
Prepared by the Maryland Task Force on Child Welfare Accountability

December 1, 2004
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Executive Summary

When abused and neglected children and their families fail to receive necessary services and interventions, the human and social costs are enormous. Most evident are the tragic and needless deaths of infants and children at the hands of their caretakers. Also tragic are the children who do poorly in school, have emotional or behavioral problems, become addicted to drugs, and enter adulthood unable to adequately care for themselves or their own children. The need for an effective system to provide support and interventions to these children and their families could not be more compelling.

Each year the Maryland child welfare system touches the lives of 90,000 children and their families. Maltreated children include some of the most vulnerable citizens in Maryland. Approximately 11,000 children are in out-of-home placements because of abuse or neglect or because their parents are unable to take care of them. The majority of these children reside in Baltimore City. The annual spending in fiscal year 2004 on child welfare services and subsidized adoption in Maryland exceeded $450 million in addition to $112 million for Medicaid payments for children in foster care or subsidized adoption.¹

The Task Force on Child Welfare Accountability, constituted by the 2003 Joint Chairman’s Report (JCR) of the Maryland General Assembly, called for both an overall evaluation of the child welfare system and recommendations in response to 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 a method for collecting data needed to measures outcomes; and
5. An analysis of how the State might maximize federal revenues in order to improve child safety, permanency, and well-being.

The Task Force conducted an overall evaluation of the child welfare system and identified a number of serious structural issues that must be addressed. In addition, the Task Force developed 16 specific recommendations related to the five topics listed in the budget language.

After more than ten months of study, discussion and analysis, the Task Force has identified key structural impediments that undermine performance and accountability.

¹ From the Department of Budget and Management and the Department of Health and Mental Hygiene.
The impact of these issues is so pervasive that they must be addressed if there are to be any meaningful system improvements.

**Task Force Recommendations**

This document represents the final report of the Task Force’s findings and recommendations. It provides a framework for the development of a high quality, accountable child welfare system. The Task Force developed 16 specific recommendations which fall within the following three overarching categories:

1. A Long-Term Commitment to Excellence
2. An Outcome Measurement System, and a related County Self Assessment System
3. A Quality Assurance System

These three major categories are interrelated; none can be implemented without the others. To attempt to do so would further cloud the State’s ability to help abused and neglected children. The sixteen major recommendations of the Task Force are listed below.

1. The Governor and General Assembly must make a long-term commitment to enhanced 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 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 (MSDE) should
clarify their respective roles with regard to the implementation of the recommendations contained in this report.

**Conclusions**

The bottom line is that accountability and quality in a child welfare system depends upon that system having the basics in place. Maryland has yet to achieve the basics. When caseworkers and managers have trouble addressing minimum requirements, any attention to overall quality is “hit or miss,” rather than systematic. Without the availability of automated information, managers manage by best guesses and intuition, rather than data and analysis. Priorities and decisions across local agencies are inconsistent and based on any given manager’s or supervisor’s personal priorities or current concerns, rather than on a common vision and operating principles. Performance measurement becomes punitive and accusatory rather than constructive and thoughtful.

If the State truly wishes to have a child welfare system that helps abused and neglected children, is accountable, and provides high quality services, it will have to make a long-term and stable commitment to funding such a system. Critical steps should include building on the strengths of the existing system; developing a new vision and operating principles; ensuring CWLA caseload standards are met; developing a family strengthening practice model; creating a Child Welfare Training Academy; completing the CHESSIE system and contracting for the review of federal fund maximization.

At the same time, the State should be accountable for implementing its child welfare policies and spending the funds it has wisely. Many of the accountability recommendations included in this report will cost money. However, for these recommendations to work, funds committed to improving the system must be permanent, with new funds added over time that build on previous year funding. Maryland’s child welfare system cannot, and will not improve with promises of funding that don’t materialize, or with mid-year budget cuts or other cost containment efforts. If the Governor and the General Assembly truly desire to have a child welfare system that protects children, provides high quality services to families and is accountable, rather than, at best, average, it will have to invest in the development of that system.

December 1, 2004

When abused and neglected children and their families fail to receive necessary services and interventions, the human and social costs are enormous. Most evident are the tragic and needless deaths of infants and young children at the hands of their caretakers. Also tragic are the children who do poorly in school, have emotional or behavioral problems, become addicted to drugs, and enter adulthood unable to adequately care for themselves or their own children. The need for an effective system to provide support and interventions to these children and their families could not be more compelling.

Each year the Maryland child welfare system touches the lives of 90,000 children and their families. Maltreated children include some of the most vulnerable citizens in Maryland. Approximately 11,000 children are in out-of-home placements due to abuse or neglect or because their parents are unable to care for them. The annual spending in fiscal year 2004 on child welfare services and subsidized adoption in Maryland exceeded $431 million, in addition to $112 million for Medicaid payments for children in foster care or subsidized adoption.2

The Task Force on Child Welfare Accountability, constituted by the Joint Chairman’s Report (JCR) of the Maryland General Assembly, called for both an overall evaluation of the child welfare system and recommendations in response to five specific questions. After more than six months of study, discussion and analysis, the Task Force has identified key structural impediments that undermine performance and accountability. The impact of these issues is so pervasive that they must be addressed if there are to be any meaningful system improvements.

Background

Concerns regarding the adequacy of Maryland’s child welfare system and, in particular, the size and qualifications of the child welfare workforce have consistently been raised over the last two decades. Sixteen years ago, the Maryland State Department of Human Resources entered into a Consent Decree to settle a federal court dispute, L.J. v. Massinga3, which was brought on behalf of children in the custody of the Baltimore City Department of Social Services. The class action lawsuit contended that foster children were subject to maltreatment in foster homes, denied needed health and educational services, and not given adequate opportunity for reunification or visitation with birth parents and siblings. The Consent Decree required, among many other provisions, that the Department meet caseload ratios that allowed caseworkers ample time to work with children in care and work with birth and foster parents or relative caregivers to assure that children were safe, cared for, educated, and had a plan for their futures that involved continuity of relationships and preparation for adulthood.

2 From the Department of Budget and Management and the Department of Health and Mental Hygiene
Although progress was made in implementing various aspects of the Consent Decree, including reduced caseloads, training of caseworkers, increased services for families, and an increased number and type of placement resources, progress was halting by the mid-1990’s and the data used to measure key provisions of the Consent Decree were called into question. In 1998, the General Assembly enacted HB 1133, The Child Welfare Workforce Act of 1998, that required the Departments of Human Resources and Budget and Management to take the steps necessary to improve the child welfare system, including meeting appropriate caseload-to-staff ratios. These ratios were based on the standards developed by the Child Welfare League of America (CWLA)\(^4\), a nationally recognized professional membership organization that conducts research, training and consultation for public and private child welfare agencies throughout the country.

The Governor’s budget consistently has not recommended sufficient funding to enable local departments of social services to meet the CWLA caseload standards, thus hindering provision of services needed to achieve positive outcomes. Each year since 2001, the Department has fallen farther behind in achieving that goal. The fiscal year 2002 and 2003 appropriations included funding for over 200 new child welfare positions to meet CWLA standards in every jurisdiction by June 2003. However, facing a deficit, the State abolished over 260 positions in local departments of social services that had not been filled, including 59 vacant child welfare positions. New positions included in the fiscal year 2003 allowance were abolished as well. These eliminated positions, along with a hiring freeze put in place in October 2001 by the previous Administration have resulted in a steady erosion of the child welfare workforce statewide.

The Citizens’ Review Board for Children noted in its annual report for fiscal year 2003 that the State faced a deficit of more than 500 workers in child welfare.\(^5\) The impact on children and families was apparent in the well-publicized deaths of infants and children whose caregivers were well known to the child welfare system, and in the data that have been reported by the Social Services Administration itself in annual and monthly management reports. Child Protective Services workers undertake more investigations, but fewer cases of indicated abuse and neglect receive continued services from the Department after the investigation has been completed. It is common nationwide for overworked caseworkers to “manage” their caseloads informally, by “raising the bar” for what constitutes maltreatment worthy of opening a case.

The percentage of children who have a repeat occurrence of maltreatment within six months has understandably increased. For children in out-of-home care, fewer are returned to or placed in a permanent home.\(^6\) Furthermore, more of the children in care are placed in group and institutional care at a higher cost to the State, due in part to the loss of foster homes. Children stay in care longer than is necessary and have worse outcomes.

\(^4\) www.cwla.org  
\(^5\) http://www.dhr.state.md.us/crbc/pdf/anrpt03.pdf  
\(^6\) From 5 year trend data provided by CRBC
Recognizing that the goal of reaching CWLA standards was becoming further out of reach, the General Assembly calculated how many staff could be hired within the Fiscal Year 2005 appropriation at the local department of social services level. Based on this figure, the Budget Bill specified that the Department of Human Resources ensure a workforce of 1,880 child welfare workers by October 1, 2004, or face a $1.5 million penalty. On September 17, 2004, Department leadership notified the Chairman of the Senate and House Budget Committees that they needed to hire 138 additional staff by October 1 to comply with the legislative requirement, and would be unable to do so. Citing difficulty recruiting qualified applicants and retaining staff, they hoped that their failure to meet the target would not result in the imposition of a financial sanction. Hearings on the status of the Department’s efforts were held on October 7, 2004, in the House Appropriations Committee and October 19, 2004, in the Senate Budget and Taxation Committee. Neither Committee seemed inclined to acquiesce to the Department’s request for leniency at that time.

**History of the Task Force**

In January 2003 advocates and child welfare professionals in Maryland approached the newly-elected Administration of Governor Robert L. Ehrlich, Jr. and urged him to establish a Governor’s Task Force on Child Welfare Accountability.

The Governor was supportive of the overall intent of the Task Force and of legislation to create such a planning effort. Anxious to see an immediate and independent response to the issue of child welfare program accountability and prompted by the Citizens’ Review Board for Children, Delegate Samuel Rosenberg introduced House Bill 480, entitled, *Task Force on Child Welfare System Accountability* in February 2003. This bill called on the Governor to appoint a Task Force to develop a list of performance measures and a process for the qualitative assessment of individual cases in order to monitor the safety, permanency, emotional well-being and educational development of children served through the child welfare system. The bill called for the determination of best practices in all aspects of child welfare with emphasis on outcome-based care management, program accountability and measures of compliance with federal and state policies.

Although the legislation was not enacted, key aspects of the proposed legislation were incorporated into the Joint Chairman’s Report and included in the operating budget narrative that was approved in April 2003. It required the Department of Budget and Management to convene a Task Force to evaluate the child welfare system in Maryland. The budget language that created the Task Force on Child Welfare Accountability was specific in regards to both work products and composition of the Task Force itself. In addition to an evaluation of the child welfare system, the Joint Chairman’s report asked for:

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;

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7 In addition there must be a workforce in place of 1,891 on January 1, 2005 and March 1, 2005 or DHR will face a penalty of $1 million in each instance.
4. Measures of child and family outcomes, and a method for collecting data needed to measures outcomes; and
5. An analysis of how the State might maximize federal revenues in order to improve child safety, permanency, and well-being.

The Annie E. Casey Foundation, a national charitable organization located in Baltimore, was asked to assist the Department of Budget and Management in this effort. The mission of the Foundation is to foster public policies, human service reforms and community supports for vulnerable children and families by providing support to states, counties, communities and neighborhoods to improve opportunities and outcomes of disadvantaged children and their families.

Membership of the Task Force and its three workgroups included representatives of the General Assembly, leadership from Executive Branch agencies that address child welfare issues and the health and safety of children and youth generally, representatives from the judicial branch, state child welfare administrators, and representatives from non-governmental organizations and advocacy groups that have a vital interest in the state’s child welfare system. In February 2004, the first organizational meeting of the Child Welfare Accountability Task Force was held. Task Force and work group membership is listed in Appendix A.

During the course of its work, the Task Force heard from many sources. The Secretary of the Department of Human Resources and staff of the Social Services Administration gave presentations regarding programmatic trends and data issues. A Deputy Director of the Department of Budget and Management and his staff spoke on the child welfare budget and staffing. Additionally, the Maryland Children’s Electronic Social Services Information Exchange (CHESSIE) Project Team made a presentation on the planning, functionality, and implementation of the new automated child welfare information system. Significant challenges were identified in each of these areas. Representatives of other states also spoke about efforts to improve child welfare performance in their agencies.

The Task Force also reviewed the audit of the child welfare system conducted by the Maryland Department of Legislative Services and issued in May 2003. This audit revealed major shortcomings in the ability of the system to provide basic services for maltreated children, including the failure to meet basic child welfare caseload standards. Staffing inadequacies were seen as contributing to the overall erosion of the system, and the decreasing availability of prevention and early intervention services were seen as leading to increases in costly foster care placements.

The State underwent the federal Child and Family Services Review in the fall of 2003. The federal review process was established by Congress to review the performance of state child welfare agencies on outcomes for children and families. Previous federal review procedures focused primarily on the process of delivering services rather than the effect of those services on child safety, permanency, and well-being. The 2003 review was Maryland’s first, the results of which were released in June 2004.
Maryland’s Performance on the Federal Child and Family Services Review

Maryland’s performance on the federal Child and Family Services Review added to the growing concern. Maryland failed to achieve substantial conformance (90% of cases must be in substantial conformance) on any of the seven case level analysis outcome measures. Four of the 23 performance indicators were rated as “strengths,” while the remaining 19 indicators were rated as “areas needing improvement.” Failure to improve performance on these outcome measures will eventually result in federal fiscal sanctions.

Maryland’s level of performance was fairly average among the states. Areas where the state is five percent or more above or below the national average are highlighted in the table below.

Highlights of Maryland’s Performance on the Federal Child and Family Service Review Case Level Assessment

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Percent of Cases in Substantial Conformity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MD scored at least 5% higher than the national average</strong></td>
<td></td>
</tr>
<tr>
<td>Item 1: Timeliness of investigations</td>
<td>88%</td>
</tr>
<tr>
<td>Item 9: Adoption</td>
<td>42%</td>
</tr>
<tr>
<td>Item 18: Child/ family involvement in case planning</td>
<td>71%</td>
</tr>
<tr>
<td>Item 19: Worker visits with child</td>
<td>86%</td>
</tr>
<tr>
<td>Item 20: Worker visits with parents</td>
<td>68%</td>
</tr>
<tr>
<td>Item 22: Physical health of the child</td>
<td>91%</td>
</tr>
</tbody>
</table>

| **MD scored at least 5% lower than the national average** | |
| Item 2: Repeat maltreatment | 87% | 92.5% |
| Item 5: Foster care re-entry | 71% | 85.2% |
| Item 7: Permanency goal for child | 34% | 68.4% |
| Item 8: Reunification, guardianship and placement with relatives | 38% | 64.2% |
| Item 10: Other Planned living arrangement | 56% | 66.8% |
| Item 12: Placement with siblings | 71% | 85.7% |
| Item 13: Visiting with parents and siblings in foster care | 67% | 73.1% |
| Item 16: Relationship of child in care with parents | 64% | 74.4% |

While not out of line with the average level of compliance among states nationally, Maryland is far from meeting national standards on most performance indicators.

The State’s own legislative audit findings coupled with the federal Family and Child Services Review findings clearly define the level of effectiveness of Maryland’s child

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welfare system. Given the uneven flow of resources to the system over the last several years, it is no wonder that Maryland’s performance on the audit was mediocre.

### Maryland’s Performance on the Child and Family Services Review

#### Case Level Assessment

<table>
<thead>
<tr>
<th>Outcomes and Indicators</th>
<th>In Substantial Conformity with Fed?</th>
<th>Percent of Cases Substantially Achieved*</th>
<th>Percent of Cases Where Item is Strength</th>
<th>Item Rating**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Outcome 1: children are first and foremost protected from abuse and neglect.</td>
<td>No</td>
<td>87.2</td>
<td>88</td>
<td>Strength</td>
</tr>
<tr>
<td>Item 1: Timeliness of investigations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 2: Repeat maltreatment</td>
<td></td>
<td>87</td>
<td></td>
<td>ANI</td>
</tr>
<tr>
<td>Safety Outcome 2: Children are safely maintained in their homes when possible and appropriate</td>
<td>No</td>
<td>81.3</td>
<td></td>
<td>ANI</td>
</tr>
<tr>
<td>Item 3: Services to prevent removal</td>
<td></td>
<td>83</td>
<td></td>
<td>ANI</td>
</tr>
<tr>
<td>Item 4: Risk of harm</td>
<td></td>
<td>84</td>
<td></td>
<td>ANI</td>
</tr>
<tr>
<td>Permanency Outcome 1: Children have permanency and stability in their living situations</td>
<td>No</td>
<td>26.7</td>
<td></td>
<td>ANI</td>
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<tr>
<td>Item 5: Foster care re-entry</td>
<td></td>
<td>71</td>
<td></td>
<td>ANI</td>
</tr>
<tr>
<td>Item 6: Stability of foster care placements</td>
<td></td>
<td>79</td>
<td></td>
<td>ANI</td>
</tr>
<tr>
<td>Item 7: Permanency goal for child</td>
<td></td>
<td>34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 8: Reunification, guardianship and placement with relatives</td>
<td></td>
<td>38</td>
<td></td>
<td>ANI</td>
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<tr>
<td>Item 9: Adoption</td>
<td></td>
<td>42</td>
<td></td>
<td>ANI</td>
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<tr>
<td>Item 10: Other planned living arrangement</td>
<td></td>
<td>56</td>
<td></td>
<td>ANI</td>
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<tr>
<td>Permanency Outcome 2: The continuity of family relationships and connections is preserved.</td>
<td>No</td>
<td>64.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 11: Proximity of placement</td>
<td></td>
<td>96</td>
<td></td>
<td>Strength</td>
</tr>
<tr>
<td>Item 12: Placement with siblings</td>
<td></td>
<td>71</td>
<td></td>
<td>ANI</td>
</tr>
<tr>
<td>Item 13: Visiting with parents and siblings in foster care</td>
<td></td>
<td>67</td>
<td></td>
<td>ANI</td>
</tr>
<tr>
<td>Item 14: Preserving family connections</td>
<td></td>
<td>71</td>
<td></td>
<td>ANI</td>
</tr>
<tr>
<td>Item 15: Relative placements</td>
<td></td>
<td>72</td>
<td></td>
<td>ANI</td>
</tr>
<tr>
<td>Item 16: Relationship of child in care with parents</td>
<td></td>
<td>64</td>
<td></td>
<td>ANI</td>
</tr>
<tr>
<td>Well being Outcome 1: Families have enhanced capacity to provide for children’s needs</td>
<td>No</td>
<td>61.2</td>
<td></td>
<td>ANI</td>
</tr>
<tr>
<td>Item 17: Needs/ services of child, parents, and foster parents</td>
<td></td>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 18: Child/ family involvement in case planning</td>
<td></td>
<td>71</td>
<td></td>
<td>ANI</td>
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<tr>
<td>Item 19: Worker visits with child</td>
<td></td>
<td>86</td>
<td></td>
<td>Strength</td>
</tr>
<tr>
<td>Item 20: Worker visits with parents</td>
<td></td>
<td>68</td>
<td></td>
<td>ANI</td>
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<tr>
<td>Well-Being Outcome 2: Children receive services to meet their educational needs</td>
<td>No</td>
<td>86.5</td>
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<td>ANI</td>
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<tr>
<td>Item 21: Educational needs of child</td>
<td></td>
<td>86</td>
<td></td>
<td>ANI</td>
</tr>
<tr>
<td>Well Being Outcome 3: Children receive services to meet their physical and mental health needs</td>
<td>No</td>
<td>80.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item 22: Physical health needs of child</td>
<td></td>
<td>91</td>
<td></td>
<td>Strength</td>
</tr>
<tr>
<td>Item 23: Mental health needs of child</td>
<td></td>
<td>69</td>
<td></td>
<td>ANI</td>
</tr>
</tbody>
</table>

*90 percent of the applicable cases must be rated as having substantially achieved the outcome for the State to be in substantial conformity with the outcome.

**Items may be rated as a ‘Strength’ or an ‘Area Needing Improvement’ (ANI).
Task Force Recommendations

This document represents the final report of the Task Force’s findings and recommendations. It provides a framework for the development of a high quality, accountable child welfare system. It includes three categories of recommendations, with a number of specific recommendations within each category. The three major categories of recommendations are that Maryland’s child welfare system needs:

1. A Long-Term Commitment to Excellence,
2. An Outcome Measurement System, and
3. A Quality Assurance System

The three major recommendations are interrelated; none can be effectively implemented without the others. To attempt to do so would further cloud the state’s ability to help abused and neglected children. Recognizing that an outcome measurement system should be viewed as part of a quality assurance process and in view of the federal performance measure requirements Maryland must, at a minimum, begin to measure its performance and meet federal standards in order to avoid federal fiscal sanctions. But the development of a quality assurance system that includes the ability to measure outcomes and quality of care requires more than an outcome measurement system, and will require a long-term and stable commitment to excellence on the part of state decision-makers.

The questions asked in the Joint Chairman’s Report mirror the frustration of many stakeholders in the system, including those who work within the system: While we have a general picture of our overall performance, practitioners on the front line simply do not know how well they are doing, and have no way to measure it. We want a system that meets the needs of abused and neglected children and families and is cost effective, but we are not sure what that system should look like or how much it should cost. Even at the highest levels within DHR, there is little ability to link performance and spending.

Unfortunately, in spite of a six-year old legislative mandate, the state has not made a long-term, stable financial commitment to the level of quality it expects from its child welfare system. Total spending in fiscal year 2004 was very close to spending in fiscal year 2002. Meanwhile, the average foster maintenance payment rose from $1,313 per month in fiscal year 2000 to $2,008 in 2003. These figures exclude subsidized adoption.

“Regular” foster family reimbursements rates were not raised during this time period, therefore, the increase is due to the increased costs of treatment foster care and group care. Since overall spending did not increase, this shows the amount spent on other areas (e.g. family preservation, foster parent support, reunification and adoption) must have decreased. According to the federal Child and Family Services Review, Maryland’s performance is about average in its failure to meet federal performance standards. Its financial commitment is inadequate and unless the state is willing to commit resources to improve and enhance the system and build it into one that provides high quality services and achieves positive outcomes for children and families, the system’s performance is not

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9 From the Department of Budget and Management
likely to improve. Meanwhile, more and more of the child welfare budget goes to maintain children in high-cost placements. This represents a long-term failure of strategy and will.

1. **Maryland’s Child Welfare System Needs a Long-Term Commitment to Excellence**

**Recommendation 1:** The Governor and General Assembly must make a long-term commitment to enhanced 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.

Since the *L.J. v Massinga* lawsuit, the only consistency in State support of the child welfare system has been its inconsistent and ambivalent commitment toward improving the system. The child welfare system has been treated like the abused and neglected children it serves, abused because of its poor performance, yet barely fed enough to allow it to survive, let alone thrive. At best, the system “makes do”, and, at worst, it falls far short of adequately serving abused and neglected children and their families. Until State leaders are prepared to commit, on a long-term basis, to enhanced and stable funding and support for the system, a culture of excellence cannot be developed or maintained. The “make do” culture that currently exists forces workers to prioritize among statutory and regulatory requirements and to focus on crisis situations, resulting in neglect of everything else. The neglect of known problems among families and children has created a system that is sinking into the quicksand of a deep-end spending spiral.

The system is currently based on the minimum level of case activity to meet the most pressing needs, with workers and managers hoping to achieve compliance with State and federal minimum standards. The current system is not, and cannot afford to be, based on best practice or a culture of excellence. Until workers, supervisors and administrators see a determined commitment to excellence in the child welfare system on the part of State decision-makers, performance will continue to be mediocre at best. The highest quality of services is not possible given the current level of resources provided. Developing a culture of excellence requires a commitment to adequate staffing, infrastructure, and supportive services for children and families.

**An Adequate Workforce**

**Recommendation 2:** The Governor 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.

As part of the long-term, stable commitment to excellence, state decision-makers must establish a commitment to stable funding for child welfare staffing that is protected from periodic hiring freezes and other cost cutting initiatives. These short-term cost cutting initiatives only serve to increase the cost of serving abused and neglected children over the long run.
Child welfare workers are the first responders to child victims of abuse and neglect. The capacity of frontline workers has more to do with the ability of the state to protect children than any other single factor. A recent publication of the Annie E. Casey Foundation cites the need to strengthen the direct service workforce or face a declining ability to care for vulnerable and disadvantaged children and families. Studies show that heavy caseloads, low pay, inadequate supervision and lack of agency support lead to high turnover, poor morale and poor performance in human service agencies:

When vacancies occurred, the remaining workers had to cover the departed colleague’s cases. The more vacancies and the longer the unfilled slots remained open, the greater the burden on the already harried caseworkers. \(^{10}\)

Maryland epitomizes this phenomenon. Spurred by an economic recession, the State implemented a hiring freeze in October 2001 that has only recently improved. Caseloads grew exponentially as staff departed from every local agency. Those departures, combined with spending cuts in salary adjustments, training, and service resources that support families and children, gave child welfare workers in local departments of social services little hope of successfully helping children and families, resulting in a downward spiral of low morale and staff resignations.

To compensate for the dwindling number of staff, cases involving less serious allegations of abuse and neglect were not opened for service or closed after a brief time with no further follow-up, thus leaving some children at risk. Services to prevent abuse or neglect, or to reduce the need for placement, such as family preservation and family support, were likewise reduced by 40% statewide. \(^{11}\)

Maryland must reverse this trend and implement a recruitment and retention strategy that assures that staffing in all jurisdictions is adequate. Direct service caseworkers have multiple responsibilities, each equally important that must be fulfilled to assure the system works as it should. Caseworkers must have low enough caseloads to assure that they can:

- Consistently screen, and follow-up on referrals where abuse or neglect is reported systematically and timely;
- Open cases where safety and risk issues are likely to result in subsequent child maltreatment;
- Adequately assess family safety and risk issues and make competent, informed decisions about whether to allow children to remain in the home or be removed to out-of-home care;
- Develop, implement, and monitor case plans that adequately address families’ and children’s needs and involve families in the development process;
- Monitor and assist high-risk families where children remain in the home;
- Locate relatives or place the child in an appropriate foster setting;


\(^{11}\) From SSA Monthly Management Report May 2004 p.17.
• Visit children in out-of-home care to ensure they are safe and their needs are met;
• Work with parents of children in out-of-home care to help them address their case plan requirements;
• Follow up on children who have returned home to ensure that children are safe and supported; and
• Locate an appropriate adoptive home or other permanent living arrangement.

When caseloads are too high, workers cannot undertake all of these activities, so they are forced to pick and choose among them. When caseworkers are forced to choose among competing priorities, some of these activities will be given short shrift or be neglected altogether. When any one of these activities is not done well, the system fails and abused or neglected children pay the price.

Further, staff used to recruit, train, monitor, and support foster homes are essential to a functional child welfare system. Caseworker shortages result in the shifting of foster home staff to cover caseloads. This shift results in failures to recruit, license, train, and support foster parents. When foster parents are not adequately supported, they leave the system resulting in foster parent shortages which cannot be addressed because staff are not recruiting, licensing, and training new foster parents. It’s a downward spiral that has long-term negative consequences for children.

Allocation of staff to local departments of social services must be sufficient to ensure that turnover and lag time in refilling caseworker and support positions and training of new staff does not leave caseloads uncovered or frequently reassigned. To achieve this goal, additional positions, beyond that which is required to meet the CWLA standards, should be filled in anticipation of vacancies. The number of actual positions should reflect the number needed based on caseload, plus the vacancy rate. A portion of the excess positions can be reduced as retention rates improve over time. Rather than reduce funding to account for the vacancy rate, positions should be added to account for the vacancy rate.

A Common Vision and Operating Principles

**Recommendation 3:** DHR should convene a widely representative group of stakeholders to develop a new vision for the child welfare system and a set of principles by which workers, supervisors and administrators will operate and upon which the system will be judged.

Maryland’s child welfare system has suffered from a lack of consistent vision at the State and local levels. Inconsistency among priorities across county agencies is the norm, and results in county agencies operating differently across the State. Maryland’s system is comprised of 24 individual jurisdictions, each “doing its own thing.” This problem was
identified in the recent Final Report of the federal Child and Family Service Review, which noted innumerable inconsistencies among the three counties sampled.[3]

In order to bring the system together with a new unified vision, the DHR should convene a group comprised of DHR administrators, legislators, court representatives, CASAs, local administrators, line staff, and supervisors, advocates, providers, foster parents, foster children, and families involved with the system to define a vision and set of principles under which the child welfare system will operate. This vision must be informed by innovations implemented around the country that have improved outcomes for children and families in child welfare. These innovations include keeping fragile families together when possible or at least placing children in their own communities. Family Team Meetings are another innovation that involves using the strengths of a family and its supports to provide a safe way to keep fragile families together. It is also necessary to target supports to the communities where fragile families live. Once developed, the vision and principles should be widely disseminated, become the foundation upon which the system operates, and by which the success of the system is judged. These principles should be the basis of a performance outcome measurement system and a quality assurance system. It should be clear to every worker in the system what the vision is and what the operating principles are.

Role Clarification

**Recommendation 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.

The organizational structure of DHR is not clear to many departmental staff and to many citizens of Maryland from whom the Task Force heard. An updated, accurate organizational chart must be developed, posted on the website and in county offices. Any new central office management positions that are created should be clearly defined and their relationship to the county offices, if any, explained to county offices. Unless DHR/SSA central office roles and the reporting relationships are clarified, and the relevant management practices improved, accountability cannot be assured. The updated organizational chart should delineate clear lines of responsibility and accountability for functional areas, enabling local staff and other stakeholders to know whom to call with policy or practice questions or complaints or for technical assistance or training.

DHR, in its leadership role, must assure that federal funds are maximized by addressing IV-E eligibility deficiencies through training and oversight at the local level, by advocating for federal changes to de-link IV-E eligibility from 1996 income standards, and by advocating for more therapeutic and substance abuse services through Medicaid and the DHMH system so that all children who need these services have access and to begin to have the capacity to provide treatment to for the parents of children in care.

A primary role of SSA is resource development and contract oversight of group home and congregate care. Both of these roles should be strengthened to ensure that contract providers are held accountable to best practice standards through the use of performance based contracting, that rates are set to ensure quality services and good stewardship of public funds, and that programs provide quality services to Maryland’s children. SSA should develop standard/uniform performance measures that would be consistent with HB 1146, Juvenile Causes - Children in Out-of-Home Placement - Plan for a System of Outcomes Evaluation, for all vendors/contractors of residential programs. Vendors should regularly report outcome data based on the established performance measures. SSA must analyze the data regularly to ensure management is holding vendors accountable. In addition, before a vendor’s contract can be renewed, SSA must seek input from the local DSS offices that have children in that vendor’s care.

Local DSS offices should be charged with achieving outcomes for children and families, promoting model front line practices, and assuring high quality services to children and families. They must be part of strategic planning efforts to identify service gaps and problems and they should be held accountable for doing their part in achieving appropriate levels of IV-E eligibility to assure federal fund maximization.

2. Maryland’s Child Welfare System Should Be Based on the Achievement of Outcomes for Children and Families

_**Recommendation 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.

The federal government is now using outcomes and performance indicators to measure performance of the states. It is time that the state shift to using outcomes and performance indicators to measure its own performance and that of the local agencies. It is no longer adequate to simply measure work activity; the bottom line is the outcome of the work activity. Are the interventions provided by the child welfare system having a positive impact on the lives of abused and neglected children?

Maryland’s system should build on the federal Child and Family Service Review (CFSR) process. The CFSR examines performance in three general areas: child safety, child permanence, and child and family well-being. Maryland should expand on the federal system to make it comparable to California’s Child Welfare Outcomes and Accountability System.\(^\text{12}\)

California faced a similar challenge to Maryland when state legislation called for greater accountability for child and family outcomes in California’s child welfare system. The

\(^{12}\) This information is available at http://www.chhs.ca.gov/ccwoaas.html and at http://www.govtguide.com/govsite.adp?bread=Main*&url=http%3A//www.my.ca.gov/
state created a state-county partnership that shifted focus from process-measured compliance to an outcome-based review system. The system is data-driven and research-based, uses a family-focused, strengths-based approach, and establishes accountability through county-level improvement plans and web-based progress reports. Further, the system enables counties to access enhanced management reports for program improvement analysis, promotes sharing of promising practices, and encourages interagency coordination. The system builds on the CFSR and creates a local structure for meeting the Program Improvement Plan (PIP) goals.\(^4\)

California’s outcome-based system includes the designation of state-enriched outcome measures that are derived from the CFSR, but go further in their delineation of outcomes to be achieved and use of indicators to measure that achievement. Data elements are collected by the state from their case level management information system and then transmitted to the University of California, which produces management reports for the counties and the state. Data are also used to research best practice issues.

Outcome measures recommended for Maryland are included in Appendix B. The table on the next two pages summarizes the measures recommended. The items selected for the outcome matrix were based on whether data was available, accessible, and accurate. In some instances, data will have to be exchanged between agencies in order to measure outcomes. For example, the names, birth dates or medical assistance numbers of all children in out-of-home care must be provided by DHR to DHMH in order to obtain information on well-child medical visits and on the provision of mental health services.

To facilitate interagency planning and collaboration around child welfare issues, an interagency child maltreatment data repository should be established. Such a data repository should be independently housed, ideally in a university setting. The entities that should be asked to contribute data to such a repository include: DHR, criminal and civil courts, states attorneys, police, local and state child fatality review teams, citizens review boards, health departments, medical examiners, juvenile services, day care licensing, CASA, etc.

Such a data repository would need to ensure the strict protection of individual identities, while containing sufficient identifying data fields in its raw form to enable records to be linked for individuals or families across systems. Access to the source data would have to be strictly controlled, while access to linked data without identifiers might be made more widely accessible.

While the focus of measurement should be on outcome data, it is also important to analyze the data in relation to program size, structure, and resources. This information may be useful to help explain why performance is below standard in a local agency. This type of information can be used for quality assurance purposes as well, and will be useful at the state and local levels for corrective action plans in cases of poor performance.

\(^4\) The Program Improvement Plan is submitted by each state in response to the findings of the Child and Family Services Review. It is created to identify how each state will improve performance on a subsequent review. The plan must be approved by the federal government.
### Proposed Outcome Measures for Maryland’s Child Welfare System

#### Safety Outcomes

**Children are, first and foremost, protected from abuse and neglect.**

The incidence of unreported child maltreatment: The work group recommends that Maryland replicate the national incidence study methodology, which estimates the actual incidence of child maltreatment to collect a sample large enough to make jurisdictional or regional maltreatment incidence data available for a truer assessment of the scope of maltreatment in Maryland.

Recurrence of maltreatment: The state enriched indicator for measuring recurrence of maltreatment shall include data on all children who had an indicated report in the report year, and for whom there was a previous report.

Incidence of child abuse and/or neglect in foster care: Percent of children in out of home care who were subject of a report of maltreatment disaggregated by type of placement (foster home, kinship care, group care, DJS facility, etc.), and category of finding (ruled-out, unsubstantiated, indicated).

Rate of abuse and/or neglect following permanency: Percent of children with report of abuse or neglect, within 12 months following permanency (guardianship, Kinship care, adoption, reunification).

Screening of reports: The Department of Human Resources should collect aggregate data (with non-identifying information) on all calls not accepted for investigation by the LDSS’s and the reason for their being screened out.

Ruled-out findings: Prior to expunging of any case of abuse or neglect investigated by a local department of social services, non-identifying information should be preserved and aggregated, including the reason for the finding.

Recurrence of maltreatment: All State agencies that have contact with children or youth who may have been subject to maltreatment (DHR, law enforcement, DJS, and GOCYF / LMB’s Family Preservation Program) should place their data in a data repository so that it can be used for practice improvement, management and research.

**Children are safely maintained in their homes whenever possible and appropriate.**

Recurrence of abuse/neglect in homes where children were not removed: Percent of children with an allegation (unsubstantiated or indicated) who were not removed and whose next event was a substantiated allegation.

Percent of cases where an allegation of abuse or neglect was either unsubstantiated or indicated and the children were not removed but received some type of service from a local department of social services and where there was a subsequent indicated finding.

Caseworker visits:
- Stratified by program type and visits with child, parents and caregivers.
- Percent of families who received at least monthly caseworker visits.

#### Permanency Outcomes

**Children have permanency and stability in their living situations**

Length of time to exit foster care: Of those children in an entry cohort, % exiting foster care within 3, 6, 12, 24, 36, 48 and 60 months of entry.

Multiple placements: Of those children in an entry cohort, % of those remaining in care with 3, 4, 5 or more placements within 12, 24, 36, 48 and 60 months.
- Frequency and constellations of placements
- Reasons for placement change(s) Foster care re-entries: Of children in an entry cohort, for those exiting to reunification or guardianship, % who re-entered care or DJS custody within 12, 24 and 36 months, stratified by time in care 3, 6, 12, 24 months (48 and 60 months for guardianship) of a prior foster care episode.

Timely court hearings: Percent of children who have had timely status review hearings, stratified by program type and age.

Juvenile Justice Involvement: Percent of children in DJS custody who are or have also been in DSS custody.

**The continuity of family relationships and connections is preserved for children.**

Placement with Siblings: Percent of children in foster care, who have a sibling also in care, with whom they are living at the date of report; annual (point in time) by jurisdiction, excluding after-care.

Use of least restrictive care settings: For children entering care, what is the predominant placement type?
### Child & Family Well-Being Outcomes

*Children receive adequate services to meet their physical, emotional and mental health needs.*

Receipt of health screenings:
- Percent of children in foster care that received a well-child service in the report year, by age breaks, by jurisdiction, and inclusive of both MCO and fee-for-service providers.
- Percent of children ages 4-20 years in foster care continuously for the previous six months, receiving one or more dental services.

Receipt of mental health services among those referred: Percent of foster children who entered care in the past year that received any mental health service (excluding pharmacy) in the last year.

*Children receive appropriate services to meet their educational needs.*

Education Information:
- For children with an IEP or IFSP, the percent in non-public schools and receiving IEP or IFSP prescribed services.
- For children with an IEP or IFSP, the percent in public schools and receiving IEP or IFSP prescribed services.

School Stability: For children in out-of-home care with IEP's or IFSP's who attend either public or non-public school, the percent who had more than one school placement during the school year.

School Attendance: Percent of children in foster care and kinship care with adequate yearly attendance, less than 20 days missed. (This would require DHR to give MSDE social security numbers for all children in out-of-home care that were age 5 by December.)

School Performance: Percentage of children in care at grade level on standardized state tests (requires match to planned statewide education data); stratified by special and regular education (by entry cohort, age and placement type).

*Families have enhanced capacity to provide for their children's needs.*

Parent services: For children in out-of-home care for at least 6 months with a plan of reunification, the percentage of parents able to access and use support services identified in case plans.

*Youth emancipating from foster care are prepared to transition to adulthood.*

Transition to self-sufficient adulthood:
- Percent of youth emancipating from foster care who receive independent living services;
- Of youth receiving independent living services and emancipating from foster care, the percentage who:
  - Have a High School diploma or GED;
  - Are enrolled in college or higher education program;
  - Have completed a vocational training program;
  - Are employed or have other means of support
  - Have housing
  - Have health insurance
Information Technology

**Recommendation 6:** State decision-makers should commit stable funding to implement a fully-functional, statewide child welfare information system as quickly as possible.

It is impossible to efficiently and effectively manage and monitor child welfare services without adequate information technology. A very large part of a truly integrated system of accountability and service delivery is dependent on the timely implementation of CHESSIE. Its functionality in every aspect, from locating children in care to attaining federal fund reimbursement, is critical to the very future of child welfare in Maryland. In 1993, the U.S. Department of Health and Human Services began providing substantial financial incentives to states to develop automated systems that would enable child welfare data at the case level to be aggregated and reported to the federal government. Maryland, like virtually all other states at that time, had limited capacity to provide information on children in the child welfare system. This information is essential to monitor placements, resource needs, costs, services provided, services needed, and relevant information on family members, court and review dates and overall agency performance. It is also critical to supervision, an important aspect of quality monitoring.

Most states moved forward expeditiously using the enhanced federal reimbursement made available for this purpose and many have completed outstanding, user-friendly systems that provide excellent data for decision making. Maryland, however, through fits and starts over the last decade, has moved haltingly in the development of the CHESSIE system.

When fully functional, the CHESSIE system will maintain a running history of all child welfare activities, and be able to:

- Provide fiscal accountability with accurate and timely payments to foster care providers and documentation for maximum federal reimbursement;
- Serve as a tool to provide quick and easy access to information about children and families to facilitate good casework decisions; and
- Enable supervisory monitoring, program evaluation and trend analysis to be done simply and accurately.

Funds for CHESSIE have been reduced and withheld in a series of actions by both the Governor and the General Assembly due to cost containment initiatives, questionable oversight of the project, and reluctance to commit millions of dollars to a system that many doubted could live up to these expectations. The result is that local departments of social services have continued to limp along with record-keeping systems that were developed in the mid-1980s, are antiquated, and labor and paper intensive.

Case information is recorded on many hand-written forms that cannot be entered into any current automated system and therefore non-accessible. Real time information is not available at the worker or supervisory level. This has resulted, at times, in uninformed decisions and more than half of the child welfare workers' time being spent in the office.
doing paperwork rather than working with or monitoring children or families. Furthermore, workers do not have any automated capacity to review cases or monitor case activities, and supervisors have no automated ability to monitor the work of their staff. It is remarkable that an agency with a budget of over $400 million has such limited capacity to monitor cases and costs and no single automated information system into which its extensive client information is input.

Full implementation of the CHESSIE system needs to occur as expeditiously as possible. Technological support for the field as well as for management is critical for case monitoring, resource identification, improved decision-making, tracking of services, and day-to-day work activities. The entire development of accountability in Maryland’s child welfare system rests with the completion of CHESSIE. Without it, all of the recommendations in this report are meaningless. Problems in service delivery need to be identified with valid data available in real time. Only then can meaningful solutions be developed and implemented.

Data from the new system would be used to identify and address emerging trends and issues such as service needs, outcomes, geographic trends, caseload changes, etc. to drive necessary policy or program changes. Critical to the development of new information technology is the ability to access timely and comprehensive program data. By highlighting management data, it is possible to drive planning and decision-making based on the most current state of the child welfare system in each area of the state. When data is readily available in an easily usable form it will be possible to develop a child welfare planning process based on program and management data.

3. **Maryland’s Child Welfare System Needs a Quality Assurance System**

**Recommendation 7: DHR should develop a quality assurance system that includes an assessment of performance at the state and local levels.**

A quality assurance system for child welfare should adopt the continuous quality improvement model with measurement of outcomes at the state and local levels and measurement of case level quality of care statewide and in each local office and where findings from outcome measures and quality reviews are used to change and improve policy and practice. Findings are used to guide worker training, to clarify policies and procedures, and to develop and improve best practices.

In order to develop, plan, and implement a genuine quality assurance program, there must be full-time staff assigned to a quality assurance unit responsible to oversee the various elements of a quality assurance system. These staff would develop, oversee, and participate in the specific quality assurance elements discussed in the recommendations below. Sufficient funding must be provided to enable the state to give meaningful feedback to the counties.

Additionally, the quality assurance system should include an enhanced planning and evaluation capacity, possibly in conjunction with a state institution of higher learning. These staff would be used to:
• Analyze program and caseload trends for at a minimum, the three prior and three future fiscal years;
• Update information system functionality;
• Compare caseload information to the county allocation process and recommend any needed changes in allocations based on factors such as community need;
• Review provider rates and quality of care issues and recommend any needed changes in procedures;
• Undertake or develop specifications for contracted special studies and analyses; and
• Provide the fiscal impact.

The simple fact is that quality assurance requires an infrastructure that currently does not adequately exist within DHR. Measurement of quality, and the resulting change in policies and practices that result from that measurement, has a cost. These costs must be met. With the needed focus on adequate levels of staff for direct casework activities, infrastructure needs have been not been met. However, in order to ensure that casework staff are providing quality services to children and families, a quality assurance process with dedicated staff must also be implemented.

The Citizens’ Review Board for Children is an existing monitoring and advocacy structure that is funded by DHR that undertakes some of the obligations of a quality assurance system. Local departments accept the great majority of the case recommendations made by CRBC’s out-of-home placement review boards. Historically there have not been formalized channels of communication to address CRBC’s data, analysis, and recommendations for system improvements at the state level. DHR and CRBC should explore how this gap can be filled.

Another body, the State Council on Child Abuse and Neglect (SCCAN) meets monthly to carry out the duties and responsibilities defined by state and federal law, including the Child Abuse Prevention and Treatment Act (CAPTA). SCCAN’s primary responsibility under CAPTA is to examine the extent to which state and local agencies effectively discharge their child protection responsibilities. The Systems Improvement Committee (formerly the Research Subcommittee) develops and implements methodology to evaluate the effectiveness of state and local agencies in discharging their child protection responsibilities. The most recent undertaking of this committee is a study of screening practices of child protective service workers in reported cases of child maltreatment, focusing on "screened out" cases. DHR should explore whether the work of SCCAN can be of use in meeting this recommendation.
Best Practice

**Recommendation 8:** Maryland should fund 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.

Much research has been conducted in the last 25 years to determine what works in child welfare. Foundations, universities and professional associations have developed many guides to sound practice to assist states in developing greater competency in carrying out their state and federal mandates in child welfare. Certain tenets are found throughout the literature regardless of the site from which the findings and recommendations arose.

These tenets include:

- **Prevent out-of-home placement whenever possible; preserve families.** This requires a larger investment of resources, staff and dollars on the front end of the child welfare system. Children have better lives and better outcomes as adults if intervention is directed towards improving their families’ ability to care for them, rather than removing them from their birth family and placing them in foster care. As a matter of policy the Social Services Administration and local Departments of Social Services should improve the quality of case management for kinship care and commit additional funding to support services for both children and their relative caregivers to avoid more costly out-of-home placements.

- **Develop a continuum of resources for out-of-home placement; use the least restrictive, most family-like setting possible.** Children thrive best when they are raised in a family with caring and committed adults with whom they can have an ongoing relationship. The younger the child, the more critical a family setting is for developing the ability to form emotional attachments. Such attachments are necessary for neurological development, cognitive and social growth, and learning throughout childhood and adolescence. Group care and residential treatment should only be used when a less restrictive environment is not appropriate to meet the child’s needs. Senate Bill 711 requires that a statewide assessment be made on the types and locations of placements that are needed to serve children across the state.

- **Build neighborhood and community strength to support children and families.** Children from disadvantaged families are much more likely to become involved in the child welfare system. Children in at-risk families tend to live in neighborhoods that lack cohesion and resources to support families who are poor, socially isolated, and struggling to meet the adult family members’ needs as well as the children’s needs. Community services that support the social, health, and educational needs of families, as well as the economic well-being of the community can assist parents in meeting the demands of parenthood. Early intervention in the lives of fragile families decreases the likelihood that abuse and neglect will occur.

- **Use Multi-Disciplinary Teams in complex cases according to criteria developed by DHR and utilized in all jurisdictions.** The support for these teams should be spread across the jurisdictions according to the estimated number of
cases that will need to use them as opposed to the same amount of funding
going to each jurisdiction regardless of caseload

- Implement practices found in the Family to Family program.  

Unfortunately, the progress made toward achieving these best practices has been
markedly reduced in recent years. Local Department of Social Services staffing levels
for the provision of family preservation and family support services have been reduced;
community-based programs such as Family Support Centers, home visiting and parenting
education programs no longer receive the same level of state support and have been
forced to reduce their services. A larger percentage of children in foster care are in group
and residential care because hundreds of foster homes have closed and not been
replaced. The infrastructure for providing family and community-focused interventions
is in disarray and must be rebuilt. Moving forward requires renewed investment in
programs in both the public and private sectors and a commitment to promote excellence
throughout.

Across the country, child welfare systems are moving toward protecting children by
strengthening families through using specific service techniques. Maryland has not
employed many of these innovations. Two such innovations, among many, are the
geographic assignment of workers and Family Team Meetings.

Geographic assignment of workers is a service innovation that assigns workers to
families within a specific geographic area. This allows workers to become familiar with
the unique problems and individual resources within that area. It can also serve to use
worker time more efficiently by reducing travel time throughout a metropolitan or rural
area. This works particularly well when children are placed in care near their families,
one of Maryland’s few CFSR strengths.

Family Team Meetings (FTM) are designed to effectively engage the family and the
family’s relatives, friends, neighbors and others in the process of addressing the issues
which brought the family into the child welfare system and in constructing solutions in
order to achieve successful closure of a case. These meetings bring together the wisdom,
resources, and expertise of family, friends, informal supports (neighbors, clergy, etc.) and
formal supports (counselors, health professionals, etc.) to:

- Focus on solutions to meet the family’s needs and to ensure the child’s safety;
- Learn what the family hopes to accomplish;
- Set reasonable and meaningful goals;
- Recognize and affirm the family’s strengths;
- Assess the family’s needs;
- Design individualized support systems and services that match the family’s
  needs and build on its strengths;

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13 Information on Family to Family can be found on the Annie E Casey Foundation website: www.aecf.org
under the Initiatives section.

14 According to a SSA Monthly Management report the number of foster family homes in Maryland fell
from 4,648 in October 2001 to 3,463 in April 2004
• Achieve clarity about who is responsible for agreed-upon tasks; and
• Agree on the next steps.

The meetings are generally held at critical junctures of a case, are facilitated by an objective professional who is not directly assigned to the case, include all the relevant and available supportive resources for the child and family to strategize as a team about how to keep the child safe and meet his or her permanency goal, and identify the resources needed to achieve these ends. For example, community representatives can attend to help identify neighborhood resources and open the decision-making process around initial placement and subsequent moves. If a supervisor’s input is necessary to support a less experienced caseworker, the supervisor may also attend. If for example, the mother’s drug rehabilitation service provider would help inform the discussion, that person will also attend. The caseworker becomes a problem-solving partner. In this way, service plans will be tailored to the family’s individual strengths and needs, and will reflect the family’s own goals and aspirations in their own language, rather than become another government document unrelated to the family’s own identified needs.

In places like Louisville, Kentucky and Maine, where FTM has been implemented, the number of kids entering out-of-home care has decreased dramatically. The data from smaller systems has been compelling enough to drive large systems like New York City and California towards implementing Family Team Meetings as part of a policy move to strengthening families in their own communities.

Establishing a quality driven system of care requires that we rethink how we use all of our resources that involve vulnerable families. Building a safety net in communities and families via techniques such as FTM helps broaden responsibility for child safety beyond the child welfare agency alone. Those involved in family team meetings are able to help the caseworker know when issues need to be resolved to keep the child safe.

Worker Training

Recommendation 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.

After committing to the goal of strengthening families and communities, the next step is to adopt the practice model and standards necessary to accomplish change and impact the quality of care a child and family receives. The entire system of care needs to be updated and modernized, including the addition of cutting edge techniques from across the country such as Family Team Meetings. The best way to educate and train staff to competently undertake these new ideas and to integrate them into their every-day case practice is through a State Training Academy.
Currently, Maryland has a mandatory 40 hour pre-service training for all workers along with continuing education requirements. In addition, there is a Title IV-E program at the University of Maryland which helps to pay for BSW and MSW degree programs for individuals who then must work for the state.

A Child Welfare Training Academy goes beyond degree programs and basic training to continually provide the link between policy and practice. This helps ensure that policy changes are adopted in practice by the front-line workers and that best practices from around the country can be incorporated into casework. The Training Academy should develop a continuous curriculum that represents and reinforces national standards, child welfare best practice, and adopted model programs that meet the shared vision. It should include not only introductory training for new workers, but a robust series of professional development seminars for current workers, supervisors, and managers to expand their knowledge about emerging best practice and management techniques, including self-evaluation, from around the country. Under the current Title IV-E program, training related to Title IV-E allowable activities is 75% reimbursable based on the percentage of Title IV-E eligible children, regardless of who provides it. The advantage to having it provided through a university is that the university can, if it so chooses, use its indirect funds for the non-federal match for the portion of costs attributable to IV-E children.

Clarity in Budgeting, Cost Accounting and Performance Measurement

**Recommendation 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 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.

Accountability in government presupposes the ability to access information about the performance of government agencies. Even within Maryland State government, DBM staff have difficulty deciphering budget codes and producing expenditure statements that simply and directly portray how funds in the child welfare system are being spent. Bundling of expenditures by cost codes and payment dates makes tracking of specific costs difficult and makes comparisons of the cost-effectiveness of various treatment or casework strategies impossible.

Similarly, information that has been used to describe the functionality of the child welfare system has been composed of gross process measures, such as the total number of investigations of suspected child maltreatment, or the number of children freed for adoption. Measuring performance must include valid and timely information about inputs, such as recruitment of foster families, number of child welfare workers, training, caseload ratios, home visits made, and specific services provided, as well as dollars spent. This information has not been readily available in Maryland, and what has been available has been repeatedly subject to dispute as to its accuracy.

In addition, in order for the local assessment and planning process (see Recommendation 12) to work properly, more flexibility in budgeting – as well as new resources – will be
needed at both local and state levels. Currently, the cost of maintaining children in placement drives the budgeting and leaves little room to divert resources to identified areas of need.

DBM and the Department of Legislative Services (DLS) should:

- Develop a fiscal note for each recommendation in this report;
- Compare Maryland spending on child welfare to that of comparable states;
- Develop a trend analysis that examines child welfare population dynamics over the past three years and projections for the next three years. This analysis can then be compared to past spending by category and projected into the future. These analyses should be done for the whole state and for Baltimore City;
- Calculate what investment in workforce and services are needed to reduce over-reliance on costly group home and institutional forms of care. This analysis should include how potential savings from reduced deep end costs could be used as a source of funding for more prevention and early intervention services. Again, the analysis should be done for Baltimore City separately and, in addition, for the entire state; and
- Use geocoding technology to map the child welfare population to determine those areas of the state that should be given first priority in the distribution of resources and in implementation efforts.

The Quality of Casework

Recommendation 11: DHR and CRBC should implement the Quality Service Review Protocols process as a means of measuring the quality of case level activities.

The Quality Service Review (QSR) Protocols, as designed by the Child Welfare Policy and Practice Group in Alabama, have been implemented in 11 states and the District of Columbia. The goal of the QSR is to examine how child welfare practice is actually implemented at the case level, with an analysis of what is done for a case, how well it is done, based on best practice, and whether the desired outcomes have been achieved. Rather than simply ask if there is a case plan, which is the process used in a typical case review, the QSR process would ask, “Is the service plan relevant and current to the needs and goals of the family?” The QSR process measures both child and family status as well as system performance. Typically, the process involves direct interviews by qualified and trained reviewers with children, family members, caseworkers and others in the community such as judges, Court Appointed Special Advocates, foster parents, teachers, medical personnel, and others involved in providing support to the family. The child and family status review answers such questions as:

- Are the children safe?
- Are the caregivers safe?
- Does the family have stability?
- Are the family’s basic needs being met?
• How are the children doing in school?
• Are the primary caregivers in the household fulfilling their parenting responsibilities?

A system performance review interviews multiple related persons and agencies to ascertain information in the following areas:

• Has the family participated in planning and making service decisions?
• Does the service team include the necessary people to best plan and deliver services and supports?
• Is the service plan being implemented?
• Is the family making progress and is the service plan producing results?
• Is the team tracking the progress of the family and making changes to services and supports as necessary?

The philosophy behind the QSR is that good outcomes are determined by good practice. The model strives to improve practice by giving feedback not just on problems, but also by identifying real-life solutions. It sets the framework for staff training, policy enhancements, and utilization of resources in a way that clearly is linked to the needs of children and families.

Once a unified system of outcomes, indicators and performance measures is developed this system could replace the current CAPS (Child, Adult Performance System) system for the child welfare population, and should be implemented to provide regular feedback to caseworkers and supervisors. The results should be used to guide technical assistance, training, and policy development. DHR should work with citizen based review groups such as CRBC, the State Child Fatality Review Team, and the State Council on Abuse and Neglect to think about how their current functions could be reworked so that there is a minimum of overlap and a maximum number of children have these intensive case reviews.

The Citizens’ Review Board for Children is an independent, objective agency in Maryland that employs hundreds of volunteers to conduct case reviews and perform other monitoring and advocacy functions for Maryland’s child welfare system. It has a budget of about $1.4 million. CRBC currently conducts about 6,000 interested person reviews of children in out-of-home placement annually and sends a written case recommendation to the local department and the court for each child. It also conducts about 100 in-depth record reviews of child protection cases each year through the local child protection panels. Both types of reviews bear some similarity to the QSRs proposed here. DHR and CRBC should explore how the manpower and budgetary resources of CRBC could be redirected to meet the recommendations set out by this Task Force.

County Self-Assessment

**Recommendation 12:** DHR should adopt California’s county self-assessment process as a means of monitoring the quality of services provided at the local level.
The county self-assessment process would be conducted every three years, and would be based on an analysis of the outcome indicator data. These data would be enhanced by client surveys, focus groups and stakeholder input. A county team, including child welfare agency staff, other local agency staff, and interested individuals and stakeholders would complete the assessment. As part of the process, this group would consider agency and county-specific data and demographics to interpret the significance of data trends and resources such as size and structure, workforce/caseload, technology capacities, law enforcement and judicial participation.

Peer Quality Case Review (PQCR), which is an extension of the self-assessment process, would be used to train peer reviewers from other counties to do an in-depth analysis of social work practice through structured interviews with families, caseworkers and other professionals who have been involved with the case.

The county self-assessment process would culminate in the development of a county self-improvement plan. Its intent would be to provide the blueprint for targeted technical assistance that supports those providing social work services, with priority given to areas needing improvement. Improvements would be monitored through quarterly data outcome reports with continuous monitoring of outcomes, which would enable improvement goals to be set and measured.

In California, this process led to the discovery of significant variations between counties in practice. For example, one jurisdiction investigated every child abuse and neglect report that it received, while another investigated only a portion of the reports received. Since Maryland’s CFSR results reveal wide variations in practice priorities among the three counties where cases were reviewed, a system that identifies these variations would be useful in addressing these inconsistencies across the State.

“Drilling down” through the data to the case level is recognized as an important step for the greater understanding of the system. Additionally, interpretation of trends is important in order to understand what is happening in the lives of children. For example, a rise in adoption rates should reduce the percentage of children in long-term foster care who have no chance of reunification. This outcome would have a long-term impact on staffing costs.

In each jurisdiction, the self-assessment would include consideration of:

- Demographic profile of the jurisdiction
- Outcome data supplied by the state
- Data from in-depth case reviews
- Client and stakeholder feedback
- Agency characteristics
- Systemic factors (similar to CFSR systemic factors) and interagency collaboration

Following the self-assessment, the local jurisdiction would develop a Child Welfare Plan to maintain performance that meets state standards and strengthen areas needing
improvement. This plan would include a description of how resources would be shifted or new resources obtained, if needed, to most effectively implement strategies to address identified weaknesses in the local assessment. The state would revise budget policies and procedures to provide sufficient flexibility for local jurisdictions to shift a reasonable amount of funding as needed. The state and local jurisdiction would negotiate agreement on the plan, which would have included an opportunity for public input.

The state would develop a state self-assessment for use in the CFSR process by combining and synthesizing 24 local assessments, and assessing factors unique to the state such as centralized information systems, resource development, resource allocation, policies, and technical assistance. The state self-assessment would also incorporate the expanded, enriched outcomes adopted by the state, client, and stakeholder feedback mechanisms, and Quality Service Reviews. In completing the federally-required Program Improvement Plan, the state would include relevant elements of the local improvement plans.

Unreported Child Maltreatment

**Recommendation 13:** Maryland 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.

The Joint Chairman’s Report was interested in knowing the actual incidence of child maltreatment in the State compared to the reported incidence of maltreatment, and the number of cases opened. There is only one widely accepted methodology for determining the actual incidence of child maltreatment, The National Incidence Study. This study, mandated by Congress, was designed and has been undertaken three times since 1979, the most recent having been completed in 1996, by a Maryland research organization. Its goal was to go beyond cases of child maltreatment that come to the attention of the child welfare system and to assess the overall national incidence of child maltreatment.

If the General Assembly wishes to understand the relationship between the actual incidence of child maltreatment, reports to the child welfare system, and investigations of reports, a replication of this study methodology in Maryland should be done every six years.

This study should be used to recommend improvements in the protocols for screening reports of maltreatment and deciding which reports to investigate. It should also assist in identifying inconsistent practice issues across county agencies.

Accreditation

**Recommendation 14:** Maryland 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.

Accreditation establishes a common understanding of requirements for excellence related to management, program/practice, community, and other operational necessities for any agency serving abused and neglected children and their families. It is both instructive and quality-focused for use by policy makers, administrators, practitioners, and the public. Both the state and all county offices should actively pursue national accreditation. Accreditation ensures that certain national standards are met. These standards include staffing issues, clarity of policies and procedures, staff training and qualifications, quality assurance procedures, management, and administrative procedures. Because accreditation is conducted by an outside entity, it avoids the inherent conflict when the state monitors local agencies, or when the state monitors itself. This is a lengthy and time-consuming process that can only be undertaken when direct service and management staff are sufficient to have the time to worry about quality of care. To date, 12 counties have gone through the accreditation process and 11 are accredited. The 12th county will receive the final decision about their accreditation in January.

Federal Fund Maximization

**Recommendation 15:** Maryland should contract for a review of federal funding maximization issues specific to Title IV-E, and the DBM should assure that any new revenues obtained are kept within the appropriate agency to improve services to children and families.

Eligibility for Title IV-E and how costs are allocated to the program are complex processes. Without continuous administrative attention and in-depth knowledge of the federal regulations and challenges to federal interpretations, a state’s federal reimbursement tends to diminish over time. It is time for Maryland to re-examine its policies and procedures related to the Title IV-E program, which is the only open-ended program available to support the child welfare system directly. Because of the complex nature of the requirements, an external review is warranted. It is important, however, that if additional federal funds can be captured through changes in procedures or policies that those new funds remain in the child welfare and juvenile justice systems, rather than used to supplant State expenditures.

Interagency Coordination

**Recommendation 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 (MSDE) should clarify their respective roles with regard to the implementation of the recommendations contained in this report.
Jurisdictions that contribute the highest number of children to out-of-home care must be the first priority for a renewed interagency effort. The role of the Governor’s Office of Children, Youth and Families and the Special Secretary should be evaluated and clarified to address system integration and interagency issues and strategies and to address federal fund maximization strategies across departments. The Office should be charged with addressing interdepartmental issues, policies, laws, and funding that have resulted in service shortfalls, children falling through the cracks, and simply impeded access to needed services. Several child well-being indicators included in the Child and Family Service Review relate to interagency performance, including those related to children receiving appropriate educational, health and mental health services. The Office should be charged with identifying service gaps and shortfalls across the system of services for children and families.\footnote{All of this should be done in accordance with the functions of GOCYF which can be found in the Maryland Manual archives at \url{http://www.mdarchives.state.md.us/rmsa/mdmanual/08conoff/html/07chf.html#office}}

As an integrating agency, GOCYF should undertake an interagency strategic planning process that identifies priorities for services across service systems, and identifies specific cross-systems improvement goals. State agencies tend to operate independently and may be working at cross purposes, or toward different goals that leave children and families in the lurch. GOCYF should help identify where those problems may exist and negotiate problem resolution among state agencies.

GOCYF, in conjunction with other child serving agencies, should examine the State’s CINA laws to determine appropriate referrals to the child welfare system versus to other systems. Maryland’s child welfare system may be unable to adequately serve abused and neglected children due to the “safety net” features of its laws. The child welfare system’s resources are stretched thin from serving voluntary placements, children with mental health problems, children with developmental disabilities, and unruly/delinquent youth, many of whom have no current abuse or neglect issues. If the agencies responsible for serving these children and youth cannot or will not address these issues, children are referred to the child welfare system for services or care. Yet the child welfare system is not funded to adequately meet the needs of children and youth with other types of problems and issues. An interagency solution to this problem needs to be developed\footnote{Two state initiatives, Governor Ehrlich’s Executive Order #01.01.2003.02, issued January 17, 2003, and House Bill 1386 of the 2002 legislative session, mandated a systematic review of the status of interagency services and the needs of children and families who rely on those services, with an emphasis on the issue of custody relinquishment. The Governor’s Office for Children, Youth and Families these two initiatives were integrated and a work group was formed in the Spring of 2003 to meet the combined goals of these mandates. A comprehensive plan was produced and adopted by the Governor in June 2004. A copy of this plan can be found at \url{www.occf.state.md.us}. A prominent strategy woven throughout this plan is the development of a wraparound model for Maryland. In November 2003, the Wraparound Committee was formed.}. 

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Conclusions

The bottom line is that accountability and quality in a child welfare system depends upon that system having the basics in place. Maryland has yet to achieve the basics. When caseworkers and managers have trouble addressing minimum requirements, any attention to overall quality is “hit or miss,” rather than systematic. Without the availability of automated information, managers manage by best guesses and intuition, rather than data and analysis. Priorities and decisions across local agencies are inconsistent and based on any given manager’s or supervisor’s personal priorities or current concerns, rather than on a common vision and operating principles. Performance measurement becomes punitive and accusatory rather than constructive and thoughtful.

If the state truly wishes to have a child welfare system that helps abused and neglected children, is accountable, and provides high quality services, it will have to make a long-term and stable commitment to funding such a system. Critical steps should include building on the strengths of the existing system; developing a new vision and operating principles; ensuring CWLA caseload standards are met; developing a family strengthening practice model; creating a Child Welfare Training Academy; completing the CHESSIE system and contracting for the review of federal fund maximization.

At the same time, the state should be accountable for implementing its child welfare policies and spending the funds it has wisely. Many of the accountability recommendations included in this report will cost money. However, for these recommendations to work, funds committed to improving the system must be permanent, with new funds added over time that build on previous year funding. Maryland’s child welfare system cannot and will not improve with promises of funding that don’t materialize or with mid-year budget cuts or other cost containment efforts. If the Governor and the General Assembly truly desire to have a child welfare system that protects children, provides high quality services to families and is accountable, rather than, at best, average, it will have to invest in the development of that system.
Appendix A
Members of the Task Force and Work Groups

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Delegate Samuel Rosenberg, Maryland General Assembly
Chief Judge Robert Bell, Court of Appeals of Maryland
Secretary Christopher McCabe, Department of Human Resources
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Emily Brosi, The Annie E. Casey Foundation
Appendix B

Outcome Measures
<table>
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<th>Safety Outcomes</th>
<th>Indicators</th>
<th>Short-term Development</th>
<th>Future Development</th>
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<tbody>
<tr>
<td>1. Children are, first and foremost, protected from abuse and neglect.</td>
<td><strong>1A. Recurrence of maltreatment:</strong> Of all children who were victims of substantiated or indicated child abuse and/or neglect during the first six months of the reporting period, what percent had another substantiated or indicated report within a six month period?</td>
<td><strong>1F. Incidence of child abuse and neglect in community:</strong> Maryland replicate the national incidence study methodology to collect a sample large enough to make jurisdictional or regional maltreatment incidence data available for a truer assessment of the scope of maltreatment in Maryland.</td>
<td><strong>1I. Recurrence of maltreatment:</strong> All State agencies that have contact with children or youth who may have been subject to maltreatment (DHR, law enforcement, DJS, and OCYS/LMBs Family Preservation Program) should place their data in a data repository so that it can be used for research.</td>
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<td><strong>1C. Incidence of child abuse and/or neglect in foster care:</strong> Of all children in foster care in the State during the period under review, what percent were the subjects of substantiated or indicated maltreatment by a foster parent or facility staff?</td>
<td><strong>1G. Screening of reports:</strong> The Department of Human Resources should collect aggregate data (with non-identifying information) on all calls not accepted for investigation by the LDSS's and the reason for their being screened out.</td>
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<td></td>
<td><strong>1D. Incidence of child abuse and/or neglect in foster care:</strong> Percent of children in out of home care who were subject of a report of maltreatment disaggregated by type of placement (foster home, kinship care, group care, DJS facility, etc.), and category of finding (ruled-out, unsubstantiated, indicated).</td>
<td><strong>1H. Ruled-out findings:</strong> Prior to expunging of any case of abuse or neglect investigated by a local</td>
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<td>or neglect, within 12 months following permanency (guardianship, Kin-GAP, adoption, reunification).</td>
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<tr>
<td>Disaggregate this data by type of placement and category of finding.</td>
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<td>department of social services, non-identifying information should be preserved and aggregated, including the reason for the finding.</td>
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<tr>
<td>Safety Outcomes</td>
<td>Indicators</td>
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</table>
| 2. Children are safely maintained in their homes whenever possible and appropriate. | **Federal**  
Source: No quantifiable federal measure available; obtained during review of 50 cases statewide.                                                                                                      | **State Enriched**  
2A. Recurrence of abuse/neglect in homes where children were not removed: Percent of children with an allegation (inconclusive or substantiated) who were not removed and whose next event was a substantiated allegation.  
- Subsequent substantiated allegation at 3, 6, 12 months (a) after initial report and (b) after case closure  
- By inconclusive vs. substantiated initial allegation  
- By abuse type  
- By perpetrator  
2B. Recurrence of abuse/neglect in homes where children were not removed: Percent of children with an allegation of abuse and or neglect that was either unsubstantiated or indicated and the children were not removed; but received some type of service from a local department of social services, and for whom there was a subsequent indicated finding. Disaggregate the data by type of service received. |
|                                                                                |                                                                                                                                                                                                            | **Short-term Development**  
                                                                                                                                                                                   | **Future Development**  
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<tr>
<th>Permanency Outcomes</th>
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<tr>
<td>3. Children have permanency and stability in their living situations</td>
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<td>(State modification: without increasing reentry)</td>
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<td>3B. Stability of foster care placement: Of all children who have been in foster</td>
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<td>care less than 12 months from the time of the latest removal, what percent had</td>
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<td>no more than two placement settings?</td>
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<td>3D. Length of time to achieve adoption goal: Of all the children who exited foster</td>
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<td>care during the period under review to a finalized adoption, what percent exited</td>
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<td>care in less than 24 months from the time of the latest removal from home?</td>
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<tr>
<td>3E. Length of time to achieve reunification: Of all children who were reunified</td>
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<td>with their parents or caretakers at the time of the discharge from foster care,</td>
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<td>what percent were reunified in less than 12 months from the time of the latest</td>
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<td>removal from the home?</td>
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<td>3C. Multiple placements: Of those children in an entry cohort, % of those</td>
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<td>remaining in care with 3, 4, 5 or more placements within 12, 24, 36, 48 and 60</td>
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<td>months.</td>
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<td>3A. Length of time to exit foster care: Of those children in an entry cohort, %</td>
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<td>exiting foster care within 3, 6, 12, 24, 36, 48 and 60 months of entry.*</td>
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<tr>
<td>• % exiting to adoption;</td>
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<td>• % exiting to Kin-GAP;</td>
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<td>• % exiting to other guardianship;</td>
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<td>• % exiting to reunification;</td>
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<td>• % exiting to emancipation;</td>
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<td>• % exiting to probation or incarceration;</td>
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<td>• % exiting for other reasons;</td>
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<tr>
<td>• % still in care</td>
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<td>3H. Timely court hearings: Percent of children who have had timely status</td>
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<td>review hearings, stratified by program type and age.</td>
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<td>3I. Caseworker visits: Stratified by program type and visits with child, parents</td>
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<td>and caregivers.</td>
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<td>• Percent of families who received at least monthly caseworker visits.</td>
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<td>3J. Juvenile Justice Involvement: Percent of children in DJS custody who are or</td>
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<td>have also been in DSS custody.</td>
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<td>3K. Permanency Placement: Percent of children who received out-of-home placement</td>
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<td>or in-home service, living in the designated permanent placement one year after</td>
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<td>case closed. (This would be measured on a sample and would require some new</td>
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<td>method of contacting people after case closing.)</td>
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<td>3F. Foster care re-entries: Of all the children who entered care during the year under review, what percent reentered foster care within 12 months of a prior foster care episode?</td>
<td>3G. Foster care re-entries: Of children in an entry cohort, for those exiting to reunification or guardianship, % who re-entered care or DJS custody within 12, 24 and 36 months, stratified by time in care 3, 6, 12, 24 months (48 and 60 months for guardianship) of a prior foster care episode.*</td>
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<tr>
<td>Permanency Outcomes</td>
<td>Indicators</td>
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| 4. The continuity of family relationships and connections is preserved for children. | 4A. Placement with Siblings: Percent of children in foster care, who have a sibling, child, or parent also in care, with whom they are living at the date of report; annual (point in time) by jurisdiction, excluding after-care.  
4B. Use of least restrictive care settings: For children entering care, what is the distribution of placement types?  
• Identify by relative and non-relative placement type  
• Identification by group care or foster home.                                                                                       | Source: No quantifiable federal measure available; obtained during review of 50 cases statewide.                                                                                                         | 4C. Same as 4A but includes half-siblings as well.                        |
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<thead>
<tr>
<th>Child &amp; Family Well-Being Outcomes</th>
<th>Indicators</th>
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| 5. Children receive adequate services to meet their physical, emotional and mental health needs. | Federal: Source: No quantifiable federal measure available; obtained during review of 50 cases statewide. | State Enriched: 5A. Receipt of health screenings:  
- Percent of children in foster care that received a well-child service in the report year, by age breaks, by jurisdiction, and inclusive of both MCO and fee-for-service providers.  
- Percent of children ages 4-20 years in foster care continuously for the previous six months, receiving one or more dental services. | Short-term Development | Future Development |
<table>
<thead>
<tr>
<th>Child &amp; Family Well-Being Outcomes</th>
<th>Indicators</th>
<th>Short-term Development</th>
<th>Future Development</th>
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<tbody>
<tr>
<td>6. Children receive appropriate services to meet their educational needs.</td>
<td><strong>Federal</strong>&lt;br&gt;Source: No quantifiable federal measure available; obtained during review of 50 cases statewide.&lt;br&gt;&lt;br&gt;<strong>State Enriched</strong>&lt;br&gt;6A. Education Information:&lt;br&gt;• For children with an IEP or IFSP, the percent in non-public schools and receiving IEP or IFSP prescribed services.&lt;br&gt;  • For children with an IEP or IFSP, the percent in public schools and receiving IEP or IFSP prescribed services. Specify whether they received none, some, or all of the prescribed services.&lt;br&gt;&lt;br&gt;6B. School Stability: For children in out-of-home care with IEP’s or IFSP’s who attend either public or non-public school, the percent who had:&lt;br&gt;• one school placement during the school year;&lt;br&gt;• two school placements during the school year;&lt;br&gt;• three school placements during the school year;&lt;br&gt;• four school placements during the school year;&lt;br&gt;• more than four school placements during the school year.&lt;br&gt;6C. School Attendance: Percent of children in foster care and kinship care with adequate yearly attendance, less than 20 days missed.</td>
<td><strong>Short-term Development</strong>&lt;br&gt;6D. School Performance: Percentage of children in care performing at the proficient or advanced levels on standardized state tests (requires match to planned statewide education data); stratified by special and regular education (by entry cohort, age and placement type).</td>
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(This would require DHR to give MSDE social security numbers for all children in out-of-home care that were age 5 by December.)
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<th>Child &amp; Family Well-Being Outcomes</th>
<th>Federal</th>
<th>State Enriched</th>
<th>Short-term Development</th>
<th>Future Development</th>
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<tr>
<td>7. Families have enhanced capacity to provide for their children's needs.</td>
<td>Source: No quantifiable federal measure available; obtained during review of 50 cases statewide.</td>
<td><strong>7A. Parent services:</strong> For children receiving in-home services or in out-of-home care for at least 6 months with a plan of return home, the percentage of parents able to access and use support services identified in case plans.</td>
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<tr>
<td>Child &amp; Family Well-Being Outcomes</td>
<td>Indicators</td>
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| 8. Youth emancipating from foster care are prepared to transition to adulthood. | 8A. Transition to self-sufficient adulthood:  
• Percent of youth emancipating from out-of-home care who receive independent living services;  
• Of youth receiving independent living services and emancipating from out-of-home care, the percentage*:  
  - with High School diploma or GED;  
  - enrolled in college or higher education program;  
  - who completed a vocational training program;  
  - are employed or have other means of support  
  - have housing  
  - have health insurance | Short-term Development | Future Development |
Appendix C
Recommendations for Self Assessment Process

Recommended Elements of the Local Assessment
1. Demographic Profile and Outcomes Data (both CWS-FC and general population)
   a. County Data Profile
   b. Caseload demographics
   c. Demographics of general population (Need to identify the demographic data to be included, e.g., level of poverty and other factors known or believed to correlate with varying rates of child maltreatment)
   d. Education system profile including performance of schools and educational outcomes for students
   e. Trend Analysis and projections
2. Performance Data
   a. Outcomes including safety and permanency outcomes and changes/improvements in functioning in areas of well being.
   b. Case Review to measure performance of required functions
   c. Client and Stakeholder involvement and satisfaction
3. Agency characteristics
   a. Size and Structure of Agency
      i. Staffing, organization and interrelationship of Child Welfare Units including caseload ratios (Distinct from and in addition to the overall agency staffing addressed under c. below).
      ii. Relationship of Child Welfare units to other agency components
          Information flow- in particular how does information flow between in-home and out-of-home units
   b. Relationship to/with County government
      i. Social Services Board
   c. Number/Composition of Employees
      i. Staffing characteristics/issues
      ii. Turnover ratio
      iii. Private contractors
      iv. Caseload
      v. Bargaining Unit issues
      vi. Student Units
   d. Financial/Material Resources
      i. Source and Expenditure of Funds by program distinguishing revenue and expenditures for child welfare by function, e.g., CPS. Foster care, etc.
   e. Facilities and Equipment
      i. Office Space – adequacy of facilities to achieve child welfare mission
      ii. Extent of access to needed communications and information technology
      iii. Capacity to use CHESSIE, SAS, SPSS, Business Object, or other software
      iv. Access to information resources- resource directories, COMAR online, internet
v. Adequacy of Transportation

4. Systemic Factors (describe each factor and assess whether it is working as intended)
   a. Relevant Management Information Systems
   b. Case Review System
      i. Court Structure/Relationship
      ii. Process for timely notification of hearings
      iii. Process for parent-child participation in case planning
      iv. Process for older youth participation in case planning
      v. Extent of parent involvement in child’s treatment or in treatment prescribed as a condition for reunification and/or continued involvement
   vi. Citizen Review
   vii. Assessment of needs and provision of services to children, parents, and foster parents
   viii. Evaluation of the adequacy and timeliness of activities required in the case plan, e.g., school enrollment, sibling visitation, medical and dental screening, assessment and treatment, etc.
   c. Foster/Adoptive Parent recruitment and retention
      i. Adequacy of Placement resources and actions to stimulate needed resource development
      ii. Adequacy of supports for foster parents to enhance performance and retention rates
   d. Quality Assurance (QA)
      i. Description of existing county QA system (QA systems should conform to a consistent standard developed or approved by DHR
   e. Service array (composition/issues of service delivery system, are services provided in the Child Welfare unit or outside by a public or private agency)
      i. Physical health
      ii. Substance abuse and mental health services
      iii. Child care and transportation services
      iv. Domestic violence prevention services
      v. Prevention and Family support Services
      vi. Education Services including Special Education and Developmental Services
      vii. Employment development/School-to-work
      viii. Housing Assistance
      ix. Pilot or demonstration projects
   f. Staff/Provider Training
      i. Training requirements for social work staff
      ii. Training for foster parents and relative caregivers
      iii. Adequacy of training in private sector programs with which the agency contracts
   g. Agency Responsiveness to the Community
      i. Collaboration with Public and Private Agencies
         1. Existing MOU’s
         2. Local WIBs and youth councils
         3. Local Management Boards
4. Local School systems  
5. Local Health Departments  
6. Child Fatality Review Team  
7. Core Service Agencies  
8. DJS  
9. DDA  
10. Other  

ii. Responsiveness to stakeholders and the public  
1. Local Review Boards and Child Protection Panel  
2. Consumer Groups Child/Parent/Family Satisfaction  
3. Foster parent, and private provider satisfaction  
4. Collaborating agency satisfaction, e.g., Local School System, Health Department, Local/Regional DJS Office, etc.

h. Local Systemic Factors

5. Summary Assessment  
   a. Discussion of system strengths and weaknesses  
   b. Identification of service gaps and needs  
   c. Identify Priorities

Recommended Elements of the County Improvement Plan
The plan should identify goals to maintain good performance or improve poor performance for each outcome indicator or systemic factor. The following elements should be included in the plan:

- Improvement goals should be specific, measurable and attainable;  
- Strategies that will be used to achieve the goals;  
- Timelines for progress and improvement milestones;  
- Systemic changes that may be needed to achieve goals;  
- Education/ training needs necessary to achieve the goals;  
- Regulatory or statutory changes needed to achieve the goals;  
- Partners and their roles implementing strategy and achieving these goals; and  
- Staff and budgetary resource transfers or additions necessary to achieve these goals

The local assessment teams would include the following representatives, who would also be involved in the local plan:

- Local Department of Social Services (Lead)  
- Local law enforcement  
- Judge, master, or CINA attorney  
- Local Health Department  
- Local Education Authority  
- DJS Regional Office  
- Core Services Agency  
- Substance abuse treatment agency  
- Domestic violence treatment agency  
- Citizens review board  
- Citizens review panel
- Foster parent [or kin caregiver]

**Methods of Incorporating Client, Caseworker and Stakeholder Feedback**
Successful family services engage clients and make them allies and partners to promote desired outcomes. It is incumbent on the self-assessment team to gain a clear understanding of how the child welfare system is serving clients, as well as to identify deficits from the perspectives of clients and stakeholders. There are two levels of feedback that must be obtained:

- **Level 1:** There must be an advisory board to provide feedback on the self-assessment both during the drafting and after a draft is prepared. The board may include additional representatives of the groups listed as mandated members of the Local Assessment Team and should also include the following types of persons:
  - Biological parents
  - Pediatricians or other health providers
  - Mental health providers
  - Child care providers
  - Children recently in care
  - Labor Unions
  - CASA volunteers

- **Level 2:** There must be methods of obtaining information about how casework operates at the frontline. Both *focus groups* and *questionnaires* are acceptable methods and may be used jointly or alone. In each case, however, the content of the information received must cover the results developed by the Outcomes Committee. Questionnaires should be given to families with children in care and to foster families either while the child is still in care or up to a year after the child leaves care so the responses can be as specific and timely as possible. Focus groups of the following groups of people should be convened:
  - Service providers
  - Placement providers
  - Employees from all levels/services of LDSS
  - Community group leaders
  - Religious leaders
  - Local Governing Body
Appendix D
Tool for Thinking About Data

The attached tool was shown to the Task Force when they heard about California’s accountability system. It is useful to use to help think about how different data elements interrelate and affect each other.
Data are Your Friends:  
Using Outcome Information to Improve Child Welfare Services

Any particular measure, viewed in isolation, tells you nothing useful about county performance.

The Cycle of Experiences in the Child Welfare System*


- Start at the beginning (e.g., rate of children with referrals) and examine outcomes around the "cycle of experiences."

- Determine which outcomes (possibly for which subgroups) are "high priorities" and "high performances" within your own county:
  - Examine differences between kin and non-kin placements.
  - Analyze age, gender, and particularly ethnic disparities.

- Review performance trends over time (e.g., you may be a "high priority" county compared to others, but have been steadily improving over the past several years). Consider the relationships between outcome measures.
  - Has the number and rate of entries changed over the past several years?
  - Has this impacted proportion of children reunified within 12 months?
  - Has this impacted the proportion of reunified children who reenter care?

- Identify linkages between outcomes and practice processes.

Process changes lead to outcome changes