2004\[2\].12.1.pdf](http://progressivemaryland.org/files/public/documents/archive/2004/TaskForceReport2004[2].12.1.pdf)

offices to allow a clear and comprehensible understanding of how funds are spent and to permit more flexibility in spending to meet families' needs while reducing reliance on high-cost placements.

11. DHR and the Citizens' Review Board for Children should implement the Quality Service Review Protocols as a means of measuring the quality of case level activities.
12. DHR should adapt California's county self-assessment process as a means of monitoring the quality of services provided at the local level.
13. An independent researcher should replicate the National Incidence Study every six years to understand the actual incidence of child maltreatment in the State, and its relationship to reports of child maltreatment and investigations of child maltreatment and program performance.
14. DHR should aggressively pursue national accreditation for each local office and the State Agency. The State should negotiate the cost of accreditation for the remaining jurisdictions with the Council on Accreditation to make the process more affordable.
15. Maryland should contract for a review of federal funding maximization issues specific to Title IV-E, and the Department of Budget and Management (DBM) should assure that any new revenues obtained are kept within the appropriate agency to improve services to children and families.
16. Interagency coordination should be improved in order to improve outcomes for Maryland's most vulnerable children and families. The Governor's Office of Children, Youth and Families (GOCYF), DHR, the Social Services Administration (SSA), the Department of Juvenile Services (DJS), the Department of Health and Mental Hygiene (DHMH) the Courts, and the Maryland State Department of Education (MSSDE) should clarify their respective roles with regard to the implementation of the recommendations contained in this report.

The Task Force evolved from a CRBC recommendation that was highlighted in our out-of-home placement Annual Report for FY 2002 (<http://www.dhr.state.md.us/crbc/pdf/annrpt02.pdf>, pages 4 and 20). With action by the Coalition to Protect Maryland's Children, Delegate Samuel I. Rosenberg, the General Assembly, and, finally, the Task Force itself, the subject matter was greatly expanded compared to our original recommendation.

Kathleen Feely, a nationally recognized child welfare consultant with the Annie E. Casey Foundation, chaired the Task Force. In addition, the Foundation provided significant staff and funding support and brought in experts from across the nation. Much credit also goes to the Department of Budget and Management as well as to DHR for supporting a diverse membership and investing considerable time, effort, and expertise in the process.

We endorse all the recommendations, many of which we have been advancing ourselves for years. The first two recommendations regarding enhanced and stable funding, the third regarding a vision for fundamental reform, and the eighth on implementing best practices dovetail with our 2003 report, which focused on the fact that spending on high-cost placements is displacing spending on child and family services. This trend bodes ill for children and for taxpayers.

Exhibit X shows how the trend continued in FY 2004. This spending pattern portends a forbidding prospect of rising costs and worse results for children and families. The direct service categories (first three lines) declined by \$7.5 million, while the costs of out-of-home payments rose \$18.1 million. We are jeopardizing the State's ability to investigate abuse and

neglect thoroughly, help families care for their children so that removal can be avoided, and place children in foster homes. Placing children in the most family-like setting is a fundamental, time-tested principle of child protection. (The decline in foster family placements is also mentioned on page 3 in the discussion of workforce issues.) Maryland has declining resources to recruit, screen, and train foster families; provide foster families with casework help; or assist foster families pay for day care or respite care. Consequently, local departments of social services may be forced to place children in homes that are not well suited to their needs, thus increasing the chances of a placement disruption. Every placement disruption risks the emotional health of the child and subjects the taxpayers to liability for escalating cost. Treatment foster care and groups homes cost between \$36,000 and \$90,000 per child per year.

Exhibit X
Cost Components of Child Welfare Services
(dollar amounts in millions)

Type of Cost	FY 2003 Amount	FY 2003 Percent	FY 2004 Amount	FY 2004 Percent	Percent Change
Prevention & support services	\$118.7	27.5%	\$114.2	25.7%	-3.8%
Out-of-home services	\$ 52.2	12.1%	\$ 49.6	11.2%	-5.0%
Adoption services	\$ 6.8	1.6%	\$ 6.4	1.4%	-5.9%
Out-of-home payments	\$200.4	46.5%	\$218.5	49.1%	+9.05%
Foster Family Care, including Treatment FC ¹¹	\$ 73.0	16.9%	\$ 80.3	18.1%	+10.0%
Group Home & Residential Treatment	\$ 125.7	29.2%	\$ 138.2	31.1%	+9.9%
Other ¹²	\$ 1.7	0.4%	\$ 0.0	0.0%	-100.0%
Adoption subsidy payments	\$ 41.0	9.5%	\$ 48.6	10.9%	+8.5%
Administration/management	\$ 11.9	2.8%	\$ 7.3	1.6%	-38.7% ¹³
Total	\$431.0	100.0%	\$444.6	100.0%	+3.2%

Source: Social Services Administration, DHR Budget Management Division

Recommendation 10 addresses the spending trends directly and calls for increased flexibility in budgeting. Currently, 60% of the entire budget is tied up in the payments accounts. Funds for services can be spent on payments but the reverse is not permitted. Spending flexibility is an integral part of the quality assurance recommendations, which are discussed below.

Recommendation 9 embodies a major amplification of ideas we advanced in advocating for the Child Welfare Workforce Initiative of 1998. That legislation required training for caseworkers prior to their being assigned a caseload¹⁴ and annual in-service training. A training academy would be 75% federally funded. It would greatly enhance pre-service training so that new recruits have a firm base in policy and practice techniques and would allow management to tailor in-service training to information that comes from the local assessment process (see recommendation 12, discussed below).

Recommendations 5, 11, 12, and 13 are of particular interest to CRBC as they carry forward the agenda we developed when we brought the idea for accountability reform to Del. Rosenberg. The Task Force has adapted a set of accountability measures from a system in use in California. These parts of the Task Force's agenda would be relatively low in cost.

¹¹ Note that the number of children in regular family foster homes (which cost an average of about \$600 per month) is declining and the payment rate has not risen in a decade. Therefore the increase in this cost is due to treatment foster care.

¹² This line accounts for a certain share of spending for managed care project that ended in 2003.

¹³ The huge drop in this line is caused by the end of the managed care project (\$1.3 million) and a decline in workers' compensation expenditures. SSA carries the workers comp costs for the local departments.

¹⁴ This is a concept that has been all but abandoned; the current "pre-training" occurs sometime in the first few months of employment.

Recommendation 5, regarding outcomes measures, establishes the foundation for the others. It builds on the federal outcome categories (seven outcome areas split into the three domains, safety, permanency, and well-being – see page 14), but recognizes that the federal statistical indicators are not rich enough to reflect the complexity of the child welfare system. The Task Force recognized that any single statistical indicator can be manipulated to suggest good performance without real substance. A suite of indicators gives a fuller and more accurate picture. Therefore, the Task Force recommended that a series of additional indicators be developed (some immediately, and some when CHESSIE is implemented). Among the indicators is one that would implement a sampling procedure to determine whether children are still living in their permanent placement a year after the local department has closed their case.

A second critical component of a new accountability system is embodied in Recommendation 11, which calls for in-depth case reviews, known as Quality Service Reviews (QSR). These case reviews would track whether best practices were followed and would be closely tied to the outcomes established under Recommendation 5. In order to maintain the necessary objectivity in the case review process, the Task Force called for DHR and CRBC to implement the QSRs in partnership. Objectivity and independence from political or bureaucratic influence are critical parts of CRBC's mission, and the Task Force recognized that these qualities are necessary to make an accountability system effective. The level of detail required under QSR protocols that have been implemented in other states exceed the requirements of CRBC's current protocols; however, there are similarities with both the out-of-home placement reviews and the child protection reviews.

The current quality assurance function within the Social Services Administration focuses primarily on casework procedures and case record documentation. Recommendations 7 and 12 would create a revamped quality assurance operation at the State level and a linked system of self-assessments at the county level. The self-assessments would be based on the outcomes (Recommendation 5) and the QSR system (Recommendations 11). In addition, the process incorporates many levels of client and stakeholder feedback. CRBC members would sit on the committee that performs the local assessment. Each jurisdiction would then create a program improvement plan to show how it would maintain good performance and improve weak performance. It will be critical that local agencies have the flexibility called for in Recommendation 10 in order to implement improvement plans. The Social Services Administration would establish standards for completing the local assessments and have authority to accept or reject assessments submitted. It would also perform a State-level self-assessment that incorporates the 24 local assessments and evaluates how well State-only functions such as resource allocation and policy-making are performed.

The Citizens' Review Board for Children has been advocating for needed improvements for many years, including many of those cited in the CFSR and by the Task Force. Recommendations 7, 11 and 12 create an important opportunity for us to forge a more productive working relationship with DHR and the local departments so that our own system improvement recommendations are more likely to be implemented. We are encouraged by Secretary McCabe's invitation to meet with him regarding his vision for reform and to create a new partnership that is badly needed. We are willing to be flexible in adapting our program to meet the goals of the Task Force.

In Recommendation 13, the Task Force calls for a scientific method of estimating the incidence of abuse and neglect in Maryland, using a model established by the federal government. Current estimates are based solely on the results of investigations performed by local departments. This process is inherently flawed because abuse and neglect reports are made only in a fraction of the actual cases. Having a scientific estimate of incidence would enable DHR to track over time whether it is effective in combating the scourge of child maltreatment.

THE CITIZENS' REVIEW PROCESS

ADMINISTRATIVE REVIEWS

Title IVB of the Social Security Act, section 422(b) (10)(ii), requires that children in out-of-home placement have an administrative review every six months. This may be achieved through a court review, a citizen review, or a panel review (conducted by LDSS). Failure to document the review may result in a state receiving a financial penalty.

As of June 30, 2004, timely administrative reviews were documented in CRBC's computer for 81.9% of children in care compared to 80.3% for June 30, 2003. Although some children's files lacked proper documentation, the federal reviewers found that Maryland was in compliance with requirements for periodic case review. CRBC's review process was praised.

Citizen Review Process

- ◆ Child welfare agencies must provide information to the boards, including the case plan and lists of interested persons who may be invited to a case review.
- ◆ Interested Persons including child's caseworker, parents, relatives, and foster families are invited to the review. They provide vital information and opinions regarding the child's current and proposed living arrangement. Educational and health providers, and the child if over age ten may be invited to the initial review and subsequent reviews when the case plan changes. Siblings are reviewed together to ensure continuity and coordination of services since there may be multiple caseworkers and services providers.
- ◆ After the discussion, the Board makes findings and recommendations related to the child's permanency plan, current living situation, and safety.
- ◆ The Board sends a summary of the findings and the recommendations to invited interested persons, the local department, and the juvenile court. Local departments are required to respond in writing to the recommendations and findings from the reviews. The juvenile court is required to consider the boards' recommendations when conducting permanency planning review hearings.

Self-Examination

One of the boards conducted multiple reviews of a family in which infants were murdered. (The parents, one of whom was a runaway from foster care, are now charged with those murders.) The State Board convened a Special Committee with State and local board members and staff, which found both strengths and weaknesses in the local board's findings. Certain systemic changes are being made in internal procedures so that boards can be better informed about policies and procedures and can more effectively pursue individual child advocacy following a case review. The State Board is working towards integrating several of these modifications with its joint work with DHR to implement the recommendations of the Child Welfare Accountability Task Force. In addition, the Special Committee observed that the case illustrated the need for multi-disciplinary consultation and casework continuity. The case involved a family with many siblings in care who were served by at least seven different DSS caseworkers over a period of 45 months.

Summary of Findings and Recommendations made during the Citizen Review Process

The following findings represent the 6,094 citizen reviews that were conducted during FY 2004 (a 13.8% decrease over FY 03) and not the status of all children in Maryland's out-of-home system. In rare instances, a child may have a citizen review more than once in a year.

Exhibit XI
Findings and Recommendations made during the Citizen Review Process

Votes Taken during the Citizen Review Process	FY 04 Results								
<p>Waiver of reunification services is the denial of time-limited services to parents or guardians to assist in returning the children home.¹⁵ The boards must decide if they agree with LDSS' decision to pursue or not to pursue a waiver of reunification services against the mother, father, or both. Generally this finding is made at the first review. Federal reviewers cited Maryland for failing to use this legal tool to expedite permanent placement.</p>	<p>Boards found 74 instances in which the waiver was not used and the Boards believed it should have been applied.</p>								
<p>Termination of parental rights results from court action terminating parents' legal rights and responsibilities and awarding guardianship to LDSS or a child placement agency. Seventy-seven percent (77%) of 4,711 reviews reviewed qualified for consideration of TPR. In 45% of these instances, federal requirements for mandatory consideration of TPR were applicable. If the federal requirements are applicable, the boards may nevertheless find that there is a compelling reason not to pursue TPR such as the child is with relatives who do not want to adopt, parents are making progress, or the child is a teenager and does not want to be adopted.</p>	<p>Boards made these recommendations:</p> <table style="margin-left: 20px;"> <tr> <td>Don't file for TPR</td> <td style="text-align: right;">76%</td> </tr> <tr> <td>File TPR petition</td> <td style="text-align: right;">15%</td> </tr> <tr> <td>Grant filed petition</td> <td style="text-align: right;">9%</td> </tr> <tr> <td>Deny petition</td> <td style="text-align: right;">0.1%</td> </tr> </table>	Don't file for TPR	76%	File TPR petition	15%	Grant filed petition	9%	Deny petition	0.1%
Don't file for TPR	76%								
File TPR petition	15%								
Grant filed petition	9%								
Deny petition	0.1%								
<p>A permanency plan specifies when and with whom the child shall live and the proposed legal relationship between the child and the caregiver(s). Two votes are taken regarding the permanency plan:</p> <ul style="list-style-type: none"> • The concurrence rate is the percentage of times the reviewers agree with the permanency plan. • A vote for adequate progress indicates that the responsible agencies¹⁶ acted in a reasonable and timely fashion to promote permanent placement. 	<p>See Exhibit XVI</p>								
<p>The Boards must consider the safety of the child while living in the out-of-home placement. This includes whether all applicable safety assessments and child protection protocols have been used, such as whether DSS has completed an inventory of people living in the home. The Boards must also consider whether there are indicators of risk that may include, but are not limited to, parental visits that may subject the child to risk, domestic violence, and/or a household member with a history of violence, child abuse, or child neglect. They found risk indicators in 4% of the overall reviews.</p>	<p>One or more safety protocols were not used in approximately 3% of the reviews. Of these, the Boards found indicators of risk in 65% of the cases.</p>								
<p>The board also makes a finding about placement as to whether the current living arrangement and any planned changes of placement short of permanent placement are appropriate for the child.</p>	<p>Boards found inappropriate placements in 1% of reviews.</p>								

¹⁵ For the waiver of reunification services and termination of parental rights, votes may not be taken if 1) the child was 18 years of age or over, 2) the parents were dead, or 3) the parental rights had already been terminated.

¹⁶ Responsible agency includes LDSS, courts, private child placement agency, medical and educational systems.

Exhibit XII
Summary of Permanency Plans by Concurrence Rates and Adequacy of Progress For
Fiscal Years 2003 and 2004

PERMANENCY PLAN	July 1, 2002 – June 30, 2003				July 1, 2003 – June 30, 2004			
	# of Plans & % of Total		Concurrence Rate	Progress Adequate	# of Plans & % of Total		Concurrence Rate	Progress Adequate
	#	%			#	%		
Return Home	2024	29%	82%	90%	1952	33%	82%	89%
Relative Placement	1108	16%	90%	92%	1117	19%	90%	90%
Adoption	1712	25%	99%	86%	1187	20%	98%	83%
Independent Living	868	13%	99%	97%	680	12%	99%	95%
Long-term Foster Care	1059	15%	96%	96%	823	14%	97%	94%
Permanent Foster Care	165	2%	96%	96%	101	2%	98%	99%
Guardianship	1	0%	100%	0%	3	0%	100%	100%

Source: CRBC's Information System.

Compared to 2003, the boards found progress towards permanent placement to be inadequate more frequently for nearly every type of permanency plan.

Return home had the lowest concurrence rate and the second lowest percentage of reviews in which progress was found adequate. Board members cited high caseloads as a major barrier to progress. Lack of housing was a barrier to reunification in over 50 instances. Lack of group or residential treatment placement facilities was a frequent barrier in the counties, especially the smaller ones, and was cited over 120 times.

Exhibit XIII shows how many reviews were conducted in each jurisdiction, how many problems the boards found for each required type of finding, how many cases had at least one problem, and how the local departments responded to the recommendation reports. Overall, problems requiring corrective action were found in 1,676 of 6,094 reviews conducted, a rate of 28%, with a range from 7% to 42%. Regulations require local departments to respond in writing to reach report, indicating whether they accept the board's recommendation. The statewide response rate of 56% is misleading because Baltimore City (37%) dramatically drags down the rate. (Baltimore City is beginning to show rapid improvement in meeting this requirement as of this writing.) The counties responded at a rate of 73%. The local departments agreed with the boards' recommendations 6.6 times as frequently as they disagreed.

Exhibit XIII
Corrective Action Case Review Recommendations and Disposition by County

Jurisdiction	Waiver of Reunific'n	TPR	Permanency Goal	Permanency Progress	Safety Protocols	Risk Indicated	Placement Plan	Corr Action Reviews	Total Reviews	DSS Return Rate	DSS Agree/Disagree Ratio
Allegany	1	8	5	13	0	3	1	22	89	100%	6.3 : 1
Anne Arundel	5	21	31	7	13	18	2	57	164	96%	2.7 : 1
Baltimore	9	50	33	9	0	8	2	91	456	80%	5.5 : 1
Baltimore City	49	524	345	374	160	154	45	1,050	2,909	37%	8.1 : 1
Calvert	0	2	2	6	0	4	0	13	51	69%	8 : 1
Caroline	0	0	0	3	0	0	0	3	24	0%	N/A
Carroll	0	8	4	14	1	4	2	25	60	100%	4 : 1
Cecil	0	7	2	4	0	4	0	14	59	93%	2.3 : 1
Charles	0	6	5	28	0	8	2	39	141	67%	26 : 0
Dorchester	0	1	0	0	0	2	0	3	41	100%	3 : 0
Frederick	0	19	36	19	0	10	1	49	175	93%	5 : 1
Garrett	3	2	4	13	0	6	1	17	46	100%	14 : 0
Harford	2	17	14	12	3	7	0	37	193	97%	3 : 1
Howard	0	5	6	8	1	4	0	20	86	100%	20 : 0
Kent	0	3	2	0	1	1	0	6	22	100%	4 : 0
Montgomery	2	11	32	14	8	9	3	67	418	94%	6 : 1
Pr. George's	0	10	15	29	0	2	0	49	537	94%	20 : 1
Queen Anne's	0	0	0	2	0	0	1	2	11	100%	2 : 0
Saint Mary's	0	5	3	10	0	9	0	25	74	84%	1.1 : 1
Somerset	0	5	1	14	0	6	1	22	70	73%	16 : 0
Talbot	1	1	1	3	0	0	0	3	28	67%	2 : 0
Washington	1	12	7	12	0	7	1	31	227	84%	7.7 : 1
Wicomico	1	6	3	12	0	5	0	22	145	91%	20 : 0
Worcester	0	4	1	2	0	2	0	9	68	56%	5 : 0
State	74	727	552	608	160	273	62	1,676	6,094	56%	6.6 : 1

The most frequent areas problems identified were failure to file for termination of parental rights (TPR) in a timely fashion, inadequate progress toward permanent placement, and an inappropriate permanency goal. Note that these problems may be caused by various agencies. The court establishes the permanency plan, although the local department may share responsibility if the plan is not appropriate. In 2004, 40% of the findings of inadequate progress were identified as being the responsibility of an agency other than the local department.

The results of citizen reviews are quite consistent with the patterns highlighted by the Child and Family Services Review. Permanency issues regarding reunification, termination of parental rights, and adoption deserve a high priority. CRBC and the local departments are developing improved channels of communication to correct problems identified during case reviews. Baltimore City DSS administration has been responsive and is improving its relationship with its local review boards. The CFSR and the Task Force report offer Secretary McCabe an opportunity to take the initiative to create deep and fundamental reforms. We are pleased that he has reached out to us to forge a new partnership and trust that it will be one that fully responds to the crisis in Maryland's child welfare system.

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Representing Calvert, Charles, Prince George's, and Saint Mary's Counties

APPENDIX I
Summary of Findings of Child and Family Services Review

Below is a summary prepared by CRBC staff pointing out highlights of the federal report on Maryland's performance in the Child and Family Services Review.

OUTCOMES

Domain	Item	Score
Safety	Children are protected from abuse and neglect <ul style="list-style-type: none"> • Baltimore City met this outcome in 100% of 22 cases 	87.2% ANI
	1. Timeliness of investigations	88% Strength
	2. Repeat maltreatment <ul style="list-style-type: none"> • Scarcity of services available for families • Practice of closing cases without addressing all maltreatment issues • Need to address substance abuse and domestic violence 	87% ANI
Safety	Children safely maintained in their own homes <ul style="list-style-type: none"> • Maryland can be effective in addressing risk and providing services, but performance is inconsistent 	81.3% ANI
	3. Services to prevent removal <ul style="list-style-type: none"> • Lack of service provision to address identified needs after a comprehensive risk assessment and safety assessment • Lack of adequate post-reunification services in some counties 	83% ANI
	4. Risk of harm reduced <ul style="list-style-type: none"> • Ability of workers to assess risk or plan to reduce risk • Safety of children in group homes • Inexperience and youth of group home staff 	84% ANI
Permanency	Children have permanency and stability of living arrangements	26.7% ANI
	5. Foster care (out-of-home placement) re-entry <ul style="list-style-type: none"> • Anne Arundel after care services praised • Parental substance abuse or mental health relapse • Lack of adequate post-reunification services in some counties 	71% ANI
	6. Stability of out-of-home placements <ul style="list-style-type: none"> • Relative placements are often stable • 18 of 29 children had one placement during review period and another 5 had 2 placements • Insufficient number of foster family and group home providers • Poor matching of children with placement resources, particularly for older children and teens • Too many children in some foster homes • Lack of training and services to support foster parents when placement stability is threatened 	79% ANI
	7. Permanency goal is in child's best interests <ul style="list-style-type: none"> • Court practices a key barrier to timely and appropriate goals • Stakeholders say courts maintain the goal of reunification even when the prognosis for reunification is poor • Waiver of reunification services not used • Concurrent permanency planning exists in form but not in function • Too many plans for long-term care, including young children 	34% ANI
	8. Reunification, guardianship, or placement with relatives is achieved within one year <ul style="list-style-type: none"> • Lack of awareness of strategies needed to achieve permanent placement with relatives, especially guardianship • Lack of services to parents or lack of timely services 	38% ANI

Domain	Item	Score
	Adoption is achieved within two years <ul style="list-style-type: none"> • Inadequate effort • Lengthy TPR appeals process • Lack of placement resources • TPR delays include <ul style="list-style-type: none"> ○ Late notice to parents ○ Delays in scheduling hearing ○ Granting continuances ○ Court waits too long to set plan of adoption • Failure to use mediation early • Failure to use waiver of reunification • Inconsistent use of dual licensure 	42% ANI
	Other planned permanent living arrangements are achieved <ul style="list-style-type: none"> • Too many plans of LTFC – it is increasing • Relative caregivers reluctant to adopt • Older youth may not receive Independent Living services, especially in group homes 	56% ANI
Permanency	Continuity of family relationships	64.3% ANI
	Proximity of placement	96% SC
	Placement with siblings <ul style="list-style-type: none"> • Lack of resources or lack of effort to place together 	71% ANI
	Visiting with parents and siblings in care <ul style="list-style-type: none"> • Different caseworkers in same family • Lack of reimbursement for foster families who provide transportation 	67% ANI
	Preserving connections <ul style="list-style-type: none"> • DSS lacks resources • Fathers rarely included 	71% ANI
	Relative placement <ul style="list-style-type: none"> • Sometimes focus only on one side of the family • Lack of search for absent fathers or late search 	72% ANI
	Relationship of child in care with parents	64% ANI
Well-Being	Families have enhanced capacity to care for children	61.2% ANI
	Needs and services of child, parent, and caregivers are assessed <ul style="list-style-type: none"> • Needed services not rendered or inappropriate services rendered for the child • Parental needs often not assessed or assessment missed underlying needs (e.g., substance abuse or mental health) • Needed services for parents or foster parents not rendered • Lack of availability of MH and substance abuse treatment 	63% ANI
	Child and family involvement in case planning <ul style="list-style-type: none"> • Caseworker creates the plan and gives to parent for signature • Fathers routinely not involved 	71% ANI
	Worker visits with child	86% SC
	Worker visits with parents <ul style="list-style-type: none"> • Minimal or no contact with fathers 	68% ANI
Well-Being	Services to meet educational needs of child	86.5% ANI
	<ul style="list-style-type: none"> • Caseworkers need training • Some local schools resistant to agency and foster parent efforts 	

Domain	Item	Score
Well-Being	Services to meet health needs of child	80.4% ANI
	Physical health of child <ul style="list-style-type: none"> • Shortage of dentists available to serve Medicaid patients 	91% SC
	Mental health of child <ul style="list-style-type: none"> • Services not given for identified need • Parents refuse to consent to MH treatment • Lack of available MH services for children 	69% ANI
Systemic	Statewide Information System <ul style="list-style-type: none"> • Inaccurate data made it difficult to select CFSR sample; cannot accurately locate kids in care • CIS/FACTS lack user-friendly query system • Workers have no direct inquiry access • CIS/FACTS Data cannot be shared with local systems • Caseworkers not trained in entering or interpreting system codes • LDSS cannot create their own management reports 	ANI
	Case Review System <ul style="list-style-type: none"> • Case plans not routinely developed for children placed with relatives • Many cases without signed service agreements • Periodic reviews occur, but courts may not adequately consider CRBC recommendations • Court continuances • Notification to caregivers of court reviews needs improvement 	ANI
	Quality Assurance System <ul style="list-style-type: none"> • Standards in place to ensure quality service and child safety/health • Lack of mechanism to monitor and enforce CAPS corrective action • System monitors only for compliance and does not provide feedback on the quality of services and outcomes 	ANI
	Training <ul style="list-style-type: none"> • Initial and ongoing training for staff • Training for caregivers and adoptive parents 	SC
	Service Array <ul style="list-style-type: none"> • Critical service gaps: <ul style="list-style-type: none"> ○ Bilingual services ○ MH services ○ Services for children leaving residential facilities ○ Substance abuse services ○ Services for DJS co-committed youth • Only half of eligible children receiving independent living funds • Problems in individualizing services 	ANI
	Agency Responsiveness to the Community <ul style="list-style-type: none"> • Consultation with stakeholder in developing Child and Family Services Plan and annual progress reports • Services coordinated with other federal programs 	SC
	Foster/Adoptive Parent Licensing, Recruitment, Retention <ul style="list-style-type: none"> • Standards in place for foster families and institutions • Criminal history checks are completed • Diligent recruitment so that diversity of foster parents reflects diversity of child population • Problems with inter-jurisdictional placements 	SC